Self-labeling Processes in Mental Illness: The Role of Emotional Deviance

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Thomas Scheff's labeling approach to mental illness is based on reactions of others to "residual rule-breaking." This article develops a theory of self-labeling processes to account for the unexplained phenomenon of voluntary treatment seeking. By taking the role of the generalized other, individuals can assess the meaning of their impulses and actions. When individuals observe themselves frequently or persistently breaking "residual rules," they attribute disturbance to themselves and may seek professional help. Drawing from Hochschild and Pugliesi, the article reconceptualizes "residual rule-breaking" as violations of feeling or expression norms. When individuals are unable to manage or transform deviant feelings, self-attributions of disturbance should result. The conditions under which feeling management attempts are likely to fail and result in self-attributions of disturbance are outlined in the context of a more general theory of emotional processes. Some conditions under which labeling by others may occur are also identified, using the same theoretical approach.

Since the publication in 1966 of Being Mentally Ill, Thomas Scheff's labeling, or social reaction, approach to mental illness has suffered a barrage of criticism (e.g., Gove 1980a, 1980b; Cockerham 1979). It is interesting that one of the least criticized aspects of Scheff's approach has been its limited scope of applicability. Scheff (1966) intends his theory to explain "stable or recurring mental disorder" (p. 25) resulting from "particular acts which have been publicly and officially labeled as norm violations" (p. 33; emphasis added). By implication from this statement, Scheff limits his analysis to chronic mental illness resulting from involuntary commitment to treatment.

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Because the majority of mental health clients, both inpatient and outpatient, seek treatment voluntarily and do not become chronically ill (Kadushin 1969; Gove 1980a, 1980b), the applicability of Scheff's explanation of mental illness is quite restricted. My purpose in this article is to expand the scope of labeling theory to account for voluntary treatment seeking for short episodes of psychological disturbance or distress. I will do so by drawing on symbolic interactionist conceptions of the self and self-control and on recent developments in the social psychology of emotion. In brief, I will outline a theory of self-labeling processes in mental illness that incorporates a reconceptualization of disorder as emotional deviance—the outcome of unsuccessful emotion management attempts.

SELF-LABELING PROCESSES

Labeling theory and its parent approach, symbolic interactionism, share the assumption that self-conceptions emerge from and are sustained in social relationships. In particular, Mead (1934) argues that one's sense of self as a meaningful object arises from taking the role of specific and then of generalized others. That is, the individual sees himself or herself as one or more kinds of person, first from the eyes of primary others and then from the perspective of the wider community. More recently, some theorists have termed such self-conceptions "social identities" (e.g., Stryker and Serpe 1982). When one assigns to oneself the same positional designations (e.g., parent, spouse, schoolteacher, mental patient) that others do in social interaction, one can be said to have acquired a set of social identities. Scheff explicitly incorporates these ideas in his labeling approach to chronic mental illness (1966, p. 88).

But these identity-making, identity-taking processes are not always dependent on the actual reactions of others. A crucial symbolic interactionist insight is that social control is largely a product of self-control (Shott 1979). That is, role-taking abilities enable individuals to view themselves from the imagined perspective of others. One can anticipate and respond in advance to others' reactions regarding a contemplated course of action.

These considerations suggest that one can also reflexively assess the meaning of one's actual or contemplated behaviors. Those people who contemplate violating social norms or who engage in actual rule breaking do not depend on the presence and reactions of others to assess the meaning of those actions. They can do so imaginatively or vicariously. In short, public, official labeling of one's rule breaking is not necessary for the emergence of a deviant identity; there can be private self-labeling. Consider these statements of tentative self-labeling from two new mothers: "If after the three o'clock morning feed he had one of those
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gemmy times when he wouldn't settle, I'd get irritable with him and I felt dreadful about it. I said to Stan 'I'm a bad mother,' you know, because I was picking him up and shouting at him and frightening him more'; 'One night I was past myself with it (being up and down with the baby), and I remember I shook him. And I thought 'oh I'm a battering mother' and I cried my eyes out after that' (Graham 1981, p. 48).

Matza (1969) describes the process in this way: "The subject is not simply considering the experience [of a deviant act]. He is considering himself in relation to it. . . . no one else need be there" (p. 120); "He can apprehend himself" (p. 173); "The subject is prepared to be a key witness against himself . . . the subject may draw the conclusion of a deviant identity from the fact of reoccurrence. . . . He has done the damned thing again; therefore, he is essentially, or simply, a thief" (p. 179).

Implicit in the self-labeling processes suggested above are three assumptions. First, the individual who self-labels is a well-socialized actor who, by sharing the cultural perspective of the larger society, can recognize rule breaking or the violation of normative expectations. Second, there are known categories of norms, whose violations carry cultural labels (e.g., ill-mannered, sinful, criminal) that can be applied to persons who perform such behaviors. This implies that for the label "crazy" or "mentally ill" to be applied to the self by oneself (or by others), there must be some degree of cultural agreement regarding the rule-breaking behaviors involved. (This point will be discussed further in the next section.)

The third assumption underlying this discussion of self-labeling processes is that the actor is motivated to conform to social expectations. In particular, there is motivation to adhere to the role expectations attached to the social positions accepted by the actor as identities. From competent identity enactment the individual obtains important social rewards—reflected self-esteem, approval, prestige, power over others, financial remuneration, and so on. Social rewards can be presumed to encourage voluntary conformity to normative expectations.

Given this latter assumption, why would a well-socialized person consider violating, or actually violate, norms and risk reward deprivation or punishment? The answer to this question, I believe, depends on the special nature of the rule-breaking acts associated with mental illness and on the social situations in which such rule violations occur.

MENTAL ILLNESS AS DEVIATION FROM FEELING OR EXPRESSION NORMS

Scheff argues that the rule violations associated with mental illness are unclassifiable, unnameable, or "residual" in nature (1966, pp. 33-34). That is, the norms involved are so taken for granted that only their
violations bring the norms and their transgressors to attention. This argument, however, is contradicted by empirical evidence that stereotyped images of mental disorder do exist (Rabkin 1974) and are reinforced continually in the mass media (Scheff 1966, pp. 64–80). This evidence suggests that “residual” rules are not residual at all, but are, instead, culturally identifiable. In particular, these “residual” rules may be identifiable, at least in part, as feeling and expression norms (Pugliesi 1981). The concepts of feeling norms and expression norms were introduced by Hochschild (1979, 1983).

Briefly, Hochschild argues that emotional behaviors, like other behaviors, are governed by sets of expectations or beliefs. Emotion norms, or feeling rules, indicate the range, intensity, and duration of feelings that are appropriate to given situations. We know what we should feel in a variety of circumstances (e.g., sad at a funeral, lively at a party, happy at a wedding, proud on success, angry at an insult, and so on). Although these rules usually are not codified formally, they are learned and repeatedly reinforced in social interaction. We are all familiar with such phrases as “You must be happy about that,” “You have a right to be angry,” “You should be ashamed of yourself,” “You shouldn’t feel so guilty,” or “It’s time to stop grieving.”

In addition, Hochschild suggests that expression rules—norms that govern the display of emotional reactions—exist. We learn that there are appropriate times and places for and appropriate degrees of emotional expression. For example, we learn that “big boys don’t cry,” that we should keep “a stiff upper lip” in the face of adversity, and that kissing in public is inappropriate.

Pugliesi (1981) draws on Hochschild’s conceptions to suggest that observed violations of feeling or expression rules may trigger attributions of mental illness by others. Pugliesi offers four supporting arguments for this hypothesis.

First, she observes that the terms “mental illness” and “emotional disturbance” are frequently used interchangeably in ordinary interaction. Second, she refers to an examination of the diagnostic criteria used by psychiatric clinicians summarized in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association 1980), which indicates that inappropriate affect or improper affect displays are important indicators of many types of disorders.2

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2 My informal analyses of the diagnostic criteria in DSM-III indicate that inappropriate or socially undesirable emotional states or emotional displays are essential defining features of 45.7% of a total of 210 disorders and “associated features” of 64.8% of these disorders. These percentages would be even higher if mental retardation and organic disorders were excluded. For example, 50.3% of the remaining 153 disorders are essentially defined by affective deviations, and 69.9% have associated emotional disturbances.
Third, Pugliesi notes that psychiatric treatment often concentrates on controlling or changing patients' emotional states through the use of tranquilizing or mood-elevating drugs. Her final argument is that research on attitudes toward, and stereotypes of, the mentally ill consistently shows that they are considered unpredictable and dangerous (Rabkin 1974). Although the bases of these attitudes are not known, emotions, in this culture at least, are thought of as uncontrollable forces that seize helpless individuals—for example, "I was swept away by passion," “I fell hopelessly in love,” or “I was overcome by grief” (Averill 1980; Hochschild 1983). An intense display of inappropriate, seemingly uncontrollable feeling may contribute to observers’ impressions of unpredictability and danger. In sum, these observations suggest that emotional deviance (socially inappropriate feelings or feeling displays) may play an important part in the recognition and labeling of mental illness.

To assess this hypothesis, Pugliesi presents a sample of 140 college students with short descriptive phrases and written vignettes depicting a variety of appropriate and inappropriate behaviors, thoughts, feelings, and emotional displays. Respondents were asked to classify the short phrases as indicators of “ill-mannered, immoral, criminal, strange, psychiatrically disturbed, or normal” conduct. Persons depicted in the vignettes were to be rated on two five-point ordinal scales, from “not at all psychiatrically disturbed” to “very disturbed” and from “not at all dangerous” to “very dangerous.” Several consistencies emerged in the data analysis. Phrases indicating appropriate feelings or displays (e.g., “cries at a sad movie” or “becomes angry at an insult”) were overwhelmingly classified as “normal” by 81.4%–99.3% of the respondents. Phrases indicating inappropriate feelings or feeling displays (e.g., “laughs throughout an exam” or “is indifferent to father's death”) were consistently categorized as “strange” or “psychiatrically disturbed” by 63%–95% of the sample. Phrases indicating cognitive inappropriateness (e.g., “believes s/he is here to save the world” or “daydreams frequently”) and behavioral inappropriateness (e.g., “won't look at person s/he is talking to” or “stares at wall for 15 minutes”) were inconsistently categorized by respondents. Similarly, the main characters in the vignettes were rated as most disturbed and dangerous when they exhibited inappropriate feelings (Pugliesi 1981, p. 54)—independent of the sex and social status of the main characters and the order of vignette presentation. This exploratory study offers some support for the hypothesis that observed emotional deviance elicits mental illness attributions.

Pugliesi focuses on the nature of the rule-breaking acts judged by others as evidence of mental illness. This paper focuses on judgments made by the self on the self. Unfortunately, as far as I know, direct evidence regarding the exact nature of self-judgments made by treatment
seekers is unavailable. However, indirect evidence supports the proposition that self-observed emotional deviance can lead to psychiatric treatment seeking.

An examination of studies of psychiatric treatment seeking reveals an interesting phenomenon. The majority of researchers in this area assume that emotional problems cause people to seek lay or professional help. That is, researchers typically ask respondents whether they have had an “emotional or personal problem” in a past time period or a problem that “bothered” or “worried” them and, if so, whether they sought assistance for it (e.g., Brown 1978; Horwitz 1977; Kessler, Brown, and Broman 1981; Veroff, Kulka, and Douvan 1981). For example, in one of the most extensive and detailed of such studies, respondents were asked if they had sought help for personal problems—defined as being “very unhappy, or nervous and irritable all the time” or having problems with their marriage, a child, or a job (Veroff et al. 1981, p. 78). Instead of exploring the intrinsic nature of the presenting complaints, researchers generally presume their nature with such questions. These presumptions suggest some cultural agreement regarding the underlying cause of voluntary treatment seeking.

An alternative approach used by researchers is to compare the social and clinical characteristics of patients to those of a random community sample of nonpatients. Studies consistently show that those who seek treatment from physicians or psychiatrists are significantly more “psychologically distressed” (for a review, see Goldberg and Huxley 1980). In fact, distress scores are among the most powerful predictors of formal help seeking. It is interesting that psychological distress scales almost always assess feelings of anxiety and depression and/or somatic indicators of such states (e.g., trembling hands, shakiness, fatigue, sleeping trouble). In other words, emotional distress appears to predict treatment seeking. But, again, because these scales presuppose the nature of disturbance by their questions, this evidence still remains indirect.

Surprisingly little research has directly examined the initial presenting problems of psychiatric clients. In fact, I was able to find only three such studies (Kadushin 1969; Gurin, Veroff, and Feld 1960; Veroff et al. 1981). Veroff and his colleagues, repeating the earlier national mental health survey of Gurin et al., find (as Gurin does) that the majority of personal problems for which individuals seek professional help center on interpersonal difficulties. However, note that “personal problems” (as defined above) tie emotional disturbance to such difficulties. In contrast, Kadushin (1969) simply asked people who had sought treatment at psychoanalytic, “religiospsychiatric,” or hospital clinics in New York City why they had gone for help. He reports that 83%, 63%, and 63%, respectively, cited emotional problems (e.g., feelings of anxiety, depression,
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and/or low self-confidence) as reasons for seeking help. A second major type of presenting problem can be classified as social, or interpersonal, in nature (Kadushin 1969). At psychoanalytic, religiopsychiatric, and hospital clinics, respectively, 77%, 74%, and 58% mentioned marital, parental, or occupational difficulties, most often with troublesome affective components (e.g., "I want to care for my children but they get on my nerves. Sometimes I just want to scream" [Kadushin 1969, p. 97]).

In sum, although the evidence is scarce and primarily indirect, emotional problems do appear to be important in the process of self-labeling and psychiatric treatment seeking. But let me add an important qualifier. Self-observed emotional deviance is obviously not the only reason people seek treatment. Some people present cognitive problems (e.g., trouble in concentrating, trouble in making decisions) or performance problems (e.g., repeated failures at school, at work, or in love relationships; see Kadushin 1969). However, evidence indicates that the majority of presenting complaints center on troublesome feelings or on interpersonal difficulties that are usually accompanied by undesirable affect. Emotional problems are not the only reason, but they predominate among reasons for treatment seeking. Consequently, a closer look at the causes and consequences of emotional deviance seems warranted.3

To return to our earlier question, if one is a well-socialized actor and is motivated to conform to rules, how is it possible to ever deviate emotionally? In the next section I will discuss five possible sources of unconventional feelings.

Sources of Discrepant Feelings

For convenient discussion, I will say that individuals who are aware of discrepancies between their private experiences of emotion and the states prescribed by emotional norms are in a condition of "norm-state discrepancy."4 (I will forgo a parallel discussion of "norm-display discrepancy" here for simplicity in presentation.) I will reserve the term "deviance" for discrepant feelings that occur persistently or repeatedly.

First, evidence clearly indicates that certain environmental stimuli (e.g., novel, sudden, threatening, or familiar cues) can trigger spontaneous, automatic reactions that are recognized reliably across cultures through facial expressions as fear/surprise, anger, sadness, revulsion, and

3 Seeking treatment for cognitive or role performance difficulties also implies self-identified deviance from norms—in these cases, norms regarding how one ought to think or perform.

4 When an individual is not aware of norm-state discrepancy, this theory of self-labeling processes is not applicable. Rather, processes of labeling by others should apply (see Schaff 1966; Pugliesi 1981; and see below in this article).
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pleasure (Ekman, Friesen, and Ellsworth 1982; Kemper 1978; Shaver and Klinnert 1982). These spontaneous reactions, when noticed and labeled, may be found to be discrepant from a feeling norm. For example, an initial involuntary reaction to a deformed person is often horror or disgust. This emotional state conflicts with a norm of affective neutrality, or even sympathy, that governs interactions between the handicapped and nonhandicapped (Jones et al. 1984). Phobic reactions, learned from earlier traumatic experiences or parental modeling, still occur despite knowledge that these fears are normatively "irrational" or inappropriate.

Second, one may inadequately or incompletely learn the often subtle, complex associations between bodily sensations, situational cues, and emotional labels and, therefore, experience a discrepancy between what one should feel and what one actually feels (or fails to feel). A person may not be able to locate the internal sensations associated with the situationally required state. For example, it has been suggested that because of differential feeling socialization, women are less able to feel or express anger, and men are less able to feel or display grief and tenderness in situations that normatively call for such feelings (Hochschild 1981, 1983).

Third, situations are complex and multifaceted and contain a variety of possible cues. Individuals may label their spontaneous reactions appropriately according to one set of cues, but these emotions may be normatively inappropriate when other aspects of the situation are considered. For example, one may say, "I always get excited whenever I'm around Pat—I must be falling in love" but also realize that "Pat is my client in therapy."

Fourth, time and memory affect emotional experience. Physiological changes can lag behind new situational demands (Zillman 1978). Previous situational cues may still be salient in consciousness: "I should be having fun at this party, but I'm still depressed over the outcome of that job interview." Emotions are carried over from one situation to the next and, though appropriate in the first context, are inappropriate in the second.

Finally, stress situations can give rise to a discrepancy between feelings and feeling rules. Problems stemming from (1) multiple roles, (2) major role transitions, and (3) structural strains are possible sources of norm-state discrepancy. I will discuss each briefly.

Multiple Roles/Multiple Identities

As noted earlier, people occupy a number of social positions and claim those positions as social identities. Multiple identity enactments can

5 One's degree of commitment to each identity will affect the importance one attaches to discrepant feelings that arise during identity enactment. Discrepant feelings during the performance of roles to which the person feels little commitment will be less likely to be viewed as meaningful for self-assessment. This paper focuses on outcomes of
cause problems of interrole conflict, role strain or overload, and status inconsistency. These conditions create numerous possibilities for discrepant emotional experience.

Interrole conflict.—Multiple roles can require not only incompatible behaviors but incompatible feelings for their incumbents. Employed parents, for example, experience conflict not only over how time should be allocated between work and home, but over feeling expectations. Worry or upset generated by a sick child at home is not only inappropriate on the job but may interfere with job performance. Marital difficulties can also produce feelings that are inappropriate at work, or vice versa. Thus, feelings appropriate in one identity context can carry over into a second context in which they are viewed as inappropriate.

The problem of sociocultural marginality is related to the possession of multiple identities. Individuals socialized in two or more cultural or subcultural worlds may often experience situational feelings appropriate to one cultural context but inappropriate by the standards of another. Jealousy or outrage at sexual infidelity may be expected of spouses in traditional American marriages, but not of spouses who are members of a “swinging” subculture.

Role strain.—Role strain or overload can create another form of norm-state discrepancy. Even when incompatible expectations are absent, multiple demands on time and energy can produce fatigue, which can, in turn, dampen or interfere with emotional responsiveness. In some identity contexts, particularly in family and marital relationships, emotional numbing (e.g., apathy, indifference) is inappropriate.

Status inconsistency.—Some individuals hold a mixture of valued and devalued social identities. Black physicians, male nurses, female managers, and handicapped workers are prototypical examples. Such combinations of statuses can create serious interaction difficulties, as has been pointed out in exquisite detail by a number of sociologists over the years (Hughes 1944; Goffman 1963). When presumably irrelevant identities are made salient by co-workers or clients, the individual may react with anger, hurt, or embarrassment—inappropriate (and often dysfunctional) feelings in a work context.

Role Transitions/Identity Transitions

Normative life-cycle changes (e.g., marriage, birth of a child, retirement, or widowhood) and nonnormative events (e.g., divorce, loss of job, or unexpected family deaths) each entail transitions from old identities to

emotional processing for individuals who are committed to the roles they enact (i.e., where role distance is minimal).
new ones. Normative identity transitions tend to be marked by ritual, to which are attached well-defined expectations regarding feelings. The simplicity and clarity of these feeling norms virtually guarantee one or more instances of norm-state discrepancy because the realities of the ritual transition rarely correspond to the ideals.

For example, although brides and grooms are expected to be somewhat nervous, the predominant expectation is that they be in love, confident, and happy. However, doubts about the depth or lasting power of one's love, exhausting wedding preparations, and angry conflicts with relatives over details of the ceremony are often reported (Hochschild 1983). Bereavement has culturally well-defined periods of mourning beyond which the experience and display of intense grief is inappropriate. But situational reminders of a lost loved one often produce grief reactions long after a mourning period has ended. Childbirth, normatively a joyful event, can generate enduring apathy or depression caused by the massive physiological changes that occur and the exhausting early weeks of infant care. The above are only a few of the many possibilities for discrepant feeling production. Normative identity transitions have several identifiable stages, each of which makes multifaceted and complex demands on the person. Feeling norms for these transitions tend to be clear and general, providing numerous opportunities for discrepant feelings to be recognized by the person undergoing the change.

In contrast to normative transitions, unexpected or unusual identity transitions are not ritualized, and feeling norms for those transitions are not well defined. Separation and divorce, "coming out of the closet," becoming a stepparent, and job loss are examples of transitions that generate strong, often complex sequences of emotion but that lack clear rules for their proper range, intensity, or duration. These changes create a variant form of norm-state discrepancy. The individual may know what emotions are felt but lacks standards against which to judge their acceptability.

Moreover, at a broader cultural level, emotion norms change over time as roles change in structure and function (Hochschild 1983; Gordon 1981). The appropriateness of possessive jealousy, anger in women, vulnerability in men, and love for children has changed historically, often because of major economic shifts. During such cultural transitions, people are likely to wonder whether what they feel is appropriate or inappropriate. Such uncertainties can prompt an individual to seek guidance, a topic discussed in more detail in a subsequent section.

Discrepancies between the Ideal and the Real: Structural Strains
Most often within one identity context, structural conditions generate feelings that differ from those that are normatively required. Hochschild
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(1983) notes that such problems are particularly prevalent among workers in the service sector. Service workers sell not only goods or expertise but also their personalities. This aspect of work may be made more or less explicit by employers ("Keep smiling!"). Flight attendants, for example, are required to be genuinely warm, cheerful, friendly, open, and unafraid of flying. But crowded planes, delayed flights, smoky cabins, risky landings, and angry, disrespectful, demanding, or offensively drunk passengers are recurrent job conditions (Hochschild 1983). The anger, fear, frustration, and exhaustion that are common responses to these conditions make genuine warmth and concern for passengers extremely difficult to feel. Similarly, on the home front, young children (mandatory objects of love) create noise, confusion, mess, and unending demands on parental time and attention. The objective conditions of caring for children often cause feelings far different from love and concern. (In a recent study, 81% of 120 new mothers who were interviewed indicated that they could understand why some parents batter their children [Graham 1981].)

In sum, in spite of social inducements to conform to normative expectations, even well-socialized actors often face structural situations that result in nonnormative feelings (which may be transitory, as in many of the above heuristic examples, or persistent). When aware of such feelings, the individual should anticipate, or imaginatively share, the imminent disapproval of others and the possible loss of valued rewards. Motivated to prevent these possibilities from becoming actualized, the individual can engage in "emotion-work"—efforts to change feelings to fit the normative situation or to justify existing discrepant feelings normatively.6 In the next section, I outline processes by which norm-state discrepancy can be eliminated or reduced then turn to the conditions under which these emotion management processes should be unsuccessful, causing individuals to conclude that they are "going crazy."

EMOTION MANAGEMENT PROCESSES

Hochschild (1981, 1983) has demonstrated through analyses of written accounts by students and in-depth interviews with flight attendants that people notice inappropriate feelings or expressive displays in themselves

6 It has been pointed out by reviewers that some people take pride in professing unconventional beliefs, values, or perceptions. Such stands are individuating; they indicate one's uniqueness (Santee and Maslach 1982). Unconventional feelings should not motivate emotion work in such cases. However, I would argue that individuating stands are most likely when the social costs of such stands are low. When an individuating stand entails little risk of reprisal or when a person has the power or resources to resist sanctions for nonconformity, discrepant feelings are more likely to be retained and cherished than transformed.
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and actively work to bring them in line with social expectations. She terms these efforts "feeling-work." We actively try not to experience or express an inappropriate emotion in particular situations, or we try to induce a proper feeling or feeling display. We shape, induce, or reduce emotions to fit what we believe we ought to experience or express.

Hochschild (1979, 1983) suggests that there are three major ways to change feelings to fit a situation: cognitive, bodily, and expressive. Unfortunately, Hochschild does not fully specify the underlying conception of emotion from which these techniques would follow. However, these processes (and others) can be easily derived from a four-factor associative model of emotion (Thoits 1984).

A Four-Factor Theory of Emotion and Emotional Dynamics

Drawing from previous social psychological work on emotion, I have suggested that a conscious feeling or emotion (interchangeable terms) can be viewed as a package or configuration of four associated elements present in awareness: (a) external situational cues, (b) changes in physiological sensations, (c) expressive gestures, and (d) a cultural label (for a similar four-factor approach, see Gordon 1981). Evidence indicates that the associations between these four elements are learned and reinforced in social interaction (Gordon 1981; Thoits 1984). A useful example can be found in Becker's (1963) classic article on "becoming a marijuana user." The novice user is unable to experience being "high" without the joint occurrence of all four elements of the experience having been pointed out by others. The user perceives relevant situational cues (having smoked a particular substance) and knows the label for this sought-after state (getting "high"), but until the relevant physiological sensations (e.g., dizziness, hunger pangs) and expressive gestures (e.g., giggling, dreaminess) are suggested by more experienced users, the novice is unable to experience the state consciously.7

A caveat is necessary at this point. I do not mean to imply that feelings only occur with cognitive awareness. Ten minutes spent with any infant or two-year-old would quickly disabuse anyone of such a notion. Moreover, cognitive processing of stimuli can be so rapid that emotional reactions seem immediate or automatic. Like others, I assume that many feelings occur spontaneously or automatically in response to perceived situational or internal physiological cues, without much cognitive mediation (Lazarus and Folkman 1984; Mandler 1980; Zajonc 1980). However, only through language do we know what we feel and, implicitly, why

7 It is, of course, entirely possible to be perceived as emotional or in an altered physiological state by others but to be unaware of this oneself (see above).
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(Heise 1979): a cultural label is placed on a conjunction of situational cues, physiological sensations, and bodily gestures. Furthermore, through our culture or subculture we learn elaborated distinctions between feelings. Basic, possibly innate, reactions become refined and distinguishable—fear can be panic, a thrill, or even free-floating anxiety, depending on the degree of discernible physiological change, bodily movement, and variations in situational cues. Although my focus in this article is on that subset of feelings that the individual is consciously aware of, this focus should not be taken as a strict position that “all feelings are socially constructed.”

To explain the process of emotion work, I strongly emphasize the learned and interrelated nature of these four elements. Because situational cues, physiological sensations, expressive gestures, and cultural labels have been repeatedly associated in past experience, it follows that the manipulation of any one can elicit or turn attention to others and thus change the nature of conscious experience. Considerable evidence in the social-psychological literature (under topics such as false physiological feedback, the misattribution of arousal, placebo effects, and facial feedback effects) shows that experimental manipulations of perceived physiological sensations, situational cues, expressive gestures, and cultural labels can each produce measurable changes in subjects’ self-reported feelings and expressive displays (for comprehensive reviews of these different literatures, see Cotton 1981; Reisenzein 1983; Hirschman and Clark 1983; Ross and Olson 1981; Marlatt and Rohsenow 1982; Ekman, Levenson, and Friesen 1983; Laird 1984; Zillman 1978; Scheff 1983). These various strands of research taken as a whole strongly suggest that changes in emotion can be produced from changes in any one or more elements of the packages or configurations that make up emotional states.8

From this four-factor theory of emotion, we can derive not only

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8 The view of emotion proposed here and elsewhere (Thoits 1984) assumes that the same physiological changes can be variously labeled depending on situational cues (consistent with Schachter and Singer’s [1962] formulation and with the findings of the experimental “misattribution of arousal” literature). However, I do add a qualifier. Physiological states of quiescence are unlikely to be labeled with terms associated with arousal, and vice versa. That is, I assume a broad correspondence between general directions of physiological sensations (arousal vs. quiescence) and the situational labels that can be applied (fear or joy vs. depression or fatigue). However, unlike Schachter, I argue that initial arousal is not necessary for an emotional experience to occur. Past associational learning of feeling elements enables the presence of only one element of a configuration to elicit or turn attention to the others. Probably the most powerfully evocative elements are situational cues and gross physiological changes because these are the basic elements of spontaneous reactions, but sheer expressive role playing of an emotion or an emotional label’s suggestion to an individual can also result in conscious emotional experience.
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Hochschild's (1979) three methods of emotion work but other techniques as well. If one assumes that a person can alter elements of an emotional configuration behaviorally or cognitively, six emotion management or emotion transformation techniques are derivable as summarized below:

<table>
<thead>
<tr>
<th>Feeling Element</th>
<th>Manipulation</th>
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<tbody>
<tr>
<td>Situational cues</td>
<td>(a) Behavioral or (b) cognitive</td>
</tr>
<tr>
<td>Physiological sensations</td>
<td>(a) Behavioral or (b) cognitive</td>
</tr>
<tr>
<td>Expressive gestures</td>
<td>(a) Behavioral</td>
</tr>
<tr>
<td>Cultural label</td>
<td>(b) Cognitive</td>
</tr>
</tbody>
</table>

The most obvious and straightforward technique is to directly alter the situational circumstances perceived to induce a discrepant feeling. One can actively avoid or leave the situation, replace certain situational features with others, or construct entirely new situations. Phobics avoid the objects of their fears. A therapist inappropriately in love with a client can terminate the therapy and retain the love relationship. Bored married couples may retreat to a romantic setting in order to rekindle mutual sexual attraction. Dissatisfied workers can change jobs. However, the use of this emotion management technique is usually possible only for persons with situational power or resources. Consequently, most people are likely to use other techniques to eliminate or reduce norm-state discrepancy.

Situational features can be altered cognitively instead. Situations can be reinterpreted to seem less threatening or problematic and, therefore, to elicit less intense undesirable affect. When confronted by an offensively angry or drunk passenger, for example, one of Hochschild's flight attendants reports, "I try to remember that if he's drinking too much, he's probably scared of flying. I think to myself, 'he's like a little child.' Really, that's what he is. And when I see him that way, I don't get mad that he's yelling at me. He's like a child yelling at me then" (Hochschild 1983, p. 55). Similarly, individuals facing major financial or job strains can devalue the importance of money or job satisfaction or shift comparisons to others less fortunate than themselves (Pearlin and Schooler 1978). Alternatively, situations can be reinterpreted to allow an individual to retain an existing emotional state and see it as appropriate. For example, "I shouldn't be so angry with my two-year-old for breaking that vase. But he's been getting into trouble all afternoon—I have a right to lose my temper." Ignoring or using distraction are other cognitive techniques. One can concentrate on listening to Muzak, for example, to block out the sound or effects of the dentist's drill. Cognitive manipulations of the situation, then, can alter the meaning of cues that elicited a discrepant state in the first place or remove attention from them.

Physiological sensations can be deliberately manipulated as well.
through the use of drugs, alcohol, coffee, cigarettes, deep breathing, or exercise. By acting directly on sensations to induce the arousal or quiescence associated with a desired normative state, one alters a crucial element in the experience of feeling, enabling its reinterpretation. This technique lessens undesirable reactions or replaces them with normative states.

One can alter physiological sensations cognitively instead, although this technique requires considerable concentration and effort; biofeedback is one example. It is possible to rescann bodily sensations for those associated with an appropriate state. The sheer expectation that appropriate internal sensations will exist can elicit those sensations, and selective attention, in turn, can strengthen them. Research on expectancy effects, particularly placebo effects, confirms the ability of expectations to generate actual physiological changes (see Ross and Olson 1981; Marlatt and Rohsenow 1982).

A simpler technique consists of manipulating expressive gestures—what Hochschild (1979) has called “expressive emotion work.” One can exhibit an appropriate emotion or disguise an inappropriate one through the alteration of observable gestures, such as facial expressions, body movements, and tones of voice. It is interesting that, when prolonged, such playacting can generate internal sensations associated with the displayed state and can refocus attention on alternative situational features. “Surface acting” can become “deep acting” or genuine feeling (Hochschild 1983). (This technique is used by actors following the Stanislavski method [Stanislavski 1965].)

Finally, one can cognitively alter the label for an existing state, transforming a nonnormative feeling into a normative one. An appropriate label is simply cast over the existing configuration of feelings in the situation: “I just learned that my father died. I should be upset, but I feel nothing. I must be in shock.” One scans the range of feelings normatively permissible in the situation for an alternative that may fit one’s existing state—“I’m not depressed, just tired.” However, this technique is probably limited to cases in which the discrepant physiological and expressive changes experienced by the person are in the same general direction as the sensations associated with a required state. For example, it would be difficult to cast an appropriate arousal-state label over existing quiescent or depressed-state feelings (see n. 8).

In sum, behavioral and cognitive techniques are available to alter one or more elements of an inappropriate emotional state so as to bring it in line with situational requirements or to align situational features with an existing state. These derived emotion management techniques are supported by extensive experimental literatures that demonstrate the
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manipulability of feelings (Thoits 1984) and have been extensively documented in Hochschild’s (1983) interview and observational studies (see also Frude and Goss 1981).9

Emotion management techniques enable individuals to transform discrepant feelings into normative ones. However, under certain conditions these techniques may fail. When discrepant feelings are resistant to transformation, individuals are forced to confront the meaning of their unconventional feelings. The next section explores the conditions under which emotion-work attempts are most likely to be unsuccessful.

CONDITIONS UNDER WHICH EMOTION MANAGEMENT TECHNIQUES FAIL

Two conditions seem to be crucial in predicting emotion-work failure: the persistence or recurrence of discrepancy-producing situations and the lack of “social support.”

Many situations in which discrepant feelings occur are transitory and nonrecurrent. In such cases, discrepant feelings can be ignored, disguised through expression work, or, when they occur during the enactment of important identities, transformed through emotion work. No implications for the self should be drawn from such transitory experiences.10 However, when situations producing discrepant feelings are prolonged or frequent, those feelings cannot be dismissed easily. If one is confronted with frequent evidence of one’s failure to live up to emotional expectations, self-attributions of deviance or emotional disturbance are then likely.

The most probable source of persistent or recurrent discrepant feelings are stress situations—problems stemming from multiple role occupancy, major role transitions, or structural strains. In particular, major changes of or recurrent strains in important identities are likely to produce strong discrepant feelings that are difficult to reduce or transform over the long run. For example, unemployment confronts the individual with unrelenting and undeniable difficulties stemming from identity loss and low income, continuously or repeatedly renewing the necessity for emotion

9 It is important to note that these emotion transformation techniques are similar to what the stress literature calls “coping.” I have argued elsewhere (Thoits 1984) that these techniques of emotion management help specify more general classes of coping response (e.g., problem-focused, emotion-focused, and perception-focused coping [see also Lazarus and Launier 1978; Pearlin and Schooler 1978]).

10 In rare cases, individuals may attribute disturbance to themselves on the basis of one intense experience of emotional discrepancy, bypassing attempts at emotion management entirely. Lashing out angrily at someone or extreme emotional reactions while under the influence of drugs, e.g., may cause immediate self-labeling (Darley 1983).
management efforts and often defeating them. Reinterpreting the situation and/or altering feelings with, say, alcohol can go only so far in reducing or eliminating emotional reactions to these stressors. In short, emotion management attempts are most likely to fail when stress situations involving important identities are persistent or recurrent. Substantial evidence, in fact, indicates that major life events and chronic role strains can produce serious psychological distress and impairment (e.g., Pearlin 1983; Thoits 1983). However, here an important problem emerges.

Stress situations usually produce negative feelings: upset, tension, anxiety, or, in cases of loss or failure, depression. One might argue that such stress reactions are expected, appropriate, normal, and thus normative reactions to difficult circumstances. One would not expect attributions of deviance to be drawn from such feelings. However, two considerations suggest otherwise. First, recent evidence indicates that prolonged or recurrent negative feelings are viewed by others as socially undesirable (Averill 1978; Sommers 1984a, 1984b). When persons are portrayed as usually in negative moods (e.g., angry, sad), they are rated by others as both unconventional and unlikeable (Sommers 1984b). There may be a cultural norm against prolonged negative feelings in general—we ought not to be persistently unhappy, upset, anxious, or depressed, regardless of circumstances. Second, no matter how appropriate they are, negative feelings can have socially undesirable consequences. Displays of negative affect can disrupt ordinary interaction, eliciting either sanctions or withdrawal from others (Coyne 1976a, 1976b; Coates and Wortman 1980). Strong unpleasant arousal also can disrupt the concentration, skill, or motivation necessary for the performance of identity-related activities; that is, intense affect can impair role functioning (e.g., Wright and Mischel 1982; Sarason 1975; Isen et al. 1978). These potential (perhaps actualized) problematic consequences make even expected, normative reactions to stressors both personally and socially undesirable and, therefore, inappropriate. Individuals who face persistent stressful circumstances are likely to assess their persistent reactions as evidence of deviance.

Luckily, individuals can often compare themselves with or refer to others who are subject to similar conditions or who have experienced the same stressors in the past. We compare not only our opinions, abilities, or behaviors with those of others but our feelings as well (Schachter 1959; Shaver and Klinnert 1982; Kadushin 1969). Comparison is particularly likely when standards are unclear or problematic, as they are during periods of nonnormative role transition or cultural change. In fact, the need for emotional comparison may be responsible for the popularity of voluntary self-help associations such as Parents without Partners, Recovery Inc., widows' groups, divorce groups, and so on.
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Others who are currently or have in the past been subject to the same changes or structural strains perform a very important set of functions for individuals faced with their own apparent emotional deviance. These functions are what I believe is meant by “social support.”

First, others can validate one's deviant reactions. By validate, I do not mean that others can legitimize those feelings or make them normative (although this can happen). I mean that others can confirm that those feelings have understandable origins in objective conditions. Individuals are reassured that their feelings have some objective bases because others have also experienced them and can point to their causes, even though everyone may recognize the normative inappropriateness of those feelings. This function of social support is typically called “understanding” and “acceptance”—one receives empathy or sympathy from others (for relevant examples, see Weiss 1976).

Second, validation of deviant feelings, even when those feelings are culturally uncondoned, can somewhat reduce self-disapproval. Because others have had similar feelings, one is less deviant than one might have thought originally. This function of social support “bolsters self-esteem.” More accurately, it may reduce self-condemnation for deviance.

Third, and most important, others can aid in the individual's emotion-work efforts. They supply a drink or a drug, a new job or a vacation, a distracting joke or social occasion; they reinterpret the situation or one's emotional state; or they help expression-work performances along. In short, socially supportive others can suggest emotion-work techniques or augment one's emotion-work efforts by active participation, providing what we recognize, respectively, as “advice” and “socioemotional aid.” Thus, social support can be reconceptualized as emotion management assistance, or coping assistance (Thoits 1984).

The presence and assistance of others who have experienced similar situations reduce the likelihood of self-attributions of mental illness. One is not “going crazy” after all but reacting as others have to objective situational stressors. Further, the effects of those stressors can be minimized or eliminated with the assistance of others. That is, one's emotion-work efforts, sustained by the help of others, are more likely to succeed over the long run.

11 In some cases, social support can generate new feeling norms. That is, validation of deviant feelings may become legitimation of those feelings as not only understandable and normal, but normative. The conditions under which the legitimation of feelings occurs would require an additional article, so they are not dealt with here in detail. However, prolonged contact between similarly affected individuals, a threshold number of such individuals, ineffective threats or incentives from external authorities for conformity, and perhaps a charismatic spokesperson may be required. Shared deviant feelings may be important in the transformation of similar others into counternormative peer groups, deviant subcultures, and social movements.
Self-labeling Processes

The unavailability of support, then, should have important consequences for self-attributional processes. Without support, there is no validation for prolonged or recurrent discrepant feelings and no help in transforming them. Individuals are more likely to believe that their feelings are unusual and wrong, to suffer self-condemnation, and to conclude that they are disturbed. The availability of social support should reduce the probability of mental illness attributions; lack of support should increase their probability.

It is important to note, however, that in many cases social support can increase the probability of self-labeling. For example, individuals often solicit advice from others about emotional problems in order to confirm their own tentative self-labeling and treatment-seeking decisions (Kadushin 1969). Moreover, others, on their own initiative, may attempt to aid the individual not by validating feelings and/or helping to transform them but by interpreting the meaning of persistent feelings as evidence of disturbance (a type of cognitive feeling reinterpretation) and by urging professional assistance. That is, others may label the individual as disturbed and advise obtaining more expert emotion management assistance than they themselves can offer. This informal labeling by others appears to precede mental health utilization for a large majority of distressed persons (Kadushin 1969; Horowitz 1977; Yokopenic, Clark, and Aneshensel 1983). It is possible that such informal labeling occurs when the individual is highly distressed over long periods of time. That is, there may be an interaction between the availability of support and the individual's distress level that affects the probability of self-labeling. At relatively low levels of persistent distress, others' emotion management aid may decrease the probability of self-labeling; at relatively high levels of distress, others' help may increase its probability (compared with probabilities when emotion management assistance from others is unavailable). However, there is a fine line between supportive labeling and coercive labeling. That line would seem to depend on the individuals' perceptions of others' intentions and their acceptance of others' interpretive attempts. If such labeling is resisted by the individual, reinterpretations offered by others may be seen charitably as ineffectual attempts at social support but, more accurately, as coercive labeling by "informal agents of social control."

In sum, structural features of conventional identity enactments provide numerous opportunities for discrepant feelings to arise. When these instances are infrequent and transitory, discrepant feelings can be ignored, disguised through expression work, or transformed through the use of one or more techniques of emotion management. No self-implications from such experiences should be drawn. However, when such instances are recurrent or prolonged, the transformation of emotional reactions be-
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comes much more difficult to sustain, particularly for those who lack social support. The person is confronted repeatedly or persistently with the necessity for and only the temporary success of emotion-work efforts. The person is likely to conclude that "something is seriously wrong with me" and that this "something" is psychological in nature. Professional psychiatric assistance is then likely to be sought and sought voluntarily. Before turning to the issue of psychiatric treatment, however, I will discuss briefly how emotion-work efforts can go awry.

MISCARRIAGES OF EMOTION MANAGEMENT ATTEMPTS: LABELING BY OTHERS

Deviant feelings in response to persistent stressors may cause the individual to overuse or misuse major techniques of emotion work. Paradoxically, desperate attempts to conform emotionally can miscarry, resulting in evidence of deviance perceived only by others and not by the self.

The most obvious possibility is the overuse of stimulants or depressants to manipulate physiological sensations and, consequently, emotional states. In the worst case, overuse may result in physical addiction. In the intermediate case, inappropriate (and dysfunctional) behaviors may occur repeatedly. In both cases, the ability of the individual to make self-assessments may be impaired. Overuse of physiological manipulations, then, may more often result in labeling by others, instead of by the self.

Overuse or misuse of cognitive reinterpretations can also result in labeling by others. An emotional state may be recodified in ways discrepant with what others observe. A person who claims no affect yet displays evidence of intense angry feelings is an example. When coupled with disconfirming displays, we recognize these statements as indicators of denied or unconscious feelings. Recurrent disruptions in interaction caused by the apparent discrepancy between what people claim to feel and what they display may lead others to attribute mental illness.

Relatedly, one may reinterpret a situation in ways that lead others to question one's sanity. This can occur when a labeled state has persisted in the individual's experiential awareness but the causes of that state are obscure or have been forgotten. Grief reactions on the anniversary of a death or of an abortion are examples. To justify these seemingly inappropriate reactions, people may construct reasons that satisfy themselves but leave others unconvinced, mystified, or perhaps offended. Zimbardo (1981) has demonstrated this phenomenon empirically. Subjects who were made temporarily deaf through hypnotic suggestion and were unaware of the cause of their affliction interpreted their inability to hear ongoing conversations as evidence that others were conspiring against them. Paradoxically, a rational search for an explanation for a deviant
state can generate "irrational" (i.e., unshared) beliefs, which in turn can provoke mental illness attributions by others.

One other emotion-work technique can miscarry. Hochschild (1983) notes that repeated or prolonged expression work led many flight attendants to complain of self-alienation or self-estrangement ("playing robot"). Estrangement was accompanied by lack of feelings: "I wasn't feeling anything. It was like I wasn't really there. The guy was talking. I could hear him. But all I heard was dead words" (Hochschild 1983, pp. 187–88).

Prolonged role-playing is often carried over into other areas of life. Emotional numbing caused by the replacement of spontaneous reactions with feigned ones affected subsequent abilities to "let go" in intimate relations (Hochschild 1983). In these cases, attendants themselves were aware of and unhappy about a discrepancy between how they felt and how they ought to have felt (and many sought psychiatric help). But if carried to an extreme, statements of self-estrangement ("I'm really dead") in conjunction with numbed responsiveness might result in attributions of serious mental illness by others. Laing (1965, 1969) has offered an interpretation of schizophrenic symptoms that is consistent with this possibility.

In sum, I am suggesting that overuse or misuse of certain emotion management techniques may result in behaviors, beliefs, and/or expressive displays that lead others to attribute more serious forms of disorder to the individual. Inclusion here of aberrant behaviors and irrational beliefs as symptoms of mental illness may seem inconsistent with the main thesis of this paper. However, as mentioned earlier, emotional deviance is not the only symptom of mental illness. Delusions, hallucinations, and deviant behaviors are cultural and clinical indicators of more serious disorders. However, it is significant that these symptoms are often accompanied by displays of affect (or lack of affect when affect might be expected). In DSM-III, unusual behaviors, thoughts, and sensory perceptions classified as evidence of more serious disorder (e.g., drug dependence, paranoia, schizophrenia) almost always have deviant emotional states as additional defining features or as associated features of the disorder (APA 1980). I have suggested that these nonaffective symptoms may be products of ordinary emotion-work processes gone awry. Deviant feelings may no longer be the most obvious or proximate symptoms in such cases; thoughts or actions taken to change them may be the most visible and disturbing to others.

PSYCHOTHERAPY: THE PURCHASE OF SOCIAL SUPPORT

When emotion management attempts repeatedly or persistently fail and others are unavailable to offer support, individuals who are aware of
these failures are likely to conclude that they are inadequate, distressed, disturbed, having nervous breakdowns, unable to cope, going crazy—in short, that their deviant feelings are symptoms of psychological difficulties. Such persons will be motivated to seek professional help. Depending on a variety of social and economic factors that further facilitate or hinder treatment seeking (see Mechanic 1978), they will make voluntary contact with mental health professionals.¹²

According to Scheff (1966), treatment by “official agents of social control” should initiate interaction processes that result in stable careers of mental illness. However, as noted earlier, most psychiatric clients, both voluntary and involuntary, do not become chronically ill (Gove 1980a). The reason for this, I would argue, is that mental health professionals (who here can include clergy, social workers, marriage and family counselors, psychologists, and psychiatrists) help individuals understand their feelings and aid in restoring consistency between those feelings and situational norms. That is, mental health professionals are in the business of providing effective social support.

It is revealing to note that different schools of therapy advocate techniques that correspond broadly to major types of emotion work described here. Radical therapists emphasize altering situations directly. Rational-emotive therapists, and to some extent psychoanalysts and psychodynamic therapists, focus on situation and feeling reinterpretations. Psychiatrists augment their favored techniques with mood-elevating or tranquilizing drugs, thus changing physiological sensations directly. Biofeedback and progressive desensitization therapists aid in cognitively changing physiological sensations. Psychodrama experts, and to some extent behavioral therapists, encourage expression work or proper displays. Paradoxical therapists reinterpret emotional states (e.g., hate is really evidence of love). Eclectic therapists use a combination of techniques from various schools.

Some schools of therapy do not emphasize specific management techniques but primarily perform other major social support functions. Client-centered therapy, for example, validates and accepts the individual’s deviant feelings, reducing self-condemnation and weakening self-attributions of deviance. Gestalt and primal scream therapists encourage “backstage” ventilation of deviant feelings—another form of validation and acceptance.

¹² It is often noted that low-income individuals delay treatment seeking until their conditions have deteriorated seriously. It is possible that, in lieu of treatment, such individuals resort to the overuse of emotion management techniques, increasing the probability that others eventually will identify disturbance and force the individual into treatment.
Self-labeling Processes

Obviously, the therapeutic techniques taught by various schools involve much more complex processes than those suggested here. To describe them more completely would require another paper. Although therapists are more selective, deliberate, and cogent about their methods than are laypersons, the functions and goals of therapy and social support appear to be the same.

It is well known that psychotherapy produces minor or very modest measurable improvements in client functioning and that no particular schools of therapy or therapist characteristics strongly predict client outcomes (see reviews in Garfield and Bergin 1978). Despite these findings, the majority of former clients report that they were helped by and satisfied with their treatment experiences (e.g., Veroff et al. 1981). I suggest that voluntary clients most often find in therapy what they seek: effective social support. Quite literally, therapists help clients to "feel better," that is, to feel normatively again. Stable careers of mental illness are rare among such clients because therapists validate and make sense of deviant feelings and help change feelings or situations, thus reversing the self-attributions that led the individual to treatment in the first place.

However, it seems likely, as Scheff (1966) has argued, that chronic mental illness can result from involuntary commitment. In involuntary cases, the therapist's task becomes much more difficult. Clients must first be convinced of their deviance before patterns of coping that have resulted in serious symptoms can be altered. Resistance to such persuasion (Frank 1961) may be high, particularly if clients have intense angry feelings because of perceived betrayal by others in the process of commitment (Goffman 1961). These persons, in contrast to Scheff's further contentions, may never define themselves as mentally ill or as mental patients yet remain mentally ill according to the criteria used by significant and professional others.

SUMMARY AND CONCLUSIONS

I began with the observation that Scheff's (1966) labeling theory of mental illness could not account for instances of voluntary treatment seeking or for short episodes of disturbance, both of which are characteristic of the majority of mental health clients. The theory of self-labeling processes presented here attempts to explain these phenomena, drawing on symbolic interactionist assumptions similar to those underlying Scheff's approach. Individuals can self-label because they are able to observe and classify their behaviors, thoughts, and feelings from the perspective of the wider community. However, this effort goes one step further. I reconceptualize Scheff's concept of "residual rule-breaking" as emotional deviance and suggest the origins of that deviance by using a four-factor theory of
emotional processes (Thoits 1984). In brief, I have argued that persistent or recurrent emotional deviance in the course of identity enactment or identity change will cause individuals to attribute psychological disturbance to themselves, which in turn will motivate help seeking. Although emotional deviance may not be the only source of such self-attributions, I would argue from the available indirect evidence that it is one of the most common sources (Kadushin 1969; Gurin et al. 1960; Veroff et al. 1981; Goldberg and Huxley 1980).

Four major qualifiers are necessary to complete this commentary. First, although I argue here that persons interpret their persistent or recurrent emotional deviations as psychiatric symptoms and attribute mental illness to themselves, I do not mean to imply that such persons take on this identity as a "master status" (Hughes 1944). Before seeking treatment, such self-attributions may be equivalent to trait descriptions of the self ("I'm open, friendly, a little nuts . . .") or may serve to qualify other identities ("I'm a crazy housewife," "I'm a troubled student"). After the client has entered treatment, such self-descriptions may be transformed into an identity ("I'm a patient at the counseling center"). But an identity as patient or client is only one of many identities a person can hold. Furthermore, commitment to a patient identity is likely to be low because this identity is culturally thought to be somewhat negative or shameful (Rabkin 1974), although less so now than formerly (Gove 1980a, 1980b; Veroff et al. 1981).

However, even when others are aware of a patient identity, it rarely overrides more conventional aspects of individuals in ordinary interaction (except, perhaps, when they are visited in mental hospitals). Not only has it become more acceptable to enter psychiatric treatment (Veroff et al. 1981), but, more important, the voluntary nature of that treatment seeking reduces its significance for others. Voluntary treatment implies that the person is under self-control (although, ironically, it was perceived lack of self-control that sent the person to treatment in the first place). Professionals also are most likely to stress the temporary, understandable, and alterable nature of the patient's symptoms, further discouraging self-perceptions of an overriding mental patient identity.

Second, the heavily cognitive aspects of the processes outlined in this article need some tempering. They have been necessarily exaggerated for purposes of clarity. Individuals probably rarely say to themselves explicitly, "I should be sad that my spouse died; I'm furious at him instead. I wonder if I am going crazy." Instead, feelings, norms, and discrepancies between the two are probably noted without detailed internal commentary—most often in partial thoughts, rapid sequence of images, and glossed processing of internal and external cues. However, I do emphasize that for attempts at emotion-work to be made and for self-
attributions to be drawn, persons must be consciously aware of recurrent problematic gaps between their feelings and normative expectations and have some idea of what these gaps signal. A person may simply conclude that "something's wrong with me" without verbally formulating in exact terms what that something may be. That person's appearance at the doors of a mental health agency indicates that this "something" has been at least partially identified in imagery, if not in words.

In relation to this last point, the term "mental illness" would also seem to need some tempering. Obviously, in this article, I deal primarily with milder degrees of disturbance, with what psychiatrists might recognize as neuroses or situational stress reactions (the latter now termed "adjustment disorders" in DSM-III). These are all instances in which reality testing is relatively intact. Moreover, individuals who are aware of recurrent emotional deviance are more likely to describe themselves in the gentler, more euphemistic terms provided by the culture—one is "unable to cope," "having a nervous problem," "under too much stress," "overreacting," and so on. "Mentally ill" has more severe connotations—"insane" or "psychotic" comes to mind. Despite these connotations, I have used mental illness as a heuristic term, intending it to cover a broad range of mild to severe disorders. I have done so because I believe that a wide range of deviations should be explainable as variations of the same processes—processes that underlie "normal," conforming behavior as well. I have argued that many minor and major disorders may represent failures of emotion management techniques—in the first instance, failures to convince the self; in the second, failures to convince others of one's emotional normality.

Third, because symptoms of mental illness and physical illness share many characteristics, it is important to note that self-attributions of physical illness may be made first, leading individuals to physicians rather than to mental health professionals for initial treatment. Both physical and mental illnesses can involve unpleasant physiological and bodily changes. Symptoms of both are experienced as uncontrollable and, to some degree, as induced by some agent other than the self (Horwitz 1982, pp. 25–29). Self-attributions of sickness often precede attributions of psychological disturbance (Mechanic 1978). When organic causes cannot be found, or when symptoms are unresponsive to medical intervention, physicians may assist in altering assessments of the meaning of these discomforts. Thus, on many occasions there are intermediate steps in the processes of mental illness self-labeling (Goldberg and Huxley 1980).

Fourth, and finally, it is well known that there exist cultural and subcultural differences in the degree of attention paid to bodily states and in the interpretations made of these states (Gordon 1981). Variations in attention to, codifications of, and preferred techniques for manipulating
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feelings by gender, ethnicity, age, and social class are likely (see Zborowski 1952; LaBarre 1947; Zola 1966; Hochschild 1981; Pennebaker 1982). Nevertheless, when individuals are committed to competent identity enactment and aware of discrepancies between their situational feelings and normative expectations (which may be subculturally specific), emotion-work attempts should follow and self-attributions of deviance should result from persistent unsuccessful attempts.

REFERENCES


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