DEVIANCE AS PERFORMANCE: THE CASE OF ILLNESS*

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The labeling theory of deviance, proposed originally by Lemert in *Social Pathology,* and developed by him and a growing number of sociologists,[1] has shifted attention away from the individual attributes of the deviant and focused attention on societal reaction to those attributes. In this theory, deviance is seen not as a psychological or physical flaw, but as the outcome of a social process which involves conflicting values of social groups, a social language of labels, social reactions and expectations.

The emphasis on how and why and with what consequences certain groups come to label certain behaviors as wrong, abnormal, to be punished, treated, or controlled, has been an antidote to the clinical interpretation of deviance. The latter concentrates on the characteristics of the *deviant.* The labeling approach concentrates instead on the characteristics of the *controllers* —the formal and informal agents of social control who ferret out, define, and do something about a certain kind of activity. The labeling approach tends to ignore the motives or intentions of the deviant.

This theoretical bias of the labeling approach has helped form a more purely sociological analysis of deviance and social control. Neglect of the deviant, however, while possibly justified operationally, creates large gaps in the study of deviance. Using as data the social labels only and omitting the activity, intentions, or self-view of the individual deviant make it impossible to distinguish between the falsely accused and the true deviant, and between the truly innocent and the hidden deviant. The argument of the situational theorists would be that the distinction is immaterial, that only the social label matters, not what the individual thinks or does—the mental patient in on a bum rap undergoes the same institutionalization as the genuine schizophrenic;[2] the hidden homosexual is not a social problem.[3] Only that behavior which *others* label as deviance is salient.

If the labeling theory is strictly applied, secret deviance must be excluded. As it is hidden, it is unlabeled, and as it is unlabeled, it is socially non-existent. Nevertheless, Becker's analysis of marijuana users in *Outsiders* discusses secret deviance,[4]

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[1] Edwin M. Lemert, *Social Pathology,* New York: McGraw Hill, 1951; Edwin M. Lemert, "Social Structure, Social Control, and Deviation," *Anomie and Deviant Behavior,* in Marshall B. Clinard (ed.), New York: The Free Press of Glencoe, 1964, pp. 57-97; Howard S. Becker, *Outsiders: Studies in the Sociology of Deviance,* New York: The Free Press of Glencoe, 1963; Howard S. Becker (ed.), *The Other Side: Perspectives on Deviance,* New York: The Free Press of Glencoe, 1964; Edwin M. Schur, *Crimes without Victims: Deviant Behavior and Public Policy,* Englewood Cliffs, N.J.: Prentice-Hall, 1965; Jane R. Mercer, "Social System Perspective and Clinical Perspective: Frames of Reference for Understanding Career Patterns of Persons Labelled as Mentally Retarded," *Social Problems,* 13 (Summer, 1965), pp. 18-34; Eliot Freidson, "Disability as Social Deviance," *Sociological Theory, Research, and Rehabilitation,* in Marvin B. Sussman (ed.), Washington: American Sociological Association, 1966; Thomas J. Scheff, *Being Mentally Ill: A Sociological Theory,* Chicago, Ill.: Aldine Publishing Company, 1966.

[2] Erving Goffman, *Asylums,* Garden City, N.Y.: Anchor Books, 1961, pp. 127-69.

[3] Schur, *op. cit.,* p. 107.

[4] Becker, *Outsiders, op. cit.,* pp. 66-72.

and other proponents of the labeling theory would no doubt regret the arbitrary omission of this category of deviance from sociological research.

The problem of combining the notion of secret deviance with the concept of deviance as something created by labeling can be solved by introducing the deviant into the social process of labeling. Hidden deviance implies that even though his social group assumes his innocence, the deviant either sees himself as doing wrong according to his own reference group, or, condoning his own behavior, he realizes that others will condemn his actions according to their standards. In either case, to avoid the consequences he feels will occur if his deviance comes out into the open (is socially labeled), he pretends to be conforming to the standards of the group in a position to condemn him for what he is doing secretly. In short, in response to his self-label of his behavior as apt to incur sanctioning, he acts in such a way as to achieve a social label of conformity. Like any other social actor who attempts to influence the response of others to him, *he puts on a performance.*[5]

Ironically, while an aware rule-breaker may be able to carry off a convincing impression of morality and so hide his deviance, someone who believes he is doing right but is unaware of possible public response may find himself accused of deviance. On the other hand, even the conformist may have to put on a deliberate show of sameness to achieve the label of social approval, and a conscious performance of rule-breaking may, in extraordinary circumstances, be required to socially validate immoral behavior. Of course, performances fail, and so a social label of deviant may be the price of an unsuccessful performance of conformity by either the conformist or the secret deviant.

As performances, deviance and conformity involve a presentation of self no different in arts and techniques from the everyday performances described by Goffman.[6] However, where Goffman's performers are by and large members of teams who must manage the definition of the situation so the action is not interrupted, the moral performer frequently works alone to achieve the application of a certain label—deviant or conformist.[7]

What's in a Label?

So far we have been talking too simply of the labels of conformity and deviance. As a social label, *conformity* can be applied to socially approved behavior, to deviance that is socially unimportant, and to secret deviance. In the case of conformity, the consequences of the social label are the same; it is the nature of the *self*-label that determines the kind of performance the individual may have to put on to achieve moral certification.

Deviance as a social label, however, has different consequences depending on the type of deviance implied by the label. One kind of social label of deviance imputes maliciousness or willfulness to the deviance, and carries consequences of punishment. A second kind defines the deviance as accidental, implying acquisition without the individual's wanting to be deviant. Some familiar kinds of deviance socially defined as accidental are illness, foreignness, crippling, or inherited defects.[8]

Deviance that is socially defined as

[5] See Erving Goffman, *The Presentation of Self in Everyday Life,* Garden City, N.Y.: Anchor Books, 1959, pp. 3-4.

[6] *Ibid., passim.*

[7] Actually, Goffman notes that most of us spend our lives merchandising our morality. Thus, he says, "the very obligation and profitability of appearing always in a steady moral light, of being a socialized character, forces one to be the sort of person who is practiced in the ways of the stage." *Ibid.,* p. 251.

[8] Freidson, *op. cit.,* pp. 80-82.

accidental is usually treated more kindly than deviance that is socially defined as deliberate. In our society, mercy and mitigation of punishment are traditional for those who are considered to have fallen into sin or disgrace through no fault of their own. Today, we are more likely to give therapy to those who are defined as ill (accidental deviance) and punish those who are defined as criminal (deliberate deviance).[9] If he cannot achieve a level of conformity, it is to the deviant's advantage to have his behavior socially defined as accidental rather than deliberate. If his *self*-label is that his deviance is not his fault, he must convince his audience to believe him; if his self-label is that he acted deliberately, he still may attempt to show that he deserves merciful treatment by pretending he is not responsible for his behavior.

We might now present a typology which would chart these different kinds of conformity and deviance labels:

TABLE 1
A TYPOLOGY OF DEVIANCE

		Self-Label		
		Conformity	*Accidental Deviance*	*Deliberate Deviance*
Social Label	*Conformity*	Reasonable adherence to norms	Acceptable differences	Undetected violation of rules, norms, laws
	Accidental Deviance	Culture and role conflicts	Illnesses, inherited defects, crippling	Crimes of passion, hunger, rage
	Deliberate Deviance	Deliberate violation of laws or rules for political or religious reasons	"Nuremberg pleas" ("Could happen to anyone")[10]	"Professional" deviance

These abstract categories are entirely dependent for their content on the specific norms and values of the labelers and the labeled. The definitions of conformity and deviance, and of accident and deliberateness, as well as the consequences of the labels, cannot be separated from time, place, and social situation. For this reason, performances to achieve any of the labels will vary as the categories of perception and evaluation vary.[11]

Two recent studies indicate how, in

[9] Cf. Vilhelm Aubert and Sheldon L. Messinger, "The Criminal and the Sick," *Inquiry*, 1 (no. 3, 1958), pp. 137-60. Thus, as Schur suggests, if abortion, homosexuality, and drug addiction are to be considered medical problems, they must be transformed into illnesses—the addict must be considered compulsively driven, the pregnant woman physically or mentally incapable of surviving childbirth, and the homosexual a victim of early childhood conditioning. *Op. cit.*, pp. 178-9.

[10] Essentially, a *rejected* plea in which the person being judged claims he was only following orders, didn't really know what he was doing, or was no different from anyone else in the same situation.

[11] The typology can conceivably be used to analyze virtue as well as vice. Thus, a helping hand might be accidental virtue unremarked socially, and anonymous philanthropy would be secret virtue. Revolts against oppression, good samaritanism, and heroism under fire might fill in the second row across. In the third row, we might have martyrdom, denied saintliness (for example, Joan of Arc's plight after capture by the British), and missionary work.

particular types of deviance, impressions may be varied to achieve different labels. In his study of suicide, Jack Douglas discusses the attempts of suicides to remove responsibility for their deed from themselves by placing the blame on what "drove them to it"—loss of job, family trouble, illness, rejecting lover, and so on.[12] In our terms, the suicide is trying to create the impression that the deviance was not a willful act, but forced on him.

A study of county lunacy commission hearings gives another example of impression management to achieve a label with desired consequences.[13] The authors note that

> . . . those persons who were able to approach the judge in a controlled manner, use proper eye contact, sentence structure, posture, etc., and who presented their stories without excessive emotional response or blandness and with proper demeanor, were able to obtain the decision they wanted—whether it was release or commitment—despite any "psychiatric symptomatology."[14]

The study also gives examples of failed performances. Some self-defined patients were not committed to the mental hospital because they could not hide their eagerness to be committed; that is, they were defined as chronic alcoholics and malingerers (deliberate deviants) who did not deserve the treatment reserved for the "truly" ill (accidental deviants).

Illness as a Performance of Innocence

Illness is commonly considered a type of accidental deviance—it is not felt that the individual deliberately or willfully chose to become ill. However, as Aubert and Messinger note, ". . . any situation in which an individual stands to gain from withdrawal is such as to render suspect his claim to illness."[15] Absences from school and work, and going on sick call in the army, are cases in point. Aubert and Messinger also state:

> The reverse situation may be seen to obtain as well—that is, it is easier to be categorized as ill when the situation points to significant deprivation following validation of a claim to illness.[16]

Szasz suggests that the juxtaposition of motives and symptoms forms a continuum of types of imputation within the category of illness. If a person has no motive to be ill and has symptoms, he is clearly ill. If he has a motive and symptoms, his condition may be psychosomatic or hysterical. If he has a motive and questionable symptoms, he is open to the charge of malingering.[17]

As a form of deviance in itself, illness may be fitted into the abstract typology presented above. The self-labeler is the patient; the social labelers are the medical profession.[18] Of course, as will be seen from the following discussion, this typology is still too abstract, as doctors vary in their categorization of different symptoms, and patients also have greatly varied views of illness. However, a discussion of impression management in illness, based on the typology given, may illustrate the usefulness of the performance concept in the analysis of deviance.

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[12] Jack D. Douglas, "The Sociological Analysis of Social Meanings of Suicide," *Archives Européenes de Sociologie*, forthcoming.

[13] Dorothy Miller and Michael Schwartz, "County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital," *Social Problems*, 14 (Summer, 1966), pp. 26-35.

[14] *Ibid.*, p. 34.

[15] Aubert and Messinger, *op. cit.*, p. 142.

[16] *Ibid.*

[17] Thomas S. Szasz, "Malingering: 'Diagnosis' or Social Condemnation," American Medical Association *Archives of Neurology and Psychiatry*, 76 (October, 1956), pp. 438-40.

[18] Somewhat different categories would have to be inserted into the typology were the social labelers other laymen. For example, venereal disease might be considered deliberate deviance. The question of stigmatization, which arises when the audience is primarily composed of laymen, is discussed by Freidson, *op. cit.*, pp. 79-80.

TABLE 2
A TYPOLOGY OF ILLNESS

		Self-Label		
		Conformity	*Accidental Deviance*	*Deliberate Deviance*
Social Label	*Conformity*	Health	Minor illness	Concealed illness
	Accidental Deviance	Illness discovered by doctor	Treated illness	Conversion hysteria
	Deliberate Deviance	Refusal of treatment	"Parlayed" compensation case	Malingering

In the first column, the actor feels that he is healthy—that his physical state is "normal." Presumably, unless he has some peculiar physical quirks which he knows do not affect his capacities, but which the physician has to check out for himself, there is no real need for a performance to convince a physician that he is healthy as long as his physical aspects fall into the medical boundaries of normality.[19] If an individual does have a medical abnormality that the doctor discovers, he is, despite his self-label of health, categorized as ill, or accidentally deviant. If he accepts the diagnosis and consents to treatment, he moves into the middle cell, treated illness. If he does not accept the doctor's label, insists that he is healthy, and refuses treatment, he may be categorized as a deliberate deviant by the doctor. He is now considered responsible for his deviance (or at least for permitting himself to get worse). Those who are diagnosed as ill have, in a sense, "failed" in their performances of health.

In the second column, the label desired by the deviant is one of "true" illness, that is, accidental deviance. Of course, he must in the first place define his symptoms as adding up to illness to give *himself* the label. For instance, a study of office workers with colds found that some employees would stay home from work only if they had severe colds with fever—conditions they defined as true illness.[20] Unless their colds were severe, they did not feel they had a warrant to stay home from work. In this instance, the self-label alone operated, for these employees did not feel they had to convince others that they were ill in order to get permission to stay out of work. In other instances, the person who feels he is ill through no fault of his own must manage to convince others that he neglects his obligations only because he is incapacitated, not because he wants to get out of his duties. In such cases, in order to get clear title to the label of illness, he may need the validation of a physician, which puts him into the category of treated illness.[21]

The compensation case in which the physical state is milked for financial

[19] In checking out a physical peculiarity, the physician may "create" a *non*-illness, verifying that an individual does *not* have such-and-so, which in itself is a defined state. See Clifton K. Meador, "The Art and Science of Nondisease," *New England Journal of Medicine,* 272 (January 14, 1965), pp. 92-95.

[20] Judith Lorber, "Management of the Common Cold in Office Workers," unpublished Master's thesis, New York University, New York, 1966.

[21] A label of incapacity may also depend on the requirements of the ill individual's working group—its need for manpower, and its assessment of the relative value to the group of the individual's continuing to work. Cf. David Mechanic, "Illness and Social Disability: Some Problems in Analysis," *Pacific Sociological Review,* 2 (Spring,

gain is an illustration of a performance designed to achieve a label of accidental deviance which may ultimately be refused. Interestingly enough, there is even some evidence that the industrial accident which led to the compensation itself may have been engineered.

Hirschfeld and Behan, in their review of about 300 cases of industrial accidents and injuries, found a prevalent pattern of feuding with management, almost deliberate infraction of previously followed safety rules, and an increased frequency of sick calls in the period just before the accident.[22] As psychiatrists, these authors explain the accident as an unconscious solution to an otherwise insoluble psychological conflict in the worker's life, such as inability to handle heavy physical work because of advanced age. An accident, however, might just as validly be seen as the "planned" solution to a socially imposed problem, for there is no more legitimate escape from the obligations of work in our society for a man of technical working age than through physical disability. When legal compensation for disability enters the picture, the managed aspects of accidents are thrown even more clearly into focus. Hirschfeld and Behan themselves note:

> . . . it is our conclusion that, in most cases in which legal problems contribute to chronicity, the patient's reaction is not unconscious. These people are usually aware of what they are doing. . . . It is difficult to listen to descriptions of how the patient has come to regard his injury as a means of financing his future without believing that an ordinarily intelligent man knows what he is saying.[23]

Even if the social labelers feel an accident is not accidental, they must confer a label of illness since there is a palpable injury. If a state is medically defined as illness, it must be treated; if punishment is to take place for deliberate self-injury, it can only be done when the patient is symptom-free. Then he gets a kind of retrospective label of malingering.

Ill individuals who want to *avoid* the label of illness may insist that their physical symptoms are not disabling. If they are chronically ill and wish to lead as normal a life as possible, they will try to convey the impression that they are healthy. They are, in their way, secret deviants, and therefore belong in the first cell of the third column.

In the case of conversion reactions (the hysterical enactment of an illness), where there seems to be a definite gain from the label of illness, the management of the performance to achieve a label of accidental rather than deliberate deviance must be particularly delicate. According to Ziegler and his co-workers, hysterical symptoms are chosen for their symbolic communication of emotional distress, yet to be accepted as physical and not emotional illness they must grossly coincide with medical conceptions.[24]

1959), pp. 37-41. Parsons also notes that "incapacity" is a socially determined label dependent on institutionalized expectations of standards of "adequate" performance. See Talcott Parsons, "Definitions of Health and Illness in the Light of American Values and Social Structure," in *Social Structure and Personality,* New York: The Free Press of Glencoe, 1964, p. 265.

Of course, just as the individual's importance to the group may make it difficult for him to get labeled ill, his position may subject him to label of illness for every minor symptom: the President of the United States goes to the hospital with a cold.

22 Alexander H. Hirschfeld and Robert C. Behan, "The Accident Process, I. Etiological Considerations of Industrial Injuries," *Journal of the American Medical Association,* 186 (October 19, 1963), pp. 114-15.

23 *Ibid.,* p. 118.

24 Frederick J. Ziegler, John B. Imboden, and Eugene Meyer, "Contemporary Conversion Reactions: A Clinical Study," *American Journal of Psychiatry,* 116 (April, 1960), pp. 901-09; Frederick J. Ziegler, John B. Imboden, and David A. Rodgers, "Contemporary Conversion Reactions: Diagnostic Considerations," *Journal of the American Medical Association,* 186 (October 26, 1963), pp. 307-11.

These authors feel that this type of enactment of the sick role is an unconscious mechanism of psychological avoidance, because the patients are convinced of the somatic origin of their symptoms. The authors also suspect, however, "that their environmental circumstances strongly support this rather manipulative emotional pattern. . . ."[25] Thus, women are more likely to utilize conversion reactions, because dependency is acceptable in the female role. In men, complicated conversion reactions involving many symptoms over a long period of time are usually found in settings permitting compensation for illness, such as veterans' hospitals. Conversion reactions can also be "unreasonable exaggerations of genuine physical problems."[26] The performance may not fool a psychiatrist or a psychiatrically minded physician, but by judicious "shopping around," the conversion reactor may achieve the label of legitimate illness and the secondary gains of sympathy and support. If he does not achieve the label of accidental deviance by being treated for his symptoms, the hysteric may be given the stigmatizing label, "malingerer."

The treatment the hysteric gets may be psychiatric rather than physical. The difficulty doctors have in distinguishing hysteria and malingering have led some of them to turn the whole problem over to the psychiatrist. The following discussion by a doctor is an excellent summation of the self- and social labeling process and the possible ultimate disposition of these kinds of deviants:

> Hysterical patients have no organic basis for their symptoms and findings so that in a sense, they are "faking" their disease. The important point is that this faking is on a subconscious level and the patient is perfectly sincere in the belief that his symptoms and findings are bona fide. The malingerer is also a faker but his dissimulation is on a conscious level and he knows perfectly well that he is "putting it on" for a purpose. The only difference between hysteria and malingering is the presence or absence of awareness by the patient that he is faking. This awareness is extremely difficult to prove unless the patient will confess. The borderline between hysteria and malingering is indeed a thin one because fakers may convince themselves of their illness and develop an hysterical overlay while hysterics may come to see the benefits of their illness and consciously embellish it with ornamental additions. For these reasons, recognition of the malingerer is unusual, the true malingerer actually is quite rare, probably most such patients have abnormal personality traits anyway and most often they end up with a psychiatric diagnosis of some sort.[27]

A *psychiatric* label of illness resolves the problem of distinguishing between accidental and deliberate deviance from the doctor's point of view by keeping it a "true" illness (not the deviant's doing, but due to abnormal personality traits).

As long as he incurs no stigmatization for undergoing psychiatric treatment, the malingerer may not find it disadvantageous to be labeled an abnormal personality. Even if he doesn't get "well," professional ideology prevents punishment of his deviance. Without this shift to the area of psychological deviance, the label of malingerer represents the failure of all performances of "innocence."

None of the types of illness discussed is stable or permanent; self-labels and social labels change, depending on the development of physical symptoms, shifting perceptions and evaluations, contacts with the medical profession, and consistency of performance. The compensation case may be denied further compensation, malingering may be transformed into mental illness, hidden illness may be discovered and treated, minor illness may get

[25] Ziegler, Imboden, and Rodgers, *op. cit.*, p. 308.
[26] *Ibid.*, p. 309.
[27] Warner F. Bowers, *Interpersonal Relationships in the Hospital,* Springfield, Ill.: Charles C Thomas, 1960, pp. 65-66.

worse and be treated, and then may be exaggerated into hysteria.[28] Like other social situations, illness is a combination of physical reality and social evaluation and response. It is an interactive process with elements of conflict. The deviant struggles to achieve the kind of label he desires, using his physical state and his performing arts to build up an impression that will convince his social audience "to act voluntarily in accordance with his own plan."[29]

Summary

Although the basic theoretical vocabulary of the labeling concept of deviance is that of symbolic interaction (it assumes the far-reaching effect of a linguistic symbol and self-identification as a result of social identification), the most recent emphasis has been on the *other,* on the responder. The self, the initiator of the action, has been neglected. The emphasis on the labeler has made him the initiator of action, and the deviant the responder, which ignores the fact that deviance is a reciprocal interaction process in which deviant and labeler take turns acting and responding.[30]

This paper has suggested that the deviant often more or less deliberately conveys an impression which he hopes will lead to the imposition of a certain label by his audience. The impression or performance he gives, it was further suggested, depends on his view of himself (his self-label) and his ability to determine possible social response to his behavior. The interaction sequence in deviance should follow the pattern of social interaction described by Mead: intent, recognition of the response of the other, action, actual response, revised intent, revised behavior, response, and so on.[31] Or, using the language of labeling theory: self-label, awareness of societal reaction, performance, social label, revision of self-label, performance in the role implied by the social label. In short, the sequence of interaction in deviance should be no different from that in other social situations, where roles are built up through a dialectic of self and other.

In this paper, both self-labels and social labels were broken down into conformity, accidental deviance, and deliberate deviance, and a ninefold typology of deviance was offered. Illness as a type of deviance usually defined as accidental was analyzed for its labeling and performance aspects, as an illustration of the uses of the approach.

Restoring the deviant individual to the analysis of deviance permits the use of the labeling theory in the study of all forms of deviance, hidden as well as socially labeled. Besides correcting a limiting theoretical bias, a fully interactive conceptualization of deviance also avoids an unfortunate *moral* bias. A concentration on social responses, and a neglect of the interaction processes that culminate in those responses, "sentimentalizes" the deviant by making him a put-upon victim, with the social control agents the villains of the piece.[32] An interaction

[28] If the illness results in a permanent disability, the person enters into a different area of deviance, with its own labels and performances. See Fred Davis, "Deviance Disavowal: The Management of Strained Interaction by the Visibly Handicapped," *Social Problems,* 9 (Fall, 1961), pp. 120-32; and Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity,* Englewood Cliffs, N.J., Prentice-Hall, 1963.

[29] Goffman, *The Presentation of Self, op. cit.,* p. 4.

[30] Albert K. Cohen makes a similar point in "The Sociology of the Deviant Act: Anomie Theory and Beyond," *American Sociological Review,* 30 (February, 1965), pp. 5-14. The point is made on pp. 9-10.

[31] George Herbert Mead, *Mind, Self and Society,* Chicago, Ill.: The University of Chicago Press, 1934, pp. 135-226.

[32] A warning about sentimentalizing the subjects with whom the researcher feels in sympathy is attributed to Freidson by Becker

approach admits the possibility that the deviant individual is very much aware that he is breaking rules, that he is choosing to do so, and that, with this awareness, he can attempt to manipulate those in a position to label. Thus, he may get what he wants within the limitations of the social structure that encompasses him.

in the introduction to *The Other Side.* Becker makes the distinction between *conventional* sentimentality, or sympathy with the establishment, and *unconventional* sentimentality, or sympathy with deviants. He cautions against both kinds of sentimentality, but feels the latter is the lesser evil. *Op. cit.,* pp. 4-6.

VIOLATIONS OF ACADEMIC FREEDOM: OFFICIAL STATISTICS AND PERSONAL REPORTS*

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A recurrent problem in the sociology of deviance is the unknown relation between "rates" of deviant behavior as indicated in official statistics and "actual" incidence of the behavior among a population.[1] In the absence of more reliable data, sociologists traditionally have used official statistics to indicate the degree of deviance characteristic of a population. Although "the literature on social deviance is replete with caution and foreboding on the subject of official statistics," most researchers continue to use them without regard to the cautions, perhaps because alternative sources of data are often lacking. Short and Nye suggest one alternative: Rather than relying wholly on official data, sociologists may go directly to the population in question, ask individuals about their participation in the behavior being studied, and use this "reported behavior" to evaluate official data and suggest areas in which it is inaccurate.[2]

It should be emphasized that neither personally perceived nor officially reported accounts of deviant behavior reflect objective levels of deviance; any report is subject to the bias of the reporter, whether he be participant, observer, official agent, or private citizen. This being so, it follows that there are good reasons for using both kinds of data in routine hypothesis-testing and not only when the primary aim is to evaluate the accuracy of official

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1 See, for example, John Kitsuse and Aaron V. Cicourel, "A Note on the Uses of Official Statistics," *Social Problems,* 11 (Fall, 1963), pp. 131-139; John I. Kitsuse, "Societal Reaction to Deviant Behavior: Problems of Theory and Method," *Social Problems,* 9 (Winter, 1962), pp. 247-256; James F. Short, Jr., and F. Ivan Nye, "Reported Behavior as a Criterion of Deviant Behavior," *Social Problems,* 5 (Winter, 1957-58), pp. 207-213; and Leroy C. Gould, "The Concept 'Crime' in Criminological Theory and Research," paper read at the 60th Annual Meeting of the American Sociological Association, Chicago, Illinois, August 30, 1965.

2 Short and Nye illustrate their point by using two criteria of delinquency—official reports on institutionalized persons and "reported data" based on direct interviews —to examine the relation between delinquency and certain other variables. Their findings indicate that some of the accepted notions about the relation between delinquency and socio-economic status may be open to serious question. Short and Nye, *op. cit.,* pp. 207 and 212.