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DISEASE AS DEVIANCE*

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Abstract—It has become apparent that illness can be viewed as a social response to, as well as an overt manifestation of, a pathological condition. However, some forms of disease elicit a much different type of response. A social psychological framework and a deviance perspective are used to analyze intense social reactions to certain diseases. The purpose of this paper is to consider the relevant social factors and to construct a critical perspective for explaining disease as deviance.

ILLNESS AS A SOCIAL RESPONSE

ILLNESS is certainly not an unusual condition. In Hinkle's study of health patterns of lower class men in the 20–45 age range, it was estimated that during this time span the average man reported:

1 life endangering illness
20 disabling conditions
200 non-disabling, but impairing conditions
1000 symptomatic episodes, or about
1 episode every 6 days [1].

Obviously, when conditions are this prevalent, adjustments are made.

Parsons has developed the concept of sick role to explain this basic social process. When a person becomes sick, he may invoke the sick role which provides two exemptions from responsibilities and two obligations:

1. Exemptions from performance of universal social obligations (roles).
2. Exemption from responsibility for one's own state.
3. The obligation to get well as soon as possible.
4. The obligation to seek technically-competent help [2].

The decision to employ the sick role presupposes a definitional process involving three dimensions [3]. The first dimension is pathology, and there is a range from a healthy state to severe traumatic injury or state of chemical imbalance. The presence or absence of pathology leads to a second dimension, the presence or absence of impairment and/or disabling conditions. The third dimension is sickness, or the self-perception by the person of his state.

Obviously pathology, impairment, and sickness are interrelated, but not always directly. Men have suffered severe heart attacks, but refused to admit they were sick until the damage led to a severe disabling condition. Conversely, a hypochondriac may over-react to mild

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symptoms and claim great impairing and disease conditions [4]. Similar reactions have made it imperative that double-blind studies be used to evaluate new drugs so that the placebo effect can be differentiated from the therapeutic effect of the drug.

The definition of sickness does not necessarily lead to the sick role as this is a social definition which does involve a temporary alteration of appropriate role behavior. Entrance into the sick role is contingent upon two factors: the extent of impairment and who initiates the definition of sickness. This gives four theoretical possibilities, as illustrated below.

	Impairment	Non Impairment
Self-defined	I	II
Other-defined	III	IV

They are as follows:

1. Most illnesses fall in this cell. The person recognizes certain symptoms, realizes certain impairments, assumes the sick role, and seeks to get well. Reactions to colds, flu, measles, and other common diseases can be so typified.

2. In this cell, we might place the hypochondriac. Even though there is no physiological basis for complaint, the individual believes there are symptoms and impairments, and he assumes the sick role. On a group level, there is a recent study of women factory workers who reported severe insect bites, even though no insects could be found. The study concluded that this was a form of mass hysteria whereby a group of women under stress conditions were able to get legitimatized relief [5].

It is at this level that illness behaviour can be classified as deviance. When others perceive that the person has no valid complaint and is only "playing" the sick role, he is classified as a deviant—one who will not assume the correct role in life.

3. A physician may often find himself with this problem: he detects pathology more serious than what the patient suspects, and then has the difficult task of informing the patient of his findings. Wittkower has illustrated the problems involved in telling unsuspecting or reluctant patients that they have tuberculosis [6]. The patient's reaction may be manifested in a number of ways—denial, withdrawal, acceptance or aggression. It is easy to understand why a physician may recommend that such a patient get another medical opinion. Among other things, such a time lapse and allowance for error could ease the crisis confronting the patient by giving him a chance to resolve the problem over a period of time.

4. This possibility is perhaps more serious, or at least it is the possibility Szasz is most concerned about in his criticisms on the legal aspects of psychiatry [7]. Persons with little or no psychiatric impairment have been involuntarily hospitalized for indeterminant periods of confinement as the result of one or more parties instituting legal proceedings to "put them away". There is a question which the physician faces in this respect. When there is a questionable symptom which results in an uncertain diagnosis as to the presence or absence of pathology, the physician must decide whether or not to treat the patient. This is a question that is perhaps most often raised, in terms of public awareness, in regards to rabies treatment after the patient has been bitten and the animal cannot be found for testing. The general assumption is that it is better to give treatment, as it is less risky to receive medication when there is no disease than to have the disease without benefit of

treatment. However, if the treatment involves surgical procedure, then the physician risks a possible malpractice suit.

At any rate, the ideal conditions for treatment exist when the self and the other agree that in fact a disease exists, what the disease is, and what course of action should be taken. But it is sometimes difficult to get to this position.

Generally, a person discusses the meanings of his symptoms with significant others and they help him decide what course of action should be followed. Sickness is a group decision, for if one is to play the sick role, he must perceive himself as sick, then perceive that he has convinced the significant other that he is right. Mechanic has studied the decision-making process of middle class housewives [8], and Koos has illustrated how the druggist can be a significant other in such a process [9]. The family generally is the most critical reference group in this process. Mechanic has shown that the response of a person is affected by his age, sex, and position in the decision-making group [10].

The social dimensions of the sick role is further illustrated in conceptual ability of the patient. The major determinants of the definition process appear to be the ability to recognize and interpret symptoms and the impairment of daily activities [11].

DETERMINANTS OF DISEASE AS DEVIANCE

A deviant is defined as a person who is perceived as unable to fulfill normal role expectations and is assigned to a position where he is no longer expected to. The tie between the individual and society is the normative order. The role expectation is the individual counterpart of the norm which is a cultural phenomenum. There are several levels of norms including fads, fashions, folkways, mores, and laws. The more important norms are those which are central to continuance of the society, the mores and laws which are institutionalized expectations. Fads, fashions, and folkways may be violated with minimal consequences as they are not viewed as being of central importance to the ongoing social order.

Norms and the institutionalized expectations have evolved from adjustments to environment. They forbid certain actions and enjoin positive activities. On the individual level, norms carry sense of oughtness, compel compliance, and become incorporated in the individual conscience [12].

Violations of institutionalized roles lead to sanctions which force individuals to comply or leave the social order. As Erikson indicates, the sanctioning of deviants not only serves to preserve the individual but also serves to reinforce the boundaries of legitimate behavior [13].

When people are labelled deviants and are perceived as being unable to follow institutionalized expectations, they are forced into stereotyped roles and are set apart from normal society. A criminal is prosecuted and set aside for the violations of legalized mores, but there is only one type of deviance. Blind persons, dwarfs, lepers, and mental patients are perceived as equally unable to fulfill major normative expectations and are consequently forced into stereotypic patterned behaviors. In the latter cases the labelling process may be more informal and occur over a longer period, but the consequences are no less real. Being labelled as deviant affects the style of life and opportunities available to those so labelled [14].

There are two general ways that persons who are ill can become deviants. First of all, if the impairments become permanent, the person is forced to forfeit his normal social position and act within the limitations of his impairment. The impairment becomes a disability when the individual is perceived as being permanently unable to fulfill the institutionalized expectations.

Once such permanent physical alterations take place, the person's self-concept is altered so that he realizes no viable alternative but to become a socially disabled person as defined. For example, women who face hysterectomies or mastectomies become concerned with how they will be viewed by their significant others, particularly if they are married.

The second determinant is stigma, a concept which has Greek origins. In Ancient Greece, which emphasized classical beauty, if a person had a physical disfigurement, this was taken as a cue that the person was morally and religiously inferior, that such a person had fallen into disfavor with the gods and was stigmatized [15].

Historically, certain cues have carried stigma and the stigmatized persons have been rejected. The cues of mental illness, leprosy, cancer, disfigurements and congenital malformations are some examples. Even though, in a technologically advanced society, magico-religious interpretations are used for explaining events, particularly those events which cannot be "scientifically explained". The works of Goffman [16] and Wright [17] indicate some of the psychological and societal reactions to and the responses of persons so stigmatized.

Pflanz and Rohde question the extent that illness can be viewed as illness behavior. They are correct in that the illnesses generally do not result in violation of normative rules, and this would be true of acute and chronic disease [18]. In these cases persons do conform to the sick role and return to their normal roles as soon as possible. The more severe disabling conditions lead to the permanent deviation from normal expectations. Even though disease may cause the deviance, after a time the person is stigmatized and held responsible for the condition. The discriminations applied against disabled people (most of which are non-rationally based) have resulted in an unorganized marginality group which suffers relative deprivations comparable to any other marginality group in society.

DISEASE AS DEVIANCE AND THE SICK ROLE

If an illness can be potentially placed in the category of a deviance disease, then there will be a greater reluctance for persons to define themselves as having that sickness. This is true for illnesses which lead to deviance via impairment or stigmatization.

Davis' work on non-compliant behavior indicates that patients cease co-operating with the physicians if they have a commitment to normal social roles (high work orientation) and/or when the impairing aspects are controlled and minimized through previous treatment [19]. Wittkower's work indicates that patients resist the diagnosis of TB, particularly if the person has strong personality tendencies toward autonomy and independence. Conversely dependent and passive personalities are more receptive to prolonged rest, care, and treatment, that is, a prolonged commitment to the sick role [20]. Lastly, King indicates that part of non co-operative behavior of hospital patients is related to the change in role status [21].

In Phillips' recent classic in the study of attitudes toward mental illness, he indicated that by going to a treatment facility designed for mental illness, the person labels himself as mentally ill in the eyes of the public even though he may exhibit no behavioral deviations [22]. Studies have also shown that some patients will delay seeking treatment if they believe that the diagnosis might be cancer, even though the survival chances are markedly improved if there is early identification [23]. This essentially means that doctors can become labelers of deviance, and transform a primary deviant. This often leads to the case where the physician refused to report certain cases, even though he may be required to do so by law.

DETERMINANTS OF DISEASE AS DEVIANCE

However, not all persons with similar deviant disease conditions are likely to become career deviants. There are three major determinants which affect the life chances of becoming deviants: the background characteristics of people who display symptoms or cues, the type of disabling conditions, and the type of rehabilitation facility [24].

I. *Background characteristic*

The type of roles a person plays are directly related to his position in the stratified society. The most fundamental role differentiations are made on the basis of age and sex. There is more tolerance of illness behavior in the young, the old, and women. Children and old people are expected to be sick, so rather than enter a sick role, there are built-in modified expectations in the normal social expectations to allow for this eventuality. This is probably true for children until major expectations are placed upon them which call for the exemption process at the onset of disease. Going to school probably is one of the first such major set of responsibilities. In fact, parents often become concerned about retardation or emotional disturbance when the child fails to perform properly at school. Physical, eye and ear examinations are becoming a standard preparation for beginning school.

Part of the process of growing old includes the infirmities of old age, which are routinely expected occurrences. The sick role concept is irrelevant here. To a lesser degree, women are seen to be more frail than men. They are allowed more leeway in behavior, particularly at the times of menses, pregnancy, and menopause, even though Mead suggests that such reactions are culturally defined responses [25]. Men are the strong, stalwart individuals who faithfully report to work; good health is an essential feature of masculinity.

The extent to which social class is related is a topic of debate. Kadushin believes that class differences in the incidence of disease have increasingly diminished [26]. One reason that lower-class people may have a higher prevalence of chronic and disabling conditions is that radical role alterations may lead to lower socio-economic status. Antonovsky [27], Zola [28], and Mechanic [29] contend that not only are there real differences in incidence by class, but that the lower class people are more likely not to define themselves as sick when there is pathology, and when they do so they are more likely to receive inadequate care, which makes them more likely to become disabled. Even though there is a dispute as to which processes account for the phenomenon, there is an inverse relationship between social class and prevalence of disabling conditions.

There does seem to be agreement that the poor know less about diseases and their symptoms, and what actions to take. This results in their reporting more severe illnesses with more severe impairments than upper classes.

There are variations by ethnic groups as well. Research by Zola [30], Zborowski [31], Mechanic [32] and Suchman [33] suggest that members of the Jewish, Italian, Irish and Old American groups respond differently to symptoms and/or pain. The Jewish respondents seem to be more concerned about the meaning of the illness, the Italian and Irish appear to be more likely to play the sick role, and the Old Americans appear more stoically inclined. The varying responses seem to be attributed to the cultural heritage of the groups, although it must be remembered that ethnic membership is interrelated with social class.

II. *Type of impairment*

The second major determinant refers to the type of handicap or impairment. Obviously, if it is one that carries more stigma or is one with highly visible cues, the person with such

a handicap is likely to be forced into the deviant role. To this point there have been few studies which have compared attitudes toward various disabilities. Several studies have looked at attitudes toward types of mental disorders and generally those types involving overt antisocial behavior were rejected most strongly by the respondents. Mental illness is probably the most heavily stigmatized type of disability as it does strike at the essence of man, the mind.

Generally, the more visible and handicapping the cues, and the more unexplainable they are, the greater the stigma. For example, a person with one leg amputated is less rejected than a quadraplegic, and an epileptic is more rejected than a diabetic. However, it is this writer's contention than an epileptic is more rejected than a deformed person because the reasons for the behavioral cues are not readily apparent and are left to conjecture, and because it is easier to predict the behavior of a deformed person than an epileptic who could have a fit at anytime. It is at this point that nonrational interpretations are used.

This determinant is related to the first. The white upper class members of society are quicker to recognize disease, and then are less likely to become disabled. They are better able to control the cues and minimize the possibilities of being stigmatized.

Even if an upper class person were to become impaired, the end result may result in less role alteration. A professor who becomes a paraplegic can still be a professor with some alterations while a truck driver who becomes paralyzed has no choice but to enter the deviant role of the disabled.

Similar variations occur by ethnic background.

III. *Type of rehabilitation facilities available*

There are various types of treatment for various diseases, and there are various types of treatment facilities for a given health problem, such as mental illness. Bodily disfigurements are now less likely to lead to deviant roles because of plastic surgery. Developments in the area of prosthetic appliances have resulted in minimization of impairment. Organ transplants and the use of artificial replacements have extended the life chances of previously hopeless cases and in some cases, persons moved from a disabled role to a normal role; for example, as in transplanting cornias to cure blindness.

This determinant is interrelated with the previous two. In terms of disabilities, pneumonia does not present a severe treatment problem while tuberculosis and chronic mental illness do. Polio has been essentially eradicated while morbidity and mortality rates for cancer continue to increase.

On the other hand, the upper classes are more likely to utilize specialists who are more aware of the latest developments in medicine and are more likely to employ them in practice. Lower class people are more likely to use less skilled general practitioners, faith healers, chiropractors, or home remedies.

Moreover, the physician gives preferential treatment to upper and middle class patients. They are more like him in terms of shared values, attitude, norms; the physician shares a common ethos with the upper and middle classes; they are more amenable to his treatment procedures; and, they are more able to accurately describe the symptoms and complaints which tend to lead to a more accurate diagnosis [34]. For these reasons and more, upper class people tend to get better treatment than lower class patients, even if they have the same medical facilities. Consequently, changes in public health policies benefit the lower classes and minority groups. Through new public programs the poorer people are able to utilize procedures and facilities which the preferred members of society have had for some

time. This applies to a preventive health, birth-control devices, and dentistry, as well as general medical care.

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