individuals who collude in their own social control to reproduce distressing arrangements. The splitting of emotional consciousness facilitates the smooth functioning of hierarchical relationships, even while they produce distress. Furthermore, chronically disavowing one's feelings may also blur the boundaries between self and other. By affecting one's ability to experience social situations clearly, this process makes it harder for the victim of oppressive situations to identify accurately those situations as oppressive.

SUMMARY

In this chapter we continued our discussion of mind, body, and society relationships, emphasizing the role of emotions in social interaction. Some research on social support was critically reviewed. The distribution of power is an important factor in influencing the availability and quality of supportive social relationships. We then looked at some of the stressful aspects of interaction that come from role playing. Those in subordinate social statuses may be more vulnerable to dramaturgical stress and more likely to lack resources to cope with such stress. The chapter concluded with a discussion of dramaturgical stress and health.

"... P]olitical and entrepreneurial interests are, above all, driving what is to be defined as abnormal today ... We are no longer in a mood where normal means average; we are in an era of amelioration, enhancement, and progress through increasing intervention into the 'mistakes' of nature. However, in this climate, the environmental, social, and political factors that, rather than genes, contribute to so much disease, are eclipsed, and tend to be removed from professional and public attention. Research in connection with these factors remains relatively underfunded. ... [W]hen, under the guise of health promotion, individual bodies and individual responsibility for health are made the cornerstone of health care, moral responsibility for the occurrence of illness and pathology is often diverted from where it belongs (on perennial problems of inequality, exploitation, poverty, sexism, and racism) and inappropriately placed at the feet of individuals designated as abnormal or at risk of being so because of their biological makeup" [emphasis added].


- **Illness as Deviance**
  - The Sick Role
  - The Medicalization of Deviance
  - The Medicalization of Moral Authority
  - Social Control and Power
  - Sickness and Social Dissent

- **Problems of Meaning and Order**
  - The Body as a Symbol
  - The Meaning of Affliction
What does it mean to be sick? In some ways a tree’s disease is similar to a human’s disease: Trees can recover or they can die of disease; branches become lifeless, leaves wither, and roots and trunks function poorly. Unlike trees, however, humans must also grapple with the experiential aspects of sickness. Humans are capable of reflecting on themselves, their bodily conditions, and their self-perceptions. This capacity to reflect means that humans typically suffer not merely from disease but also from their experience of illness and the meanings that they and others attach to it.

Sickness is upsetting to the social group too. Because it is a breach of the ideals or norms of the society, it can be disruptive. Illness represents a threat to order and meanings by which people make sense of their lives and organize the routines of their everyday existence. Sickness also raises moral questions, such as, “Who (or what) is responsible for this misfortune?”

ILI\NS AS DEVIANCE

The very notion of health is a social ideal that varies widely from culture to culture or from one historical period to another. For example, in the nineteenth century the ideal upper-class woman was pale, frail, and delicate. A woman with robust health was considered to lack refinement (Ehrenreich and English, 1978). In other periods, cultures, or subcultures, however, the ideal of health might be identified with traits such as strength, fertility, spirituality, righteousness, the absence of pain, the presence of certain pain, fatness, thinness, or youthfulness. The ideal of health thus embodies a particular culture’s notions of well-being and desired human qualities. Standards of health in any culture reflect that culture’s core values. Through ritual action and symbols (especially language), the social group continually reproduces these central, shared meanings (Durkheim, [1915] 1965).

Durkheim ([1895] 1938: 68–69) observed that deviance serves to remind the entire social group of the importance of certain collective values. Like crime, sickness is a form of deviance, or departure from group-established norms. Society typically imputes different kinds of responsibility for crime than for sickness. Durkheim asserted that the very existence of social norms—however defined—means there will be deviance in all societies. The way a society reacts to sickness and crime reaffirms its core values. Furthermore, the practices for sanctioning deviance (such as punishing the criminal or treating the sick person) reaffirm and re-vitalize the collective sentiments and maintain social solidarity. Durkheim ([1893] 1964: 108) argued that societal reaction against deviance “is above all designed to act upon upright [non-deviant] people.” This function suggests that the treatment of the sick in all healing systems serves to reaffirm cultural norms and ideals for the sick and the well alike.

Thus, deviance is more a description of the social group that defines it than a quality of the individual considered deviant. Labeling of an attribute or behavior as deviant is, in fact, a social product (Becker, 1963; Waxler, 1980). Cultures vary widely as to whether they consider deviant such bodily conditions as facial scars, obesity, shortness, and paleness. One cultural standard, for example, considers a certain amount of hair on a man’s chest to be desirable, representing fortitude, robustness, and manliness. Much less hair on the chest is treated as too effeminate; much more is considered coarse and animal-like. Other cultures (and subcultures), however, have different definitions of desirable body hair and different connotations of deviance from those norms.

As Chapter 9 illustrates, defining deviance is a social process involving factors such as power and stratification. Power in a society includes having significant influence in setting social norms and labeling deviance. It also involves having control over the social mechanisms by which these norms are taught and enforced. Indeed, one function of social control is to perpetuate the dominance of those in power in the establishment of norms. Socially established norms are imposed on people, regardless of their own beliefs. Power is a factor in both the creation of a deviance label and its application to some individual persons.

THE SICK ROLE

Like all social roles, the sick role is primarily a description of social expectations (including those of the sick person). Although these expectations strongly influence behavior, the sick role does not describe how sick persons actually behave (see, for example, Twaddle, 1981: 56–58).

According to Parsons (1951: 428–447), the sick role entails certain responsibilities as well as certain privileges:

1. The individual’s incapacity is a form of deviance from social norms, but because it is not deliberate, the individual is not held responsible;
2. The sickness is legitimate grounds for being exempted from normal obligations, such as work or school attendance;
3. The legitimacy of this exemption is, however, predicated on the sick person’s intent to get well;
4. The attempt to get well implies also seeking and cooperating with competent help to treat the illness.

The sick role of someone with pneumonia exemplifies Parsons’s use of this concept. A person with serious pneumonia would not be expected to report to work, do housework, or to keep an appointment. Failure to perform such basic social obligations is a form of deviance that is typically sanctioned, for example, by firing an employee. Having pneumonia, however, is usually considered an acceptable, but temporary, excuse for not meeting these obligations. The employer does not hold the sick person immediately responsible. How society responds to an instance of perceived deviance depends largely on its determination of the individual’s responsibility for the deviant behavior. This part of the sick role concept is thus connected with Parsons’s larger concern with how societies maintain their equilibrium in the face of deviance and disruptions such as sickness.
Although having pneumonia is a legitimate excuse for not reporting to work, the sick person is expected to act sick and try to get well. The employer would be less than happy to see the supposedly sick employee at a baseball game later that day, for example. According to Parsons, part of trying to get well involves seeking competent health care from a trained physician. The social expectations for a person with pneumonia thus include going to a doctor, obtaining and taking the doctor’s prescription, and otherwise conforming to whatever regimen the doctor ordered. Thus, he tied the sick role inevitably with the role of medical professionals. (Parsons was especially interested in the development of professionalism as a feature of modern society.) In his usage, the sick role directly implies the patient role; by contrast, we explore the patient role as a separate role, which sick persons may or may not enter, depending on whether their sickness is brought to the attention of medical professionals (see Chapter 10).

Parsons’s concept of the sick role is valuable in that it highlights the social control functions of how society treats sickness. It also emphasizes the extent to which social definitions of sickness reflect larger cultural values of modern Western societies (Parsons, 1972: 124). The cultural narrowness of this concept is partly due to Parsons’s explicit focus on mid-twentieth-century American values (for example, individual achievement and responsibility). The sick role, however, is not as clear cut as Parsons’s model suggests. Four problems with his approach are discussed next.

**The Sick Role Is Not Necessarily Temporary** Parsons’s conception of the sick role is based on only one, relatively narrow class of health problems. The obligations and exemptions described in his model appear to fit serious, acute illnesses reasonably well. *Acute illnesses* characteristically occur suddenly, peak rapidly, and run their course (that is, result in death or recovery) in a relatively short time. Examples include influenza, measles, and scarlet fever.

*Chronic illnesses*, by contrast, are of long duration—typically as long as the sufferer lives. They often result in the steady deterioration of bodily functioning. Examples include emphysema, diabetes; multiple sclerosis, epilepsy, and heart disease. Furthermore, some acute illnesses are considered chronic when they become a continuing pattern in an individual’s life; examples include chronic bronchitis, asthma, and ulcers. Additionally, a number of chronic, disabling conditions (such as paraplegia from a car accident) do not involve any ongoing disease, but may result in an ambiguous, lifelong sick role.

Although many acute conditions can be cured (or are self-limiting), most chronic conditions are permanent. Treatment of chronic illness is aimed at best at controlling the deterioration caused by the disease and at managing the illness. Many of the most dangerous acute (usually infectious) diseases of earlier generations have been brought under control in developed countries through improved sanitation, nutrition, housing, and the like. Inoculations, antibiotics, and other medical treatments have also had some effect in curing infectious diseases (although, as Chapter 2 shows, their role has been somewhat overstated). The proportion of persons suffering chronic illnesses has greatly increased, however; modern medical intervention does not appear so potent in the face of such conditions.

The nature of chronic illness does not fit Parsons’s sick role pattern (Radley, 1994). Obviously, his assumption of the necessity of an “intent to get well” is irrelevant if the illness is, by definition, permanent. His sick role conception presumed that the benefits were conditional, but chronic illnesses make most of the conditions meaningless (Alexander, 1982). Unlike acute infectious disease, chronic ailments are more likely to be considered partly the fault or the responsibility of the sufferer. Whereas few people consider a case of chicken pox, for example, to be the sick person’s fault, lay and medical conceptions of many chronic conditions, such as lung cancer, high blood pressure, and cirrhosis of the liver, are believed to be brought on—at least partially—by the sufferer’s own lifestyle.

Feelings about whether a chronic illness is sufficient grounds for exemption from normal responsibilities are also ambiguous. Because the condition is not temporary, the exemptions are all the more problematic for both the sufferer and those who would grant the exemptions. Just how disabling is the condition? Often persons suffering chronic illnesses do not want total exemption from normal responsibilities, but the illness prevents them from fulfilling some usual duties. As Chapter 7 shows, due to societal values enforced by the sick role, persons with chronic illness have considerable difficulty negotiating such concessions. As a means for maintaining stability and social control, the sick role allows temporary exemptions from normal role requirements without changing those requirements.

Similarly, many other “deviant” health conditions do not fit the sick role model of acute diseases and thereby lead to ambiguities about expectations. Should a person born with a physical handicap be treated as sick? What about accident victims or the mentally ill? Should such normal conditions as pregnancy or menopause be treated as sickness? Considerable ambiguity surrounds the role expectations of those whose health conditions are treated as somehow “deviant” yet do not fit the (acute) sick role.

**The Sick Role Is Not Always Voluntary** Parsons’s model holds that the sick person, in exchange for the advantages of the sick role, is motivated to assume that role and voluntarily cooperate with the agents of social control in the appropriate therapy for the deviant condition. In the preceding example of the worker with pneumonia, for example, the person’s discomfort and fear of complications would presumably motivate the individual to see a doctor, have blood tests and X-rays, get bed rest at home or in a hospital, and take medications. Parsons thus assumed that, in contrast to criminal deviance, the sick person voluntarily enters the socially prescribed role.

Not all persons, however, want to enter the sick role, even when they feel ill. Many people resist the expected childlike dependency the role often entails; many others have strong aversion to medical treatments, especially in the hospital. A Scottish study of lower-class women found considerable negative moral evaluation of persons who give in, or “lie down,” to illness (Blaxter and Paterson, 1982). Some
people, furthermore, simply cannot afford to withdraw from normal obligations; the sick role is a threat to their subsistence (Kasl and Cobb, 1966).

Some sickliness carry a negative connotation or stigma. Although the sick person would obtain some benefits (such as exemption from work or other duties) from the sick role, the stigma of that illness could be worse than the condition itself. For example, a person suffering epilepsy may actively avoid being socially identified with it because of the repulsion and often outright discrimination associated with the illness (Schneider and Conrad, 1980).

Many persons are placed into the sick role by others, regardless of their own wishes. Children and the dependent aged are generally not considered competent to decide for themselves whether to assume the role; instead, their caretakers make the decision for them. Likewise, some conditions (for example, loss of consciousness) force an involuntary entrance into the sick role. Other ambiguous situations arise when someone’s family (or unrelated caretakers, such as doctors, social workers, or police) decide that an individual is too sick to have good judgment and then place the person into the sick role. Because many people thus do not enter the sick role voluntarily, their cooperation with the medical regimen cannot be assumed. In many such cases, the social control functions of the sick role are more coercive and less benign than portrayed by the model.

By contrast, some persons seek to enter the sick role and are denied access. A process of subtle social negotiation occurs when an individual claims the sick role. This claim must then be accepted as legitimate by others, especially authoritative others. Often medical personnel such as the school nurse and the company doctor are the critical gatekeepers who have the power to determine who will be admitted to the sick role in their institutional setting. Informal negotiation also typically takes place as the person claiming the sick role attempts to convince family and others of the legitimacy of the claim, and the others judge—and sometimes test—that legitimacy. Entry into the sick role is thus essentially a social and political process. This link between social control and medical personnel’s gatekeeping roles is developed further in Chapter 9.

**Variability in Sick Role Legitimacy** Parsons’s conception of the sick role also presumes that a single, stable value system is operative for all persons in a society. Historically, however, the legitimate exemption of sick persons from various obligations has been highly variable. The criteria for such an exemption may also differ according to gender, social class, and subcultural expectations.

Legitimate exemptions from work obligations, for example, vary enormously, typically according to social class. Unskilled workers, for example, often have no paid sick days, whereas many white-collar workers are given an annual allowance of such days of absence proportionate to their rank or seniority. Indeed, the idea that absence due to sickness should not be a basis for dismissal is relatively recent; even today sickness is not a legitimate exemption for many workers, and they have no legal protection of their jobs.

The meaning of the sick role itself varies considerably according to social class. The same sickness has different connotations according to the class or gender of the sufferer. For example, in the nineteenth century, consumption (tuberculosis) was a romanticized illness among the middle and upper classes. This sick role implied a “consuming” passion as expressed in artistic sensitivity and creativity. Some of the physical effects of tuberculosis were considered beautiful: slenderness, fever-bright eyes, pallor, and a transparent complexion accompanied by pink cheeks. One young woman with consumption wrote in her diary:

> Since yesterday I am white and fresh and amazingly pretty. My eyes are spirited and shining, and even the contours of my face seem prettier and more delicate. It's too bad that this is happening at a time when I am not seeing anyone. It's foolish to tell, but I spent a half-hour looking at myself in the mirror with pleasure; this had not happened to me for some time. (Marie Bashkirtseff’s Journal of 1883, quoted in Herzlich and Pierre, 1987: 81)

The well-to-do sufferer was “apart,” threatened but all the more precious for it because it was thought to reflect ladies’ refinement and delicacy. It was expected and even stylish for well-to-do women to faint frequently and to retire to bed for “nerves,” “sick headaches,” “female troubles,” and “neurasthenia.” Lower-class women, by contrast, were considered to be more robust, as evidence of their coarseness and less civilized nature (Ehrenreich and English, 1978).

Upper-class Victorians could obtain exemption from normal obligations by claiming the sick roles of neurasthenia or hysteria, illnesses of the “nerves” believed to afflict particularly intellectual or sensitive persons. The label of neurasthenia appears to have been especially useful for men, whose normal role expectations of fortitude and active participation in the world outside of the home made it difficult for them to exhibit dependency or weakness. The vague symptoms identified as neurasthenia, however, were a legitimate basis for men to assume the sick role (Sichelman, 1978; see also Drinka, 1984).

Cultural expectations of the sick role also vary, perhaps widely. Some evidence indicates that cultures differ in the degree of legitimacy they accord various illnesses and their resulting claims to exemption from responsibilities (see Morris, 1998). For example, neurasthenia is a legitimate basis of the sick role among contemporary Taiwanese, whereas in the United States it is a far less common diagnosis or culturally recognized reason for assuming the sick role (see, for example, Kleinman, 1980). Similarly, persons of Hispanic background would be more likely than those of Anglo-Saxon heritage to consider a certain “fright” (susto), such as being startled by an animal or a possible assailant, to be a legitimate basis for the sick role (Baer et al., 1998). Because cultures vary in how they understand various
illnesses, they also have different expectations for the behavior of persons occupying the sick role, such as the amount of pain and disability they may experience (see, for example, Angel and Thoits, 1987). These examples illustrate that the expectations identified as a sick role change; problems that were identified in the past as a legitimate basis for claiming the role are no longer appropriate, whereas other problems—formerly unrecognized or discounted—are now accepted as legitimate.

**Responsibility for Sickness** Parsons’s model of the sick role held that, unlike crime, sickness was not the responsibility of the deviant person. Furthermore, he considered the professional diagnosis and treatment of medical deviance to be purely technical, neutral, and unbiased. As Chapter 9 illustrates, however, the very definition of illness is socially constructed, and social groups often impute responsibility for illness to the sick person.

Freidson (1970) observed that certain conditions are typically viewed as the responsibility of the sick individual and thus are treated relatively punitive, like crimes. Examples include various sexually transmitted diseases as well as substance abuse and conditions derived from such abuse. Freidson noted that the attitudes of both the society and the medical profession, although greatly expanding the range of conditions considered to be properly “medical” problems, do not necessarily abolish the negative moral connotations attached to these conditions. He also described another category of sicknesses that, although not technically considered the fault of the sick person, are nonetheless stigmatized (Freidson, 1970: 234–237). Stigma is a powerful discrediting and tainting social label that radically changes the way an individual is viewed as a person (Goffman, 1963: 2–5). For example, being an illegitimate child was (in the past more than now) an enormous barrier to presenting oneself as a “normal,” upright citizen.

Many sicknesses carry a stigma. Leprosy, epilepsy, and AIDS, for example, all carry connotations of disreputability and even evil. The sick role for someone with a stigmatized illness is clearly different than that for a person with a neutral sickness. Stigmas can result in various forms of discrimination: Persons with epilepsy, for instance, have experienced job discrimination, difficulty in obtaining insurance, and prohibitions against marrying (Schneider and Conrad, 1980). Even after someone has been treated and pronounced cured of such a condition, the stigma often remains on that person. Furthermore, the stigma frequently spreads to the family and close friends of the sick person in what Coffman (1970: 247–252) calls a “courtesy stigma.” For example, families and friends of persons with epilepsy, cancer, or AIDS sometimes find themselves shunned or harassed (Conrad, 1986).

The source of stigma is not the disease itself but rather the social imputation of a negative connotation. Leprosy is highly stigmatized in India, but far less so in neighboring Sri Lanka. Lepers in India are treated as outcasts, whereas many lepers in Nigeria remain in the village and carry on normal social lives (Waxler, 1981). Because cultures vary in the stigma imputed to different sicknesses, the sick role for those illnesses varies accordingly.

The degree of stigma and responsibility attached to a sickness may also change over time, often as notions about an illness change. In the nineteenth century, when tuberculosis was considered to be a somewhat romantic sickness resulting from an inherent disposition of passion and creativity, the illness had relatively little stigma. Later, however, when tuberculosis was considered infectious, those with the disease were seen as carriers to be avoided, isolated, and feared (Herzlich and Pierret, 1987).

Specific social and historical conditions lead to the stigmatizing of a sickness. Before the middle of the nineteenth century, leprosy in Hawaii was of minor importance and not stigmatized. As international trade and colonialism began to change the islands’ social and economic situation, however, many outsiders came to the islands. Large numbers of Chinese immigrants arrived to work on the plantations, and the Hawaiians believed they had brought leprosy. Although the Chinese immigrants were hard working and frugal, they were viewed as an inferior ethnic-racial group that threatened the jobs of other working-class persons. In 1880, Hawaii enacted laws to exclude the Chinese, partly based on the belief that they carried disease. Health data suggest that the Chinese were not, however, an important source of leprosy, which at the same time became stigmatized because it was identified with the Chinese. A relatively unknown and unimportant disease was thus transformed into a morally threatening sickness (Waxler, 1981).

The stigma attached to AIDS in recent years is a parallel situation. The widespread imputation of responsibility and stigma to sick persons suggests that Parsons’s sick role model understates the moral judgment and social control aspects of sickness.

**The Medicalization of Deviance**

Religious, legal, and medical institutions have all contributed to the definition of deviance in society. For example, “Thou shalt not steal” is a religious norm: Stealing is a sin. Legal systems define similar norms of behavior, and violation of the norms is a crime. In a process called the medicalization of deviance, medical systems increasingly also define what is normal or desirable behavior: Badness becomes sickness (Conrad, 1996).

The relative influence of religious, legal, and medical institutions in defining deviance has shifted in Western societies. As the Middle Ages waned and these three institutions became increasingly differentiated from each other, the religious organizations still had the greatest weight in defining deviance. This preeminence continued into the eighteenth century, but in America and France (and later in other European countries), the legal mode of defining deviance gained ascendancy (see Freidson, 1970: 247–252). In America, the increasing preeminence of the legal definitions was promoted by religious pluralism and by the increasingly rational organization of the nation-state (see, for example, Hammond, 1974).
The significance of legal definitions of deviance has diminished somewhat in the twentieth century, and medical definitions have gained in importance. This shifting balance is clearly reflected in the 1954 precedent-setting case Durham v. United States (214 F.2d 863), in which the court ruled that “an accused is not criminally responsible if his unlawful act was the product of a mental disease or mental defect.” The shift in balance favoring medical definitions of deviance corresponds chronologically with a period of the rapid professionalization of medicine, when medical discoveries and technology proceeded quickly, and public faith in science and medicine was increasing.

Part of the reason for the declining importance of religious definitions is that they appear too nonrational and, in a religiously pluralistic country, lack society-wide acceptance. Legal definitions, although more rational, seem to hinge too greatly on human decisions, such as the judgment of 12 ordinary citizens on a jury. Medical definitions, by contrast, appear to be more rational and scientific, and based on technical expertise rather than human judgment.

The concept of sickness, however, far from being a neutral scientific concept, is ultimately a moral one, establishing an evaluation of normality or desirability (Freidson, 1970: 208). The medical profession (especially its psychiatric branch) has defined a wide range of disapproved behavior as “sick”: alcoholism, homosexuality, promiscuity, drug addiction, arson, suicide, child abuse, and civil disobedience (Conrad and Schneider, 1992; Peele, 1989). Social stigma adheres to many sicknesses, such as leprosy, AIDS, pelvic inflammatory disease, and cirrhosis of the liver.1 Moral judgment is also applied in the evaluation of good patient behavior, defined as acknowledging the necessity of medical care and following doctors’ orders for various conditions, which may include receiving prenatal care, accepting blood transfusions, obtaining inoculations for one’s children, and following prescribed drug and dietary regimens. Issues of moral judgment and responsibility are at stake.

Zola (1983: 261) argued that “if anything can be shown in some way to affect the workings of the body and to a lesser extent the mind, then it can be labelled an ‘illness’ itself or jurisdictionally ‘a medical problem.’” Thus, even normal and healthy physical conditions or processes, such as menstruation, pregnancy and childbirth, body and facial shape and size, and aging, have been brought under medicine’s jurisdiction (Dull and West, 1991).

The Medicalization of Moral Authority

The same historical processes that brought about the preeminence of medical definitions of deviance also led to a much stronger role for medical authority in moral issues, such as what is good or bad?, and whose good should prevail? Sometimes court events involve a clash of several sources of authority.2

In one representative court case, claims were made from legal, medical, parental, and religious bases of authority. A young person had been comatose for months, and was as good as dead in the commonsense view. Her body was being kept alive by technological intervention, and eventually her parents sought legal permission to terminate these extraordinary measures. Because no single authority held uncontested legitimacy, the case was complicated. Medical experts gave their opinions on the medical definitions of death. Legal experts raised issues of the legal rights and guardianship of comatose patients. Theological experts offered briefs on the borderlines of life and death, and the girl’s father made a thoughtful personal statement about his request. The relevant issue is not merely the uncertainty of the outcome, but also that it was the court in which medical, legal, religious, and parental figures vied to have their statements taken seriously (Fenn, 1982; Willen, 1983).

The growing legitimacy of medical authority, relative to other sources of judgment, is further illustrated by contemporary court decisions upholding medical judgments to perform Caesarian sections. Caesarian sections are increasingly common, now accounting for about one in four births in the United States. They involve major abdominal surgery, with its concomitant risks and complications. An investigation of court cases between 1979 and 1986 showed that courts often accept physicians’ decisions to operate over the objections of patients, their families, or religious persuasion, even though subsequent medical developments suggest that many of these operations were not necessary (Irwin and Jordan, 1987).

Nevertheless, nontechnical judgments are often involved in decisions to impose medical treatment, even a serious breach of the bodily integrity of the unwilling patient. Court-ordered surgical delivery was disproportionately used on women of color, poor, and non-English-speaking women. These factors appear to be linked with doctors’ moral evaluation of some women as incompetent, ignorant, or “bad” mothers, who cannot take the interests of their child into account (Daniels, 1993: 31-55). Such a paternalistic stance was also evident in a Canadian study of aggressive medical intervention in childbirth; the physicians viewed themselves as “fetal champions,” looking out for the best interests of the fetus (Bassett et al., 2000). Similarly, medical authority has legitimated the medical prosecution of women charged with “prenatal endangerment,” for example by engaging in childbirth without medical assistance or failing to follow doctors’ orders to stop smoking or drinking (Tsing, 1990).

Medical dominance has effectively reduced the legitimacy of actions of other “encroaching” institutional areas such as religion and the family. Several courts have overruled religious or moral objections to various medical procedures. Jehovah’s Witnesses, for example, believe that blood transfusions are forbidden by scripture, but the courts have generally upheld the medical authorization of such treatments, even for unwilling recipients (United States v. George, 239 F. Supp. 752, 1964). Medical authority was also ruled to supersede parental authority in decisions presumed to determine life or death (precedent cases in 1952, 1962, and 1964 are cited in Burkholder, 1974: 41). In 1990, a lower court denied the parents’ request to terminate artificial nutrition and hydration for a patient in a

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1 Cultures vary, however, as to which sicknesses are stigmatized. For example, in China, diseases attributed to socially unapproved emotions such as anger are more stigmatized than those attributed to purely physical causes (Ots, 1990).

2 This section is adapted with permission of the publisher from Religion: The Social Context (5th ed.) by Meredith B. McGuire, 2002, by Wadsworth/ITP.
vegetative state, while upholding hospital employees' refusal to cooperate with their wishes (Gruzen v. Missouri, Department of Health, 497 U.S. 261, 110 S.Ct. 2841, 1990). Although this case was essentially about whether the parents' judgment was adequate substitution for the patient's own decision, the cultural authority attached to hospital-administered medical technology took the decision out of the parents' area of legitimate authority.

Even in instances in which the medical ability to prevent death is more doubtful, greater legitimacy is given to medical rather than parental authority. In 1994, for example, a California court ordered that a Hmong Laotian child suffering from leukemia be removed from her parents' custody because they refused medically prescribed chemotherapy for her; more than 200 Hmong demonstrated against the decision, which overruled the parents' ethnic and religious objections to Western medical treatment (New York Times, 1994c).

Social Control and Power

The labeling of deviance is an issue of legitimacy on another level as well, for the power to define sickness and to label someone as sick is also the power to discredit that person (Zola, 1983: 276–278). If a person's mental health is called into question, the rest of society does not have to take that person seriously. The individual then becomes the locus of the so-called problem. During the Vietnam War, a physician refused to train medical personnel for the army, claiming that his religious conscience compelled him to refuse this service. The army insisted that his compulsions were psychological rather than religious (Fenn, 1978: 57). By thus raising doubt about his psychological health, the army was able to evade his religious dissent as well as his legal claim to protection under the First Amendment of the Constitution.

Medical control in defining deviance also produces medical power in certifying deviance, which is another aspect of social control. The societal acceptance of medical definitions of deviance gives the medical profession unique power to certify individuals as sick or well. If a back disorder is a legitimate basis for taking the sick role (and thus to be excused from work or to claim insurance), a physician is considered the appropriate agency for certifying a valid claim. Sick persons typically use "feeling" terms to describe internal states that they experience as illness; they say, for example, "I don't feel good" or "I feel too dizzy to stand." When the bodily source of feeling sick is not obvious to their audiences, they need doctors' substantiation to legitimate their claims (Telles and Pollack, 1981). Putting a medical label on an illness can be beneficial when it validates and demonstrates serious concern about patients' symptoms and gives some meaning or coherence to their distressing experience, thereby supporting their efforts to manage the illness (Broom and Woodward, 1996; Lorber, 1997). Doctors, however, often resist diagnosing ambiguous illnesses (especially contested categories such as chronic fatigue syndrome) because they do not want to encourage patients to take the sick role. They are thus caught between conflicting roles for themselves: physician as patient advocate and patient-claimant versus physician as agent of social control.

One of the social control functions of physicians is the role of gatekeeper (Stone, 1979), making them responsible for separating the "deserving" from the "undeserving" claims for sympathy and social support, sick leave, disability pay, health insurance, hospitalization, and so on. Physicians became the chief arbiters of claims for workers' compensation for repetitive strain injuries; not surprisingly, company doctors selected by manufacturers or insurers typically were less likely to certify the injury or provide sympathetic care than were personal physicians (Reid et al., 1991). Similarly, from 1952 to 1979, when homosexuality was considered a legitimate basis for denying a person U.S. citizenship, psychiatrists were given the power to certify that a homosexual should be thus denied (see Szasz, 1970).

When a person is certified as deviant, the agency of social control must then deal with this offender. Religious responses to deviance include counseling, moral indignation, confession, repentance, penance, and forgiveness. Legal responses include parallel actions, such as legal allegations, confession, punishments, rehabilitation, and release with or without the stigma of a record. In the medical model, the responses entail other parallels: diagnosis, therapy, and counseling.

The process of reintegrating the deviant individual into the social group is therapy, which for even relatively minor deviance involves a form of social control (such as getting a young mother "back on her feet" so she can resume her family responsibilities). The social control functions of therapy are most clearly evident in such situations as the kidnapping and forcible "deprogramming" of persons with deviant religious or political views (Robbins and Anthony, 1982) and the mental hospitalization of political dissidents (Freidson, 1970: 246; see also Tumer, 1977; Medvedev and Medvedev, 1971).

The use of psychoactive drugs for social control is one area of particular concern. Several U.S. and Canadian studies have documented the very large proportion of the elderly receiving drugs that affect the central nervous system, such as tranquilizers, analgesics, antidepressants, sedatives, hypnotics, and anticonvulsants. One function, deliberate or not, of the use of these drugs is the management of elderly persons. For example, older persons need shorter but more frequent periods of sleep than younger adults, but sedatives are often prescribed in many institutions to try to keep the elderly in an eight-hour sleeping pattern, so the staff can better supervise them at night (Harding, 1981; see also Harding, 1986).

Similarly, difficult-to-manage school children are often prescribed Ritalin (or its competitors, Adderal, Concerta, Metadate CD, and so on) to calm their excess activity and get them to pay attention to their learning tasks. U.S. patients use 90 percent of the world's production of Ritalin, prescribed to up to 6 percent of elementary and pre-teen schoolchildren for a variety of behavioral disorders (Environment News Service, 2001). In 2000, doctors wrote almost 20 million monthly prescriptions for these stimulants; most were written for children, especially boys. Sales for Ritalin and related stimulants were $758 million, an increase of 13 percent since the preceding year (Zernike and Petersen, 2001). Other childhood behavioral disorders (for example, Oppositional and Defiant Disorder, Anxiety Disorder) are increasingly treated pharmacologically, as well.
Social control is also involved in the use of drugs to make it possible for persons to accommodate themselves to an unsatisfactory social role. When workers experience severe stress in the workplace, treating their stress-related health conditions with drugs keeps them performing their roles without challenging the work conditions or the appropriateness of those roles. One pharmaceutical company was investigated in 1987 by the U.S. Food and Drug Administration for sending doctors an advertising brochure depicting on the cover a very tense air traffic controller at the computer monitor in a hectic control tower. The caption read, “He needs anxiolytic [tranquilizer] therapy ... but alertness is part of his job.” Inside the folder, the worker is portrayed as cheery and smiling, and the text reads, in part, “BuSpa... For a different kind of calm.” Although the ad was criticized as misleading in its downplaying of negative side effects of the drug, the more serious sociological issue is that a tranquilizer is being promoted as a solution to workplace stress brought on by specific policy decisions. According to a U.S. Government Accounting Office study, air traffic controllers suffered low morale, extreme overwork, and other pressures due to chronic and serious under-staffing—a major problem since President Reagan had fired 11,000 striking traffic controllers in 1981 (Health Letter, 1987).

Research in the United States, Canada, and Europe shows that women have been the overwhelming majority of recipients of tranquilizers and sedatives (Ashton, 1991; Harding, 1986). Pharmaceutical company advertising to doctors specifically recommended such psychoactive drugs to deal with women’s dissatisfaction with their social roles. An advertisement for Valium (diazepam) showed a troubled young woman sitting at a table in a school gymnasium; the photo was labeled as follows:

Symbols in a life of psychic tension: M.A. (Fine Arts), PTA (President-elect), GYN (repeated examinations, normal [persistent complaints]). . . . Rx: Valium... representations of a life currently centered around home and children, with too little time to pursue a ... situation that may bespeak continuous frustration and stress: a perfect framework for her to translate the functional symptoms of psychic tension into major problems. For this kind of patient—with no demonstrable pathol...y with repeated complaints—consider the distinctive properties of Valium (diazepam). Valium possesses a pronounced calming action that usually relieves psychic tension promptly, helping to attenuate the related somatic signs and symptoms.

Like the air traffic controller, this young woman is identified as suffering from the stress and frustration of her social role. The solution of prescribing psychotropic drugs—as advocated by physicians, as well as the pharmaceutical industry (Raskin, 1997)—serves the social control function of keeping people in their roles without questioning the role demands themselves (for a review of the literature on prescription of psychotropic drugs for women, see Ettrup and Riska, 1995).

In the 1990s a newer form of medicalized social control became evident in the United States, Canada, and several European countries. In the name of improving health, the medical establishment (in the form of national health services, public health programs, corporate wellness programs, and managed care organizations) promoted moral judgments attached to “lifestyle” decisions. These lifestyle expectations were highly individualized: It became solely the individual’s responsibility to maintain a “healthy” lifestyle, for example by getting lots of exercise, eating “right,” ceasing smoking and drinking alcohol, reducing stress, maintaining the “right” weight, and so on. Although the promotion of behaviors that might help prevent diseases is an appropriate part of public health measures, by individualizing the concept of “lifestyle” these programs had the effect of diverting from the social and public causes of disease, such as environmental pollution, illness-producing work and workplaces, and socioeconomic constraints that prevent individuals from achieving a healthy “lifestyle” (Bunton et al., 1995; Mechanic, 1999). Notice the moral connotations of such notions as eating “right,” with little or no recognition of the difficulties of obtaining a good diet on a poverty-level income. These moral judgments are readily medicalized because biomedicine treats disease as a feature of the individual.

Social control may seem more pleasant or humane when the deviance is treated as sickness rather than as crime or sin, but the potency of the control agencies is just as great. Certain medically defined deviance can permanently spoil the individual’s identity (see Goffman, 1963). Even when the condition is considered medically cured or under control, stigma still adheres to such illnesses as alcoholism, drug abuse, mental disorders, syphilis, and cancer. This problem of stigma is especially evident in the case of illnesses involving deviance from one very important cultural norm: self-control. Chapter 7 further examines the problems of stigma and control in chronic illness and disabilities.

**Sickness and Social Dissent**

The social control functions of the sick role and of some medical interventions demonstrate that society’s constraints on individual behavior are real, even when individuals do not agree with the norms for behavior. Although social control measures may be objectively powerful in a society, their effect is never total. Society’s members are never fully socialized and compliant. Thus, deviance such as sickness can also be a form of social dissent—usually unorganized, but sometimes organized—against existing social arrangements.

Sickness is, as the sick role concept shows, an act of refusal that is potentially threatening to the established order. In effect, the sick person is saying, “I will not ... any longer.” By claiming the sick role, the individual may refuse to go to school or work, to be responsible for dependents, to serve in the armed forces, and to participate in everyday social obligations. Indeed, in its extreme form, sickness is a refusal to cope, to struggle, and to endure. As such, claiming the sick role resembles the political activist strategy of passive resistance (Lock and Scheper-Hughes, 1990; Scheper-Hughes and Lock, 1991; see also Herzlich and Pierret, 1987: 183–184; Kleinman, 1992). Taking the sick role is thus often a way of expressing
dissent from other social roles. Many social historians consider the epidemic of hysteria among Victorian women to be an expression of their dissent against the constraints of their social roles (Sicherman, 1978). Similarly, workers' job dissatisfaction is often expressed by high rates of absenteeism for sickness.

Sickness is not necessarily an effective form of dissent, however. Waitzkin (1971) suggested the sick role has latent (that is, not recognized or intended) functions that maintain the status quo in society and reduce conflict and change. For example, if disgruntled workers take sick leave to relieve the tensions of their job satisfaction, the sick role reduces the likelihood that those tensions will be addressed politically, such as in a confrontation with management. The sick role instead provides only a temporary safety valve to reduce pressure in various institutional settings, such as the family, prisons, and the military.

Although the sickness may not be able to change social arrangements, such as social class or gender hierarchies, it may be effective in obtaining actual advantages or relief for the sick person. Some secondary gains of sickness, such as receiving extra attention in the family, may be such a result. For example, many African societies have special healing cults for women, such as the sar cult of the predominantly Muslim peoples in Ethiopia, Egypt, Sudan, and Somalia. Some anthropologists have interpreted the sar affliction, in which the sick person is believed to be possessed by spirits, as women's assertion of dissatisfaction with their lack of social and economic power (Lewis, 1971). Taking the sick role can be a relatively successful (albeit manipulative) assertion of power of the subordinate members of the society. It poignantly expresses women's dissent, but does not fundamentally alter the social arrangements.

Similarly, sickness is sometimes the attempt to cope (although not always constructively) with an intolerable social situation, as discussed in Chapter 4. Sickness expresses frustration, dissatisfaction, and anger turned against oneself. Alcoholism and other substance abuse, depression, and suicide exemplify this potentially self-defeating attempt. To interpret, for example, the alcoholism of a middle-aged, unemployed, impoverished Native American on a reservation as a purely individual sickness is thus to miss the likelihood that it is the expression of his frustration and hostility in the face of his utterly marginalized social condition (Schepers-Hughes and Lock, 1991; see also Kleinman, 1997).

Likewise, to interpret an immigrant woman's severe case of "nerves" as a quaint relic of old-country folk beliefs misses the meaning of nerves (or "nervios," "neutra," and so on) as a physical expression of real distress (Finkler, 1989; see also Guarnaccia et al., 1989). Her distress, expressed in the physical symptoms of "nerves," may be produced by the perceived disorder of daily life in a society where she experiences exploitation as a worker and discrimination as a member of an ethnic minority. Her "nerves" may be a reaction to a lack of meaning and perceived assault on self-esteem from living in a culture that lacks the values by which she would have been honored in her native culture (Lock, 1990).

Schepers-Hughes and Lock (1991) argued that modern medicine has so thoroughly individualized its image of sickness that it has lost sight of the extent to which sickness may be the expression of social dissent about frustrated and unmet human needs. They stated:

In summary, we wish to stress that while illness symptoms are biological entities they are also coded metaphors that speak to the contrary aspects of social life, expressing sentiments, feelings, and ideas that must otherwise be kept hidden. As patients—of us—we can be open and responsive to the hidden language of pain and protest, rage and resistance, or we can silence it, cut it off by relegating our complaints to the ever expanding domains of medicine ("It's in the body") or psychiatry ("It's in the mind"). Once safely medicalized, however, the social issues are short-circuited and the message in the bottle—the desperate plea for help and the scream of protest—is forever lost. (Schepers-Hughes and Lock, 1991: 422-423)

Metaphorical aspects of sicknesses are linked with meaning and order.

PROBLEMS OF MEANING AND ORDER

Illness is upsetting because it is experienced as a threat to the order and meanings by which people make sense of their lives. Suffering and death create problems of meaning not simply because they are unpleasant, but also because they threaten the fundamental assumptions of order underlying society itself (see, for example, Berger, 1967: 24). For the individual, illness and affliction can likewise be experienced as assaults on the identity, and on the ability to predict and control central aspects of one's own and one's loved ones' lives. Healing, in all cultures, represents an attempt to restore order and to reassert meaning.

Illness disrupts the order of everyday life. It threatens our ability to plan for the immediate or distant future, to control, and to organize. Even a relatively minor malady, such as a head cold, can disturb the order of daily life; how much more so can serious, potentially fatal, or debilitating illnesses, such as cancer or diabetes, throw our lives into disorder! A study of the impact of childhood leukemia found two characteristic experiences of sufferers and their families: uncertainty and the search for meaning (Comaroff and Maguire, 1981).

Medical systems in all cultures restore order in the face of illness in a number of ways. Diagnostic action, whether accomplished by divination or computer tomography scan, divine revelation or physical examination, is a means of naming the problem and giving it a culturally recognizable form. Naming the illness imposes order on a previously chaotic set of experiences, thereby giving the sick person a set of expectations and some basis for acting. Etiologies likewise contribute to restoring a sense of order, because they identify a causal relationship between sickness and socially prescribed normal or ideal social relationships. In applying particular etiologies to a given illness episode, the medical process ritualistically reasserts these values (Young, 1976).

The healing process in many cultures (including our own) addresses not only individual disruption but also disordered social relations. The individual
Thus, she argued that bodily control is social control, and attitudes toward the body reflect the social concerns of the group (Douglas, 1970; 11–18).

Body symbolism works on several levels; often the body and its parts are used as metaphors. For example, when we say a person is upright, we are referring to both a moral evaluation and a physical posture. Similar body metaphors are applied when we evaluate people as spineless, underhanded, open-eyed, heartless, cold-blooded, brown-nosed, blue-blooded, sinister, thick-skinned, or gutless. Social relations are likewise reflected in body metaphors, such as, “He is a pain in the ass,” or “They are thicker than blood.”

Consider all the symbolic meanings we give to various body parts and body products, including hands, heart, womb, hair, eyes, milk, blood, spit, feces, and sweat. These meanings are not inherent in the physical properties but are applied by a social group. In socialization, we learn our society’s meanings. A baby is not born with an aversion to the sight of blood. A young child must learn to be disgusted by the feel of feces (usually only after having played with them and receiving several reprimands).

Through the meanings attached to the body, social structure shapes individual bodily expression. At the same time, bodily expression reflects the social structure. Numerous studies of various cultures, including Western industrialized societies, have shown how core values are revealed in body-related beliefs and practices, such as eating (Banks, 1992; Lupton, 1996a; Turner, 1982); beauty and adornment (Kunzle, 1981); birth and death (Comaroff, 1985; Davis-Floyd, 1992); sex (Foucault, 1978; Turner, 1984); pollution and cleanliness (Classen, 1994; Douglas, 1966; Elias, 1994 [1978]); fitness and healthy “lifestyle” (Bordo, 1993; Lupton, 1995; O’Brien, 1995); and health and healing (Comaroff, 1985; Crawford, 1984; McGuire, 1988).

The Meaning of Affliction

Illness is also upsetting because it raises the questions of meaning: Why is this happening to me? Why now? Who’s responsible? How could God allow this to happen? Why do the good suffer and the evil prosper? In many cultures, the medical system and the religious system are inextricably interwoven. Religious meaning is thereby connected with illness explanations.

In his analysis of religious systems, Weber noted the importance of theodicies, or religious explanations of meaning-threatening experiences, for sickness, suffering, and death ([1922] 1963: 138–150). Theodicies tell the individual or group that the experience is not meaningless but is rather part of a larger system of order, a religious cosmology (see also Berger, 1967: 24). Some successful theodicies are in fact nothing but assertions of order. A woman discussing her personal meaning crisis after her husband’s premature death said, “I finally came to understand that it didn’t matter whether I understood why he died when he did, but that God had a reason for it, and that was all that mattered.” For this believer, knowing that an order exists behind events was more important than knowing what that order was (McGuire, 1982). Theodicies do not necessarily make the believer happy or even promise future happiness; they simply answer the question, Why do I suffer?
At the same time that Western societies are experiencing the increasing medicalization of authority, Western medicine is having difficulty dealing with sufferers' problems of meaning. Anthropologists remind us that however well Western medicine deals with the symptoms the sick person suffers, it fails to address the problem of "who sent the louse" (Comaroff, 1978). Illness etiologies in Western medicine typically deal with such proximate causes as germs, viruses, and genetic defects, but these notions are not adequate explanations for many people, because questions of meaning frequently beg for ultimate causes.

A foremost characteristic of the institution of medicine in modern Western societies is its differentiation from other institutions that provide meaning and belonging. **Institutional differentiation** is the process by which the various institutional spheres in society become separated from each other (see Parsons, 1966). For example, religious functions are focused in special religious institutions, which are separate from other institutions, such as the educational, political, and economic. The medical institution has limited itself to the cure of disease, as a biophysical entity, and to the physical tending of the diseased individual. Provision of meaning and belonging is treated as relatively unimportant for healing and relegated to the private-sphere institutions of family and religion. These private-sphere institutions are allowed, even encouraged, to handle the meaning problems of the sick, but only so long as their beliefs and actions do not interfere with the medical management of the disease (McGuire, 1985).

Just as the physical body is a potent symbol of one's selfhood, so too are experiences of suffering linked with one's identity. Practically, being unwell implies being disabled, in the sense of being made unable to do what one wants or needs to do; it implies reduced agency. It means losing some control (an especially important quality in this society), and it involves losing one's routines—the very patterns by which daily existence is ordered (Cassell, 1982; see also Comaroff, 1982).

Suffering is not connected with disease or pain in any precise causal or proportionate way. The pain of childbirth, for example, may be more severe than the pain of angina, but it generally causes less suffering because it is perceived as temporary and associated with a desired outcome. A disease may be incurable yet cause little suffering if it does little damage to the person's sense of self and ability to engage in everyday life. For example, a chronic fungal infection may cause less suffering than a temporary but disfiguring episode of Bell's palsy. Many people may seek help and healing less for disease itself than for suffering and affliction.

Cassell (1982: 639) has suggested that suffering poses difficulty for the biomedical system because it is "experienced by persons, not merely by bodies, and has its sources in challenges that threaten the intactness of the person as a complex social and psychological entity." He observed that medical personnel can unknowingly cause suffering when they do not validate the patient's affliction, and when they fail to acknowledge or deal with the personal meanings the patient attaches to the illness. Cassell (1982: 642) noted that "people suffer from what they have lost of themselves in relation to the world of objects, events and relationships." One woman still suffered greatly from a hysterectomy she had undergone six years earlier. As she explained, "It meant losing a huge part of my future." Unmarried, childless, and only 29 years old, she lost hopes and dreams for the future. She expressed enormous anger at the insensitivity of physicians and hospital staff who had treated her "like an ungrateful child, crying over spilt milk" (quoted in McGuire, 1988). The medical personnel, even if thoroughly well intentioned, probably felt their sole duty was the correct treatment of her specific uterine problem; the woman's suffering was not their problem, nor relevant to their tasks.

Whether brought on by a physical problem or not, affliction often results from a threat to the **coherence** of a person's world. As noted in Chapter 4, a sense of coherence itself is related to health and healing. People suffer from a loss of connectedness—links with loved ones, valued social roles, and groups that are important to them. As Chapter 7 shows, the illness experience often involves such losses. In the face of affliction, people seek meaning and order to address this essential coherence (Cassell, 1982; see also Antonovsky, 1984).

**SUMMARY**

Sickness is not merely the condition of an individual, but is also related to the larger social order. It is connected with moral issues and the imputation of responsibility for deviance from social norms. Society deals with such deviance through social control mechanisms, including the sick role. Sick role expectations, however, vary historically and cross culturally. The discrepancies between the ideal image of the sick role (based on certain forms of acute illness) and chronic and other nonacute conditions result in ambiguous expectations for those whom society defines as sick. The medicalization of deviance and the social stigma of illness highlight the social control functions of medicine, which are yet another connection between power and health. The medical profession has successfully asserted primacy in the defining deviance and the corollary function of certifying deviance, thereby becoming a primary moral authority in modern societies.

A related issue is the problem of meaning created by illness, suffering, and death. Because of the importance of the human body as a natural symbol, bodily control and healing practices reflect social relationships and concerns. The problems of meaning brought on by illness are particularly difficult in modern Western medical settings, due to the differentiation of medical institutions from meaning-providing institutions such as religion and family. The biomedical model, with its nearly exclusive focus on physical conditions, does not deal adequately with suffering and the subjective experience of affliction.