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SEEM, JOHN ERNEST

CAUSAL ANALYTIC SICK ROLE THEORY: AN ANALYSIS OF CAUSAL PROCESS IN TWO POPULATIONS

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CAUSAL ANALYTIC SICK ROLE THEORY:

AN ANALYSIS OF CAUSAL PROCESS IN TWO POPULATIONS

by

John Ernest Seem

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Causal Analytic Sick Role Theory: An Analysis of Causal Process in Two Populations

BY

Dr. John Ernest Seem

APPROVED	DATE
Alan Booth	4-17-81
Nicholas Babchuk	4-17-81
David R. Johnson	4-17-81
J. Allen Williams, Jr.	4-17-81

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John Ernest Seem

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CHAPTER ONE:

LITERATURE REVIEW

INTRODUCTION

Parsons' (1951; 1958; Parsons and Fox, 1952) conceptualization of the sick role has generated a considerable body of sociological thought and research. The sick role has been described as "one of the more central concepts in medical sociology" (Gordon, 1966:17). Friedson 1970:228) stated that Parsons' conceptualization represents "a penetrating and apt analysis of sickness from a distinctly sociological point of view".

Parsons described the sick role as an interrelated set of institutionalized expectations pertaining to the sick status within a social system. The sick role is comprised of four interrelated normative dimensions which are generally regarded as legitimate within a society:

(1) the sick person is not personally responsible for his/her condition,

(2) the sick person is exempt from normal social responsibilities,

(3) the sick person should recognize that illness is inherently undesirable and that he/she has an obligation to try to get well, and

(4) the sick person has an obligation to seek medically competent assistance and cooperate with medical personnel.

Health is defined as an optimum capacity to effectively perform social system roles and tasks. To the degree that illness detracts from this optimum capacity the illness may be viewed as a particular form of deviance characterized by passive withdrawal from normal role obligations rather than overt rebellion. By promoting renewed health the sick role serves as a means of social control within a social system.

The sick role was recognized by Parsons as an ideal typology of social expectations. Therefore, not all persons or groups within a given society will equally support these sick role expectations. Although primarily concerned with the sick role as an abstract set of norms, Parsons suggested that the sick role will affect individual manifestations of illness behavior. This effect will be relative to the nature and severity of the specific illness.

In order to examine the veracity of the sick role concept, it is necessary that one determine the answers to four research questions: (1) To what degree are the four sick role expectations applicable to various types of illness and disability?, (2) To what degree is the verbalized or actual behavior of subjects who have been designated as ill or disabled consistent with sick role normative dimensions?, (3) To what degree do various publics perceive sick role expectations in a manner consistent with Parsons' formulation?, and (4) To what degree are public perceptions of sick role expectations a function of sociocultural characteristics such as age, sex, SES, religion, ethnicity, etc.?.

While past studies have individually addressed one or several of these research questions, none of the past inquiries have undertaken a comprehensive assessment of the four issues. The purpose of the present

study is to provide such a comprehensive evaluation within a causal analysis framework. In order to avoid substantive and methodological limitations of past studies the present chapter will review and critique sick role literature. This review suggests that past studies demonstrate a limited ability to predict and explain sick role related events and yield no clear understanding of causal processes which are implicit or explicit in past sick role literature. The proposed study will more fully explicate these sick role related causal processes and test these propositions among a general metropolitan adult sample and a home health care client sample.

PRIOR EMPIRICAL RESEARCH

Past sick role studies will be reviewed within a format consistent with the four research questions addressed by these studies. These research questions include: (1) To what degree are the four sick role expectations applicable to various types of illness and disability?, (2) To what degree is the verbalized or actual behavior of subjects who have been designated as ill or disabled consistent with sick role normative dimensions?, (3) To what degree do various publics perceive sick role expectations in a manner consistent with Parsons' formulation?, and (4) To what degree are public perceptions of sick role expectations a function of sociocultural characteristics such as age, sex, SES, religion, ethnicity, etc.?.

Sick Role Applicability to Illness Types

A number of past studies have focused upon Parsons' observation that the applicability of sick role expectations is relative to the

nature and severity of a particular illness or disability. These studies have explored sick role norms in relation to selected illness types. A review of these studies follows.

Kassenbaum and Bauman (1965) studied dimensions of the sick role among a quota sample of 201 persons with primary diagnoses of arteriosclerotic heart disease, diabetes, or psychoneurosis. All members of the sample were out-patients at an urban teaching hospital. Three-fourths of the sample were women. All sample members reported limited income. The authors agreed with Parsons that sick role expectations are "broadly normative" in American Society. However, they also predicted that different segments of the population would vary in their perception of the sick role. To test this prediction, each sample member was presented with 20 items designed to measure (a) the four sick role dimensions and (b) other "salient concerns" of this out-patient population. Factor analysis of responses to the twenty items yielded four orthogonal factors which Kassenbaum and Bauman labelled as (1) dependence, (2) reciprocity, (3) role-performance, and (4) denial. Inspection of the item-factor loadings indicated that the first two factors (dependence and reciprocity) intermix items measuring sick role dimensions of (a) exemption from personal responsibility for illness and (b) exemption from normal role responsibilities. The third factor, role performance, is comprised solely of items measuring exemption from normal role responsibilities. The final factor, denial, is comprised of items which measure (a) the third sick role dimension, that illness is undesirable and the patient has an obligation to get well, and (b) several items which measure the subject's belief that the patient must assume self-responsibility for both incurring and recovering

from an illness. No items in this scale directly measure the fourth sick role dimension, to seek and cooperate with medical personnel.

Do low income, chronically ill persons perceive the sick role in a manner different than the four sick role dimensions stipulated by Parsons? The answer to this question is not immediately obvious from Kassenbaum and Bauman's analysis. None of the scale items directly measure the fourth sick role dimension. The authors employed orthogonal rotation of factors. However, Parsons conceived of sick role dimensions as interrelated with one another. Therefore, oblique rotation would have been more appropriate (Rummel, 1970). Three of Kassenbaum and Bauman's four orthogonal factors intermix items from at least two sick role dimensions. This suggests that persons who supported one of Parsons' dimensions also supported other of these dimensions. The only evidence that Kassenbaum and Bauman present that is inconsistent with Parsons' ideal type is that some persons emphasized personal responsibility in relation to illness. However, an ideal type cannot be expected to apply equally well to all persons. Persons who emphasized self-responsibility for illness tended to be (a) female, (b) over 60 years of age, and (c) of lower social class standing than other subjects.

Gordon (1966) interviewed an area probability sample of 1000 New York City residents. Subjects were asked how they would behave towards a person experiencing (a) non-serious, temporary, (b) chronic, or (c) worsening or critical conditions. The data revealed that subjects were about equally likely to encourage the ill person to see a medical doctor, care for an ill person's physical needs, excuse the ill person from normal social responsibilities, and encourage the ill person to ask the subject for assistance under (a) non-serious, temporary and (b) chronic

conditions. Subjects indicated that they were less likely to react in such a manner in cases of worsening or critical medical conditions. These results suggest that members of the general public are more likely to view sick role dimensions as applicable to non-serious, temporary and chronic illness than to worsening or critical medical conditions.

Petroni (1969b) has also investigated the degree to which sick role expectations apply to chronic illness. He collected data from an area-probability sample of 201 nuclear families in a midwestern metropolitan area. Further analysis of the sample revealed that it over-represented lower and upper class families and was atypical of the area from which it was drawn. Legitimacy of the sick role was determined by subjects' responses to four items, corresponding to Parsons' sick role dimensions, as they pertained to seven hypothetical illness conditions. These conditions included allergy, heart disease, diabetes, arthritis-rheumatism, sore throat-running nose, vomiting with aches and pains, and nervousness-depression. The analysis indicated that subjects perceived that the sick role most legitimately applied to heart trouble and diabetes (chronic conditions) and vomiting (acute condition). Slightly less sick role legitimacy was granted to arthritis (chronic). Sick role expectations were viewed as least legitimately applicable to allergy (chronic), sore throat (acute) and nervousness-depression (psychiatric). When grouped into illness categories, the data revealed that subjects viewed the sick role as most legitimately applicable to chronic illness. The sick role was viewed as somewhat less applicable to acute conditions. Finally, the sick role was perceived as least applicable to the psychiatric condition of nervousness-depression.

Blackwell (1967) has studied the applicability of the sick role to

psychological and physical conditions. She concentrated upon the sick role dimensions of (a) admitting one's dependence to others and (b) seeking medical assistance. Data were collected from adult residents of one upper-middle class census tract in a western metropolitan area. The respondents indicated that they would more quickly seek medical assistance for a physical rather than a psychological condition. They also revealed that they were more likely to postpone admitting their dependence to others in cases of a psychological problem.

The combined results of Petroni and Blackwell do suggest that upper-middle and upper class persons grant greater sick role legitimacy to physical rather than psychological conditions. However, research has not yet demonstrated if this generalization also extends to members of other social classes.

Whitt, Meile, and Larson (1979) examined the ability of sick role theory hypotheses and labeling theory hypotheses to explain the effects of labeling and symptomatology upon self-perceptions concerning mental illness among three samples - one of psychiatric patients, one from the general public with high symptomatic impairment, and one from the general public without substantial symptomatology - in a midwestern metropolitan area. They reported that neither sick role theory nor labeling theory fully account for self-perceptions of mental disorder. They also indicated that many people ignore or resist medical definitions of mental disorder. This conclusion further supports the hypothesis that members of a general public are unlikely to perceive sick role norms as applicable to conditions of mental illness or disability.

Chalfant and Kurtz (1971) studied the degree to which 224 persons functioning in a social work capacity in a large midwestern urban area

viewed the alcoholic as a legitimate incumbent of the sick role. Forty-eight percent of this sample had at least a master's degree in some field and 84% of the sample had completed a formal course or workshop on alcoholism. Subjects were asked one question pertaining to each dimension of the sick role. Fifty seven percent of the sample agreed that the alcoholic was not personally responsible for his/her condition. Forty four percent of the sample agreed that the alcoholic defines his/her condition as undesirable. Less than ten percent of the sample saw the alcoholic as seeking technically competent medical help. Only three percent of the sample believed that the alcoholic should be excused from normal role responsibilities. This study indicates that persons with a graduate level education and who are extremely knowledgeable about alcoholism tend not to view the alcoholic in a manner entirely consistent with the sick role typology. The data tell us nothing about how the general population views alcoholism. An adequate test of Parsons' sick role norms in relation to alcoholism should focus upon perceptions among a general population. Chalfant and Kurtz' study does suggest that persons may view individual dimensions of the sick role as differentially applicable to a given illness condition. Future studies should measure and analyze sick role dimensions in a manner which allows the researcher to estimate this differential support of each sick role dimension.

The final literature to be reviewed in this section includes discussions by Callahan, Carroll, Revier, Gilhooly, and Dunn (1966) and Lipman and Sterne (1969) concerning the applicability of the sick role to terminal and chronic illness. These authors correctly pointed out that Parsons conceptualized illness and the sick status as a temporary state from which persons recover. Since chronic and terminal illness

are not temporary states from which one recovers, these authors conclude that Parsons' sick role concept is not applicable to terminal and chronic illness. While these authors are technically correct at a purely conceptual level we cannot conclude that the general public does not think of chronic and terminal illness in a manner consistent with the sick role typology unless we possess sound empirical data and analysis to support this conclusion. Such a study has yet to be completed.

In light of the preceding studies, we may again consider the question "To what degree are the four sick role expectations applicable to various types of illness and disability?". Past research (Blackwell, 1967 and Petroni, 1969b) indicated that upper-middle and upper-class individuals perceive sick role expectations as much more applicable to physical rather than psychological conditions. The findings of Whitt, Meile, and Larson (1979) also suggest that sick role norms are often perceived as not applicable to psychological illness and disability.

Are these sick role norms applicable to both temporary acute and chronic physical illness? The results concerning this question are mixed. The research by Chalfant and Kurtz (1971) suggested that at least persons who function as social workers in one urban area do not believe that all sick role norms validly apply to alcoholism. Callahan et al. (1966) and Lipman and Sterne (1969) suggested that sick role norms do not apply to chronic illness since it is not a temporary state. However, data presented by Gordon (1966) indicated that the residents of a large eastern metropolitan area view sick role norms as applicable to both chronic and temporary acute physical conditions. Finally, Petroni's (1969b) study suggested that residents of a large midwestern metropolitan area report that sick role expectations are even

more applicable to chronic than to temporary acute illness.

Why are the empirical results concerning sick role norms and chronic and temporary acute illness so mixed? There may be regional differences in sick role perceptions as suggested by the studies of Gordon (1966) and Petroni (1969b). Another reason is that different studies have examined sick role perceptions among different subgroups of the general population. Kassenbaum and Bauman (1965) utilized an outpatient sample while Chalfant and Kurtz (1971) sampled opinions among persons working in a social work capacity. The two studies which employed samples representative of more socially diverse populations (Gordon, 1966; Petroni, 1969b) concluded that sick role norms are applicable to both chronic and temporary acute physical illness. These general conclusions of Gordon and Petroni should not blind us to the possibility that perceptions of sick role applicability to a given illness condition may vary according to the sociocultural characteristics of the population under consideration, as is suggested by other past research.

Finally, the work of Gordon (1966), Callahan et al. (1966), and Lipman and Sterne (1969) indicate that sick role norms do not adequately characterize perceptions of terminal or critical illness. Patients are not expected to recover from such an illness. Therefore, the patient is not expected to so actively participate in the recovery process.

Future research concerning sick role expectations and illness types should profit from strengths and weaknesses of past work in this area. Relevant sick role dimensions should be unambiguously measured, utilizing multiple indicators of each dimension, and conceptualized as interrelated rather than discrete. Probability samples and statistical significance tests should be employed. Specific illness types to be studied

in future work should include: () Physical: (a) temporary and acute, (b) chronic, and (c) critical and terminal; and (2) Psychological. Future research should explore the differential effects of relevant sociocultural characteristics upon perceptions of sick role applicability to illness types and should also determine if these sociocultural characteristics differentially affect the perceived applicability of each individual sick role norm to a given illness type. Multiple indicators of a given illness type should be employed.

Illness Behavior: Willingness to Adopt the Sick Role

Suchman (1965) conceptualized illness behavior as a series of sick role stages. The person first experiences symptoms and then seeks substantiation of his/her illness among family and friends. The person then seeks medical assistance and assumes a dependent patient status. The final step in this process is rehabilitation and/or recovery. Consistent with Suchman's conceptualization, a second set of studies generated by the sick role concept address the research question "To what degree is the verbalized or actual behavior or subjects who have been designated as ill or disabled consistent with sick role normative dimensions?". Sick role norms, in part, specify that the ill person should consult and cooperate with medical personnel. Empirical research has indicated that between one-third and three-fourths of the members of a given population do not consult a medical doctor when they experience illness symptoms (Butler, 1970). This finding clearly points out the discrepancy between public sick role norms as outlined by Parsons and actual or intended illness behavior of individual members of a given public. To further specify this norm-behavior discrepancy, studies

reviewed in this section have investigated the social structural and social psychological correlates of expressed willingness to adopt the sick role.

Koos (1954) studied 514 families of a small town in New York. He found an inverse relationship between social class and probability of experiencing a disabling illness. Among those persons who reported a disabling illness, middle class persons were more likely to seek medical treatment (82%) than were upper class (67%) or lower class (67%) individuals. Elderly persons were less likely to seek medical treatment for a disabling illness than were younger persons.

Gurin, Vernoff, and Feld (1960) interviewed a probability sample of 2460 Americans, age 21 and older. Transients and all persons in hospitals, prisons, or other institutions were excluded from the sample. This study focused upon public views on mental health. The data indicated that persons with a college education were more likely (21%) to have obtained psychiatric counseling than were persons with a high school (15%) or grade school (7%) education. Persons with lower income and education tended to emphasize self-help for psychological problems. Lower income individuals also cited inability to afford psychiatric assistance as a reason for not seeking such consultation. Females (27%) were more likely than males (19%) to indicate a need for psychiatric counseling. Individuals of age 55 or older were less likely to have used psychiatric help (only 7%) than were younger age categories. This age difference remained when controlling for education.

Mechanic and Volkhart (1961) obtained data from 614 college freshmen at a large western university. The researchers explored the relationship between personal stress and tendency to adopt the sick role