

THE SICK ROLE, LABELLING THEORY,
AND THE DEVIANT DRINKER

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Much effort in recent years has been directed toward educating the public in the United States regarding the definition of alcoholism and deviant drinking as medical problems rather than as criminal offenses.^{12,24} These efforts are reflected in the various publications of the Rutgers (formerly Yale) Centre for Alcohol Studies, the U.S. Public Health Service, and the National Council on Alcoholism. Likewise, as the therapeutic effectiveness of Alcoholics Anonymous has become increasingly visible, the public has become aware of the assumption that is held by this organization that a form of physical allergy leads to alcoholism. The A.A. concept is somewhat different from the traditional medical model, but the two conceptions share a strong tendency to reduce individual responsibility for the genesis of alcoholism.

The effects of this redefinition have been regarded as positive by most, the most prominent being that alcoholics are committed to hospitals for treatment rather than being detained in prisons.¹¹ Medical treatment is the natural corollary of the medical model and is aimed toward "recovery" rather than toward the "character reform" goal of incarceration. In any event medical treatment is regarded as a more humane reaction to a form of behavior that may not be inherently anti-social or criminal.

However, disease or medical model conception of alcoholism and deviant drinking is not without its adverse consequences. The concerns of this paper are: the possible social psychological consequences of the use of the medical model and; the development of a scheme of preventive intervention which is based on the knowledge of these consequences. Lest there be a misunderstanding about the position taken here, we emphasize at the outset that the disease concept of alcoholism is not being repudiated. Research has definitively shown that the chronic intake of large amounts of alcohol may have pathological effects on the human organism; likewise, the pattern of physiological addiction which develops at the later stages of the alcoholism syndrome may be viewed in itself as a major symptom of disease. Thus, chronic abuse of alcohol may have as one of its consequences organic illness. However, being sociopsychological in orientation, the primary concern of this paper is the nature and consequences of the social labelling

process rather than the nature and consequences of the alcohol ingestion processes.

The basic contention of this paper is that the medico-disease concept of alcoholism and deviant drinking has led to the assignment of the labelling function to medical authorities which in turn has led to the placement of alcoholics and deviant drinkers in "sick roles."^{10 17 18} The expectations surrounding these sick roles serve to further develop, legitimize, and in some cases even perpetuate the abnormal use of alcohol.

There are two basic mechanisms operating through the medical labelling process, which is based on the disease model of deviant drinking, which may serve to reinforce deviant drinking behavior. The first mechanism is assignment to the sick role, this being the consequence of being labelled by a physician as manifesting illness. The sick role assignment may legitimize deviant drinking patterns since these patterns have been labelled results of pathology rather than as inappropriate behavior. This is due to the fact that one of the main characteristics of the sick role is that the individual is not held responsible for his illness; thus, in this case the illness is abnormal drinking behavior and assignment to the sick role removes the individual's responsibility for engaging in this behavior. In his discussion of the relation between temperance movements and the different labels applied to drinking, Gusfield points out that the sick role "renders the behavior of the deviant indifferent to the status of norms enforcing abstinence."¹¹ This "indifference" likewise applies to the norms calling for "normal" drinking behavior.

This appears to be a significant parallel between the development of the disease model of deviant drinking and the disease model of hysteria, the latter of which developed during the 19th century as an early step in a significant expansion of the aegis of psychiatry and medicine. Szasz points out that previous to the labelling of hysteria as a legitimate disease, such behavior was regarded as malingering and was met with social sanctions, the most prominent of which was the physician's refusal to pay any need to such a patient.²³ The "recognition" of hysteria as a "mental disease" changed this picture considerably; unfortunately we have no epidemiological data to indicate historical trends in the comparative incidence of malingering and hysteria, the implication being that the "legitimization" of malingering through labelling it a "real" disease may have led to more people "choosing" this behavioral alternative. The relativity of definitions of deviant and sick behavior to various sociocultural and historical conditions is borne out by the growing literature in transcultural psychiatry which focuses upon epidemiological variations.²⁶ These data likewise augur against the location of explicit genetic or biochemical factors to explain the development of types of disordered behavior which are subject to discrete societal reactions and definitions.

The second mechanism operating through the disease model which may serve to reinforce deviant drinking behavior is that the labelling process may lead to secondary deviance through a change in an individual's self-concept as well as a change in the image or social definition of him by the significant others in his social space.^{3 6 7 13 15 16 22} The individual with the medical diagnosis of alcoholic or deviant drinker occupies a social status which has accompanying role expectations, the principal expectation being engagement in deviant drinking practices. This is illustrated by the fact that we are not surprised to see a drunk alcoholic and we marvel with amazement when we see a sober one. Another sociological fact which helps explain the efficacy of the labelling process is that it is executed by the physician, who is a highly respected societal functionary whose authority is rarely questioned. The end result of the labelling process is a structure of role expectations and a set of self-concept changes that eventuate in the individual's performance of the deviant role. The behavior which is assigned is carried out.

A curious "double-bind" results from the dual operation of these mechanisms.² Deviant drinking behavior is legitimized through the disease label in the sense that the individual is no longer held responsible for his behavior and this behavior is very much rewarding to him. He is also assigned a social role which invidiously surrounds him with expectations for deviance as well as resulting in changes in his self concept. Simultaneously he is expected by significant others in his life space to "shape up," seek treatment, and above all, stop drinking. Both this message and the message of being "sick" appear legitimate but are contradictory. This double-bind may be an invidious cause of his mobility and differential association with those like himself, these behaviors representing the "escape from the field" that is postulated as a solution to a double-binding situation.² This double-bind is very reflective of society's ambivalence toward the labelled alcoholic, a sort of half-acceptance of the sick role notion of problem drinking as well as half-acceptance of the criminal, immoral or "enemy" label of this behavior.¹¹

There are two other possible consequences of labelling which may occur and serve to further "lock in" deviant drinking patterns. First is the process of rejecting the individual from primary group associations that may result from the presence of the label as well as from intolerance of his deviant drinking. The developing alcoholic seeks out opportunities to affiliate with more tolerant drinking groups.^{1 4 20 24 26} The self-concept or personal identification changes that have resulted from labelling may also tend to lead the individual to primary groups composed of other deviant drinkers and alcoholics. This differential association serves to further legitimize, reinforce, and perpetuate deviant drinking and lead further toward true addiction.

A second consequence of labelling may be the functional integration of the labelled individual into social groups which are composed primarily of non-deviants.⁵ There is a growing amount of

research evidence which indicates that certain potentially unstable social groups, such as potentially unstable families or informal friendship groups, may be stabilized by the presence of a deviant member.^{19 21 23 28 29} It is possible for the group to do its own labelling of a selected deviant, but labelling will be much more effective if executed by an outsider who has the institutional assignment to label and whose authority is not questioned. The presence of a formally and officially labelled deviant assures that it is not necessary to "pass the deviance around" among the members in order to hold the group together. The function served by the deviant's presence include (1) the definition of other group members as "normal" because they do not share the deviant's symptoms or his label., (2) the presence of a submissive and relatively helpless target for scapegoating, which in turn allows for displacement of inter-member tensions onto the weak deviant member and thereby reduces cross-cutting interpersonal conflicts which would weaken the organization of the group, and (3) the presence of a rule breaker may offer the group a ready excuse for its shortcomings in goal attainment activities. These functions serve to lock the deviant member's role behavior into the group's patterns to the extent that his behavior is invidiously rewarded and attempts by outsiders to change his behavior are strongly resisted.

The basic point we are attempting to make is that the mere process of labelling and sick-role assignment may serve to aggravate and perpetuate a condition which is initially under the individual's control. In other words, the disease label has disease consequences. We are not arguing that chronic alcoholism is simply a behavioral deviance; protracted heavy drinking with its physiological, psychological and sociological accompaniments has disease consequences in terms of physiological damage as well as in terms of physiological and psychological addiction. The point is that the use of the medical model conception of deviant drinking leads to processes of labelling and sick role assignment at a point previous to true addiction. In other words, something is called a disease or a disorder before it has actually become such. In most cases the behavior may still be under individual control at the time when the labelling occurs. Labelling and the disease model do not allow for this fact, and may serve to "lock" the deviant drinker into a nexus of role expectations as well as changing his self-concept. The performance of this role coupled with the self-reaction to this self-image sets up a system of cybernetic action and reaction which may lead in many ways to true alcohol addiction.

Having developed the theoretical dimensions of the outcomes of labelling to the development or revision of programs designed to identify and treat "alcoholics" in various stages of development.

We are acquainted with certain procedures of medical referral in work organizations which may serve to "lock in" the deviant role assignment. Early identification of the deviant drinker is stressed, and the immediate step following identification is referral to the medical department - in other words, labelling. We

would argue that mere referral to a physician is a form of labelling, in terms of changing the individual's self-concept by telling him that he "needs professional help" and in terms of changing the role expectations held toward him by those who referred him. Thus, even if the physician does not formally label him as an alcoholic, he and those in his social milieu are "told" that his drinking had led him to require medical attention. In any event, it appears that in sociological terms the stage is set for progression toward true addiction in the sense of sick role occupancy and role expectations which may lead to secondary deviance.

Obviously the labelling of every early stage deviant drinker by a medical authority does not ultimately lead to alcohol addiction. Affiliation with Alcoholics Anonymous, various therapeutic interventions, or simple response to the pressures to cease deviant drinking which are brought to bear by "significant others" may result in the termination of the progression. However, labelling and sick role assignment processes may create unnecessary risks for the individual whose drinking problem has not yet gone beyond his personal control. It is argued that the labelling and sick role assignment create actual pressures toward alcohol addiction rather than halting the progression.

In the light of this conceptual scheme, an attempt has been made to develop a model of intervention in which the risk-laden use of the alcoholic or deviant drinker label is avoided as much as possible. In light of knowledge that the early stage alcoholic or deviant drinker is unable or extremely reluctant to recognize his difficulties and do something about them, we have asked the question of what societal system possesses the institutionalized authority to bring effective pressure to bear upon him. The answer appears to be that this legitimate authority is possessed by the employer. The job is essentially an exchange relationship whereby rewards are given for a certain kind of performance. If the performance is inappropriate or inadequate, rewards may be legitimately withdrawn. This scheme of intervention is built on the assumption that the individual cannot perform a role in the work place adequately if he is impaired, and the consumption of alcohol or the presence of a hangover is defined as impairment. There is no evidence to indicate that alcohol consumption improves overall job performance (with the possible exception of a few job roles in the arts). There is an impairment in performance brought about by alcohol consumption, whether the individual has a bottle of beer or a quart of whisky.

For the want of a better term, the intervention is labelled "constructive coercion." Constructive coercion is the confrontation of any employee who shows evidence of drinking on the job or who comes to work with a hangover. This is not only the early identification of alcoholics; but also covers much broader groups. It is the "early, early" identification of problem drinkers. It is total intolerance of drinking or hangovers when the individual is to be performing his work role. The early stage alcoholic is

included under this umbrella, as well as those whose drinking may never eventuate into a problem.

The confrontation of the employee who allows alcohol to enter in any way into his work role involves a simple statement that repetition of this act will lead to termination. There is no referral to a medical department or introduction into therapy because such referrals are not necessary if confrontation occurs at this point. This approach is similar to the "no tolerance for drinking" policy employed in Czechoslovakian work organizations described by Dr. Morris Chafetz.

It should be stressed that this is not a policy where an individual is confronted after alcohol interferes with his work performance; rather, the simple presence of alcohol in the form of drinking on the job or hangover is regarded inherently as impairment of performance. The hard-line norm against the interference of alcohol with job performance must be universalistic if it is to have potency. If it is universalistic, a company policy will encounter fewer difficulties and will be less often accused of inequity. The arbitrary decision of "how much" drinking actually interferes with job performance seems to offer many difficulties, particularly in training of first-line supervisors about when it is appropriate to "confront" an employee who is a problem drinker. Likewise the notion that certain jobs are more or less compatible with alcohol ingestion seems to lead in the same direction of arbitrary decisions, foggy policies, and the risk of inequity.

It should also be pointed out that the "hard-line" approach in which the individual is held responsible for his behavior rather than being allowed to enter the sick role and the nurturance of a doctor-patient relationship does not tap into the psychic dependency of the deviant drinker. In other words, since psychological dependency has been found to be associated with the personalities of alcoholics, it may be argued that a tendency toward irresponsibility both precedes and accompanies alcoholic development.²⁶ A focus upon individual responsibility for deviant behavior runs contrary to this propensity, and constructive coercion may in this sense help to "break up" the progression toward addiction.

Several intervening factors which may temper the success of constructive coercion should be mentioned. First, it is assumed that the job role is the essential nexus of the individual's status set, particularly his status of breadwinner in the family. If he does not have such obligations or is not responsive to such obligations, the effectiveness of constructive coercion may be reduced. This factor may also reduce the potential effectiveness of constructive coercion with female problem drinkers who are not employed or whose employment role is not considered financially essential to the family.

Secondly, it is assumed that the individual has an investment in his job to the extent that quitting and obtaining other

employment is too costly for him in terms of time, training, security, and the personal benefits accompanying his present position. Employees who view quitting and obtaining a new job as a worthwhile investment in order to maintain their deviant drinking may well react in this way to the threat contained within the strategy of constructive coercion.

Thirdly, the visibility of employee behavior to the supervisor is assumed in this scheme. Those who go unsupervised for long periods of time may move too far along the alcoholic progression before they come to supervisory attention to be effectively helped by constructive coercion. This is particularly true of occupations which require extensive travelling.

Fourth, it is assumed that there will be supervisory positions in the organizational hierarchy above an individual with adequate power and authority to carry out constructive coercion. The technique may not be effective for those in executive positions or for those in staff positions where lines of authority are unclear. This same problem may occur in small organizations which lack well-defined status hierarchies. Likewise, constructive coercion is not relevant for the self-employed.

Finally it is assumed that the process will not be disrupted by the employee's total and effective denial of the existence of a deviant drinking pattern. This may present difficulties, particularly in light of anecdotal evidence of the manipulative skills of developing alcoholics.

A final word should be added regarding the relevance of this paper to current programs on the identification and treatment of problem drinking which are in operation or in the process of development in work organizations. These statements should not be interpreted as allegations that these programs are creating more problem drinkers than they are helping. Rather, the programs on the whole operate within a paradigm of problem drinking as a disorder or a disease, which is the rationale for certain characteristics of the programs.¹⁴ The purpose of this paper is to offer a supplemental paradigm for the disease model such that the disease label is not applied before the disease has developed.

It is recognized that there may be many instances in which the alcoholism progression moves beyond the point where medical assistance is unnecessary. However, in these cases the assumptions underlying the constructive coercion strategy are not irrelevant, for a policy of emphasizing individual responsibility for deviance will reduce the degree to which the individual is formally placed in the status of an "outsider" and thereby increase rehabilitation opportunities.

In summary, we have argued that the disease model of alcoholism and problem drinking has resulted in a labelling process that may in itself set the stage for the development of true alcohol addiction. We regard it as a risk factor possibly

contributing to eventual addiction rather than as a sufficient condition for addiction. Through the examination of the social role dimensions of alcoholism and problem drinking, we have presented a tentative model of preventive intervention in which the disease or disorder is applied more cautiously.

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