Published in final edited form as:

J Health Soc Behav. 2007 June ; 48(2): 99–114.

Self-Referent Constructs and Medical Sociology: In Search of an Integrative Framework*

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Abstract

A theoretical framework centering on four classes of self-referent constructs is offered as a device for integrating the diverse areas constituting medical sociology. Guidance by this framework sensitizes the researcher to the occurrence of parallel processes in adjacent disciplines, facilitates recognition of the etiological significance of findings from other disciplines for explaining medical sociological phenomena, and encourages transactions between sociology and medical sociology whereby each informs and is informed by the other.

The history of academia is characterized by the arbitrary setting of boundaries that define the subject matter of each discipline, at the same time separating each discipline from the others. The same balkanization ensues within each discipline, resulting in the proliferation of subspecialties. Nor does the process stop there. Within each subspecialty, scholars focus upon increasingly more narrow areas of interest, learning more and more about less and less.

Thus, the subject matter of sociology is differentiated from that of psychology, anthropology, physiology, political science, and other disciplines. Within sociology, distinctions are drawn among economic sociology; crime, law, and deviance; the sociology of emotions; the sociology of mental health; collective behavior; medical sociology; and so on. Within medical sociology, scholars focus upon one or a few of several areas of interest: utilization of health care facilities, the organization of health care, sick role behavior, psychosocial stress, social stratification and physical illness, mental illness, etc.

For many scholars, myself included, this process has consequences that are dysfunctional for the goal of the scientific process—that is, increased understanding of phenomena at whatever level of abstraction one specifies. These interrelated consequences include the following: (1) failure to place findings in more inclusive contexts, thus overlooking etiological relations among narrow areas of concern; (2) losing sight of the explanatory value of more general principles while simultaneously neglecting to contribute inductively to the genesis of more abstract propositions that will have relevance for other substantive areas within and between subdisciplines; and (3) loss of opportunity to observe parallel processes in, and the causal implications of, other disciplines.

*This work was supported by grants R01 DA 02497 and R01 DA 10016 and by a Career Scientist award (K05 DA 00136) from the National Institute on Drug Abuse.

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I am grateful to the editor and the anonymous reviewers for their close attention to, and their suggestions for improving, the manuscript (in some instances providing more felicitous phrasing).

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The antidote to these noxious outcomes is the development of integrative conceptual frameworks that offer promise of sensitizing scholars to the etiological relationships among, and the parallel processes reflected in, the several substantive areas and the more inclusive (sub)disciplines in which they reside. For present purposes, one such framework is offered to illustrate how it (1) facilitates recognition of etiological relations among medical sociological phenomena, (2) sensitizes the scholar to parallel processes in seemingly disparate areas, (3) gives rise to instances in which general sociological and social-psychological principles inform, and are informed by, medical sociological phenomena, and (4) provides conceptual linkages among academic (sub)disciplines.

TOWARD AN INTEGRATIVE FRAMEWORK

Over the past 45 years I have formulated a general theory of behavior that focuses upon the antecedents and consequences of four classes of self-referent responses, the relations among the self-referent responses, and the mediators and moderators of these relations (Kaplan 1972, 1975, 1980, 1984, 1986, 1996, 2001). Although initially formulated and tested as a general theory of deviant behavior (see Kaplan 1980, 2003; Kaplan and Johnson 2001 for an overview of several analyses), the theory has since been applied as an integrative framework for the literature in several other (partially overlapping) substantive areas, including psychosocial stress (Kaplan 1996), the sociology of emotions (Kaplan 2006), social psychology (Kaplan 1986), and the several disciplines constituting the humanities (Kaplan and Kaplan 2004/2005).

Building upon the seminal observations of others regarding the reflexive nature of human behavior, social influence on self-conception and self-evaluation, and the motivational force of self-feelings (see in particular Cooley 1902; James 1915; and Mead 1934), the theoretical statement delineates: (1) structural and interactional effects on self-conceptions (cognitive responses directed toward one's own person, including self-perception, self-imagination, self-awareness, etc.); (2) the influence of self-cognition on self-evaluation (a subcategory of self-conception whereby persons judge themselves to be more or less proximate to or distant from self-relevant, situationally appropriate, hierarchically oriented evaluative standards); (3) the influence of self-evaluation on self-feelings (emotional responses to internalized needs stimulated by salient self-evaluations); (4) the influence of (negative) self-feelings on initiation of self-enhancing/self-protective responses (behavioral change to approximate self-evaluative standards, distortion of self-concept, reformulation of self-evaluative hierarchy, suppression of distressful self-feelings) evoked by the intensified need to diminish negative (and increase positive) self-feelings, occasioned by negative self-evaluations; and (5) the impacts of self-enhancing/self-protecting responses on behavior that is directed toward approximating salient self-evaluative standards, reordering the hierarchy of standards, or directly diminishing the experience of distressful self-feelings (Kaplan 1986).

SELF-REFERENT CONSTRUCTS AND MEDICAL SOCIOLOGY

While theoretical frameworks centering on self-referent constructs have yet to be applied systematically to the range of literature traditionally subsumed under the rubric of medical sociology, some of my early work with colleagues in the context of medical institutions strongly suggests the applicability of this framework for organizing this literature and informing hypothesis testing. For example, observations on a psychiatric ward revealed the genesis of self-protective and self-enhancing patterns within the patient subculture that arose in response to (1) therapeutic goals of uncovering and interpreting the characterologic defenses (imperfect as they may be) used by the patient to maintain an acceptable self-image, and (2) patient perceptions of institutional and public denigration of the psychiatric

patient status (Kaplan and Boyd 1965; Kaplan, Boyd, and Bloom 1964). Other studies reported the influence of self-referent constructs (notably self-devaluation and concomitant distressful self-feelings) on: physiological responses (Kaplan et al. 1965; Kaplan 1967); on distressful states such as anxiety and depressive affect that, when extreme, are often defined as psychopathological (Kaplan and Pokorny 1969; Kaplan 1970; Kaplan, Robbins, and Martin 1983a), and on other modes of psychopathology (Kaplan, Robbins, and Martin 1983b), including suicidal response (Kaplan and Pokorny 1976a, 1976b, 1976c) and schizophrenia (Kaplan 1978); behaviors that place health status at risk, such as substance use and abuse (Kaplan and Meyerowitz 1970; Kaplan, Martin, and Robbins 1984, 1985, 1986; Kaplan and Pokorny 1977, 1978) and aggression (Kaplan and Halim 2000); the course of illness (Lorimor, Kaplan, and Pokorny 1985); and adoption of the sick role (Johnson, Kaplan, and Martin 1988). In the following pages I will review and evaluate the relevance of a theoretical framework centering on self-referent constructs as a device for integrating the literature ordinarily encompassed by medical sociology, stimulating propositions explaining relevant phenomena, facilitating interdisciplinary communication, and providing a process whereby medical sociology more systematically informs and is informed by the theoretical generalizations of ever-more-inclusive disciplines. I will also illustrate the discussion with reference to studies reported primarily in medical journals over the past five years. I consider in turn the influence of self-referent constructs (most proximally, self-feelings) on health status, and the effects of health status and its correlates on self-referent constructs.

Self-Referent Constructs and Health Status

Health status and health-risk-related variables have been demonstrated with great consistency to have been preceded by distressful self-feelings or the negative self-concepts and self-evaluations that evoked these affective responses. By way of illustrating this generalization, and referring only to longitudinal studies, the following generalizations may be offered: Lower levels of self-esteem were associated with first-onset psychosis three years later (Krabbendam et al. 2002). Barrowclough and associates (2003) reported findings consistent with the hypothesis that the effect of family criticism on schizophrenic patients' delusions and hallucinations was mediated by the influence of familial criticism on negative self-evaluation, which in turn influenced delusions and hallucinations. Decreased self-esteem preceded the onset of bipolar depression and mediated the effects of social support on this disorder (Johnson et al. 2000). Low self-esteem was associated with a higher likelihood of suicidal ideation (Lieberman, Solomon, and Ginzburg 2005) and moderated the relationship between the experience of distress and suicidal ideation. Cevera and his associates (2003) reported a prospective relationship between low self-esteem and new psychiatrically diagnosed cases of eating disorders. Low self-esteem predicted traumatic stress symptoms following the dissolution of a dating relationship (Chung et al. 2002). Finally, a comparison of subjects with chronic fatigue syndrome (CFS) with healthy volunteers and other chronic illness volunteers indicated that subjects with CFS reported lower levels of self-esteem on overt measures relative to the two comparison groups. Further, on a covert (that is, less face-valid) measure of low self-esteem, the CFS group manifested lower self-esteem than the two comparison groups. The latter effect continued to approach significance when the scores on depression, anxiety, and manifest self-esteem were taken into account (Creswell and Chalder 2002).

Lower levels of self-esteem (reflecting self-devaluation or concomitant self-feelings) were also associated with course and outcome of illness: Lower levels of self-esteem were related to the progression and severity of physical disabilities (Cornwell and Schmitt 1990). Low self-esteem has been associated with an adverse course of psychiatric disorders, including chronicity in major depression (Ezqueiuga et al. 1999), earlier relapse in seasonal affective symptoms (McCarthy, Tarrier, and Gregg 2002), and suicidality in affective disorders

(Daskalopoulou et al. 2002). Higher levels of self-esteem prior to bone marrow transplantation (Broers et al. 1998) and the experience of a stroke (Chang and Mackenzie 1998) precede more benign outcomes of these phenomena (Mann et al. 2004). Individuals with more negative self-evaluations are at greater risks of suffering new cardiac events after initial angioplasty (Helgeson and Fritz 1999). Following myocardial infarction, self-esteem is associated with choices regarding adherence to treatment regimen and the choice to return to work (Riegel 1989). Support for the hypothesis that self-devaluation is implicated in the onset of eating disorders is provided by observations that treatment of negative self-attitudes facilitated the reduction of attitudes favorable toward eating disorders (Newns, Bell, and Thomas 2003). Mann and his associates (2004) cite several other intervention programs that implicated self-esteem and its determinants that “were effective in the prevention of eating disorders (O’Dea and Abraham, 2000), problem behavior (Flay and Ordway, 2001), and the reduction of substance abuse, antisocial behavior and anxiety (Short, 1998)” (p. 368).

These relationships are interpretable in terms of the influence of the psychophysiological substrate that reflects and is stimulated by negative self-feelings on the morbid states, the self-enhancing/self-protective functions of the morbid states, and (less directly) the effects of self-feelings on the adoption of health-relevant responses that in turn influence the onset and course of illness.

Psychophysiological substrate—Self-feelings reflect the current exacerbation of need dispositions that are stimulated by contemporary self-evaluative judgments (Kaplan 1986). These feelings reflect and stimulate the psychophysiological substrate in which they are embedded. The psychophysiological responses in some instances are defined as morbid states and in other instances affect the onset and course of physical and mental disorders through the operation of biological stress mechanisms.

The embeddedness of self-feelings (in response to self-conception and self-evaluation) in the psychophysiological substrate is reflected in the following sample of studies or observations. The vagus nerve is the main conduit for parasympathetic nervous system influence on the heart. When the vagus nerve is stimulated, sympathetic nervous system activity is less of an influence on the heart. In the absence of an active parasympathetic nervous system, the sympathetic nervous system has a greater influence on the heart. Self-esteem appears to buffer anxiety and anger arising in response to self-threatening stimuli that give rise to fight-or-flight emotions through activation of the sympathetic nervous system. On the assumption that vagal tone (inhibitory effects on the heart exerted by impulses over the vagus nerve) provides physiological security as self-esteem provides symbolic security, it was expected that increases in self-esteem would lead to increased vagal tone. Consistent with these assumptions, manipulation of self-esteem through positive or negative feedback is associated with vagal tone, such that positive feedback led to higher vagal tone than negative feedback. That is, positive feedback eliminated sympathetic nervous system response to threat that was evoked in a negative feedback condition. Higher vagal tone predicted lower sympathetic response to the threat to self (Martens 2006).

Informed by the work of Dienstbier (1989), implicit self-doubt (perception of threat rather than challenge) following failure at a self-relevant task is reflected in cardiovascular measures of heart rate, ventricular contractility, cardiac output, and total peripheral resistance, which indicates net constriction versus dilation of blood vessels (Seery et al. 2004). These measures variously reflect activation of the sympathetic-adrenomedullary and pituitary-adrenal cortical axes. Self-relevance of (or engagement with) a task is reflected in increases in heart rate and ventricular contractility such that larger increases indicate greater task engagement. The interpretation of negative feedback as challenge leads to higher cardiac output and lower total peripheral resistance compared to threat, with higher cardiac

output and total peripheral resistance indicating greater challenge/lesser threat. These changes reflect differential activation of the sympathetic-adrenomedullary and pituitary-adrenal cortical axes. While challenge and threat each result in heightened sympathetic-adrenomedullary activation (and therefore an increase in heart rate and ventricular contractility), threat alone leads to increased pituitary-adrenal cortical activation, which has the effect of inhibiting the cardiac output increase and total peripheral resistance decrease (mediated by epinephrine release). Results reported provide strong support for the contention that persons with unstable high self-esteem are like individuals with low stable self-esteem, the difference being that the self-rejection is explicit in the case of the low stable self-esteem individuals and implicit in the case of the defensive stable high self-esteem people. After failure feedback, consistent with hypotheses, participants with unstable high self-esteem exhibited threat relative to those with stable high self-esteem, as did participants with stable low self-esteem.

The psychophysiological substrate for self-referent processes is indicated by the results of the event-related functional magnetic resonance imaging studies that demonstrated the selective engagement of a separate region of the (medial) prefrontal cortex during self-referential processing. Kelley and associates (2002) note that, consistent with these results, Gusnard and associates (2001) observed medial prefrontal cortex activity that was “preferentially associated with introspective judgments” (p. 790). Also in support of these findings are observations that damage to the prefrontal cortex precludes self-referential processing:

A lack of self-reflection, introspection, and daydreaming have long been associated with damage to areas of the PFC [prefrontal cortex] (Ackerly & Benton, 1947). Indeed, Wheeler et al. (1997) have argued that persons with damage to specific areas of the PFC are unable to reflect on personal knowledge. It is possible that the self-reference superiority effect depends on an intact ability to be self-reflective, and that neural activations in the MPFC [medial prefrontal cortex] reflect such a process. (Kelley et al. 2002:790)

Chronic negative self-feelings, often reflecting anxiety or depression, are said to be influenced in part by genetics as well as developmental and socioenvironmental factors (Neiss, Sedikides, and Stevenson 2002). It has been concluded that genetic influences typically explain between 30 and 50 percent of the variance in self-esteem (Neiss et al. 2005).

The impact of self-feelings on physiological systems in turn affects health states via cardiovascular and immune system functioning (Baumeister et al. 1996; Kiecolt-Glaser and Glaser 1994; Stroebe 2000; Suinn 2001).

These illustrations serve to demonstrate the relevance of extrasociological disciplines for understanding phenomena of interest to a sociological subdiscipline (here, medical sociology). In particular, physiological variables are observed to mediate the effects of social interactional phenomena on morbid states. At the same time, these studies suggest the usefulness of self-referent constructs in bridging the gap between sociology/social psychology and physiology.

Illness as self-enhancing adaptation—Paradoxically, the consistently observed relationship between negative self-feelings and morbid state in part may be accounted for by the (intended or actual) self-enhancing or self-protective functions served by the illness. The morbid state frequently is caused by the need to reduce distressful self-feelings associated with poor self-evaluations. Thus, substance dependency patterns may serve to reduce self-awareness of threats to one’s self-evaluation (Hull and Young 1983; Steele, Southwick, and

Critchlow 1981). Paranoid delusions have been interpreted as attempts to maintain or achieve acceptable levels of self-esteem on the part of persons characterized by low feelings of self-worth. Similarly, self-protective or self-enhancing motivation has been proposed regarding a number of psychiatric diagnoses, including those related to various sexual responses (Cortoni and Marshall 2001), binge eating (Heatherton and Baumeister 1991), masochism (Baumeister 1990), and suicide (Baumeister 1990).

Narcissism has been interpreted as a defensive response to fear of being rejected. The exaggerated positive self-image both reflects and defends against a self-concept of low value (Crocker and Park 2004): “Clinical accounts of narcissism describe a pathological self-focus and unstable self-esteem *resulting from fragile or damaged self-views* (see Kohut, 1971)” (p. 404, italics added for emphasis). The narcissist responding to his or her fear of being of little worth constructs an unrealistic positive self-image that he or she continually attempts to validate by being the object of favorable responses from others (Morf and Rhodewalt 2001). An extended discussion of the self-protective or self-enhancing functions of other pathological patterns is provided by Kaplan (1975, 1996).

Self-feelings and health-related behaviors—The association between self-feelings and morbid states is accounted for in part by the mediating influence of health-threatening, health-protective, or health-enhancing behaviors that are motivated by self-feelings and that in turn affect health status. According to the general theory of behavior based on self-referent constructs, virtually all behaviors (including health-relevant patterns) reflect adaptive responses to the need for positive self-feelings. By virtue of the infant’s physical dependence on others, the child comes to value the presence of others, behaviors and characteristics associated with others, positive responses from others, and behaviors and traits that evoke positive responses. Through a derivative process by which the person imagines how he or she appeals to others in order to effectively conform to others’ expectations and gain their approval, the person develops a need for self-approval (Kaplan 1986).

Motivation to conform to others’ expectations is contingent upon the overall experience of self-approval and concomitant positive self-feelings versus self-rejection and accompanying distressful self-feelings. If the person has positive experiences in the group, he or she will tend to learn and value conventional patterns that will be reinforced by group approval, and, indeed, that will become salient self-evaluative standards (Kaplan 1975, 1980, 1986). Some of these patterns will have relevance for health status. Certain of the conventional patterns will be health-protective (e.g., safety precautions), while others will be health-threatening (high-calorie diets, sedentary lifestyle, etc.).

If the individual experiences largely self-threatening outcomes in his or her membership groups, the person will lose motivation to conform to conventional patterns (whether health-protective or health-threatening) and be motivated to seek alternative (deviant) patterns that will express alienation from the conventional group and better serve self-enhancing or self-protective functions. However, this is contingent on the perception that conforming behavior will preclude social rejection and lead to group approval. If the rejected person anticipates approval, he or she will conform rather than deviate. In short, the health-relevant patterns that are adopted by the person will depend on the characteristic polarity of self-feelings experienced in membership groups, the nature of the health-relevant patterns that are endorsed by the group, and expectations regarding reentry into the conventional group.

In general, response patterns that conventionally are regarded as health-protective or health-promoting tend to be preceded by positive self-feelings, while self-rejecting feelings are associated with patterns conventionally defined as health-threatening. Such patterns include

high-risk sexual behaviors (Amaro and Raj 2000; Salazar et al. 2005; Stein, Leslie, and Nyamathi 2002), substance use and abuse (Stein et al. 2002), risky driving (Jonah 1990), poor oral health behavior (Kallestal, Dahlgren, and Stenlund 2000), and poor dietary practices and lack of exercise (Ma 2000).

The nature of the self-enhancing outcomes that are subjectively linked to health-threatening behaviors is variable. These consequences may be accidental outcomes of behaviors that are motivated by purposes that are irrelevant to health. Health-destructive behaviors may reflect, for example, the disposition to reject conventionally approved behaviors simply because they are associated with the group in which the person experienced failure and rejection. That is, as is the case for many other deviant responses, behaviors that happen to be destructive of positive health status are adopted simply because they are exemplars of deviation from conventional norms. Alternatively, the behaviors may reflect often futile attempts to gain the approval of deviant peers. Thus, among the salient correlates of distressful self-feelings that may increase the likelihood of unprotected sex is the exacerbated need to avoid rejection and gain approval. This need, for example, may preclude an individual from insisting that partners use contraceptive techniques (McDonald and Martineau 2002), and it may instigate having sex with multiple partners (Amaro and Raj 2000). In any case, the health-threatening behavior is expected to eventuate in self-enhancing outcomes, as when drinking is regarded as an easy way to reduce self-dissatisfaction (Downey, Rosengren, and Donovan 2000).

Whether a person adopts health-threatening or otherwise deviant response patterns, either as an adaptation to preexisting self-derogation or for any other reason, will be contingent in part upon the person's perception of the self-threatening nature of the response pattern in question. The disposition to adopt a health-compromising pattern of behavior would be mitigated by the self-perception that the behavior contravenes salient self-evaluative standards or identities. Similarly, once the person has adopted the pattern, the likelihood of continuing it is greatly decreased if the pattern is perceived as contradicting self-evaluative criteria that are highly placed in one's personal hierarchy of self-values. Thus, an association was observed between college students' perceptions of the disparity between their own drinking patterns and the attitudes toward alcohol use by significant others, on the one hand, and changes in the students' drinking behavior (Barnett et al. 1996; Downey et al. 2000). Similarly, alcohol and cocaine abusers were more likely to abstain over the first three months of treatment if they reported more social identities that were important to them and if these identities were incompatible with substance use (Weisz 1996).

Whether a person can discontinue a health-threatening pattern, such as drug abuse, that was adopted in order to reduce self-rejecting feelings depends in part on the extent to which the person can experience self-enhancing consequences of adopting a non-addict role in the conventional social environment (Downey et al. 2000). Thus, Kaplan and Lin (2005) observed that for individuals who experience negative self-attitudes in association with deviant behavior, the subsequent decrease in deviant behavior depends upon the feeling that one is bonded to the conventional world such that with the reduction of deviant behavior, the person will be welcomed back into that world. Absent this condition, however, the person may feel the need to further commit to the pattern (Kaplan and Fukurai 1992).

The relatively rare instances in which high levels of self-esteem are related to the adoption or maintenance of health-threatening behaviors are explainable in terms of the self-esteem motive. For example, among people who joined a smoking cessation group but relapsed, those who had high self-esteem (but not low self-esteem subjects) reduced their estimates of risks to their health. Apparently, high self-esteem relapsers were able to defend against the threat to their self-esteem posed by either the inability to conform to their public

commitment to stop smoking or by the awareness of threat to their physical being. That the reduced estimates of health risk constituted an esteem-maintenance mechanism was suggested by the observation that the relapsers who did not reduce their health-risk estimates manifested a decline in their self-esteem, unlike the relapsers who reduced their estimates of health risk and did not demonstrate a reduction in self-esteem (Gibbons, Eggleston, and Benton 1997; Gerrard et al. 2000).

Alternatively, an association between high self-esteem and health-threatening behavior might be explained in terms of group endorsement of the behaviors that are compatible with a positively valued self-image. For example, McGee and Williams (2000) did not affirm what other studies have found with regard to the temporal relationships between low self-esteem and later tobacco use. However, this relationship must be understood in the context of other theoretically suggested variables, such as the status of individuals in peer groups and peer group judgments regarding the normative/deviant nature of smoking (Glendinning 2002). Similarly, the observation that adolescent girls who hold *higher* levels of self-esteem are more likely to have been pregnant (Salazar et al. 2005) is at odds with the observation that adolescent girls who were low in self-esteem were more likely to have had a child (Kowaleski-Jones and Mott 1998). A moderating variable might be the cultural meaning of pregnancy. Salazar and her associates (2005) speculate regarding African American girls:

[For] African American adolescent girls, being pregnant is viewed as an affirmation of their ethnic identity and reinforces the importance of bearing children within their culture (Franklin, 1993). Thus, for African American adolescents, being pregnant may be a physical state in which they feel positively about themselves or being pregnant may contribute to other factors such as increased social support that may in turn affect their self-esteem (Davis, Rhodes, & Hamilton-Leaks, 1997). (Pp. 421–22)

In short, the association between self-feelings and health status is plausibly explained in part by the mediating influence of health-promoting, health-protecting, or health-threatening behaviors. Positive self-attitudes precede and predict the adoption and continuity of those patterns that are compatible with the sociocultural matrices that engender those attitudes, while self-rejecting attitudes increase the likelihood of adopting and continuing those responses that offer promise of self-enhancing or self-protective outcomes: conformity to culturally endorsed patterns when reintegration into society is expected, and deviating from societal norms when the person is alienated due to experiences of chronic rejection and failure.

The self-referent construct paradigm, which has general sociological and social-psychological relevance, proves to have utility for interpreting and organizing the literatures on the structural and interactional antecedents of health status. At the same time, the self-referent framework facilitates the bridging of disciplines such as sociology, social psychology, and physiology. Finally, in its application to the medical sociology literature, the paradigm permits the simultaneous consideration of diverse areas of interest, such as health behavior and the social etiology of illness, that frequently are considered in isolation, albeit under the rubric of medical sociology.

Consequences of the Disease Process for Self-Referent Responses

Disease and its correlates have profound implications for the afflicted person's self-concept, self-evaluation, self-feelings, and self-enhancing or self-protective responses. The following aspects of the disease process are particularly noteworthy for their self-referent implications:

Self-devaluing consequences of illness—The occurrence and consequences of illness often have deleterious consequences for one's self-image, and, therefore, for one's self-evaluation and feelings. As Beanlands and associates (2003) observe:

Cancer can profoundly affect self-concept. Once diagnosed, patients must reconcile preexisting conceptions of themselves as healthy and "normal" people capable of independently negotiating the challenges of life with new experiences of fatigue, weakness, pain, treatment side effects, limited capabilities, and the threat of death, all of which comprise the cancer experience. (P. 419)

In fact, chronic disease may adversely affect the individual's ability to perform valuable social roles—roles that are the basis for one's judgments of self-worth (Nagyova et al. 2005).

The loss of conventional social functions inevitably has consequences for loss of self-esteem (Nicolson and Anderson 2003): "People begin to experience themselves as 'different' from the person they were or expected to be before the disease took hold and that involves a sense of loss, disruption and distress" (p. 263). Sufferers of chronic disease, such as chronic bronchitis, also experience self-blame because they construe themselves to be a burden to others (Nicolson and Anderson 2003).

The impact of illness on the afflicted person's self-referent responses, including self-evaluation and concomitant self-feelings, is mediated in part by the stigmatization that often accompanies illness. The manifestations of perceived stigma vary along a number of only partly independent dimensions, such as social rejection, internalization of shame, and feeling socially isolated (Fife and Wright 2000). That stigmatization accompanies illness has been examined in a variety of illness contexts, focusing variously on HIV/AIDS (Doka 1997; Weitz 1989), cancer (Stahly 1988), leprosy (Volinn 1989), and sexually transmitted diseases (Gilmore and Sommerville 1994). The more severe an illness, the more likely it is to evoke socially stigmatizing responses (Crandall and Moriarty 1995). The basis for stigmatization resulting from having an illness lies in the violation of any of a number of normative expectations. For example, the illness may signify a disfigurement (a violation of an aesthetic norm), the inability to perform normal social roles (violation of conventional role expectations), or engagement in illicit behavior (signifying immorality).

The very fact of entering into a treatment regimen often serves to stigmatize the person. A case in point is the change in self-concept induced by the use of antidepressant selective serotonin reuptake inhibitors (SSRIs). Knudsen and her associates (2002) observe that

a major issue in the process of being diagnosed and accepting the medicine in this study was being labeled a person with a stigmatizing emotional disorder. It further became clear that the women saw SSRIs as a "double" stigma because of the perceived risk of stigmatization from the reputation of the medicine as a "happiness pill" and the association with emotional illness.... The informants felt that by taking SSRIs, they would be ascribed a role that would distance them from "normal" people, and this had a negative effect on how the women saw themselves. (P. 941)

Awareness of mortality—Illness contributes to self-awareness of one's own mortality, which increases the need to restore self-esteem to help buffer the threat of death. This terror management theory is summarized by Van den Bos (2001):

[T]he fear of death is rooted in an instinct for self-preservation that humans share with other species. Although human beings share this instinct with other species, only we are aware that death is inevitable. This combination of an instinctive drive

for self-preservation with an awareness of the inevitability of death creates the potential for paralyzing terror. Furthermore, the theory posits that this potential for terror is managed by a cultural anxiety buffer, a social psychological structure consisting of (1) people's cultural world view, and (2) their self-esteem. To the extent that this buffer provides protection against death concerns, reminding individuals of their death should increase their need for that buffer. Therefore, reminding people of their death should increase the need for things that provide an opportunity to uphold or reconstruct their worldview and to recover positive levels of self esteem. (P. 3)

(De)legitimization of illness—Ordinarily, the state of being ill and the concomitant inability to conform to conventional expectations is defended against by the self-justification and social forgiveness derived from undisputed medical diagnosis, that is, adopting the sick role. The person is still expected to acknowledge the undesirable identity of being ill, but is forgiven and permitted to self-justify failure to perform conventional role obligations because of the medical diagnosis (Clarke and James 2003). However, some disorders, such as chronic fatigue syndrome (CFS), are difficult to diagnose, thus depriving many individuals of a legitimation that is accorded others deemed to be ill (Ware 1992). The loss of self-esteem associated with those who suffer from CFS (Clarke and James 2003) stems from many circumstances. The enervation associated with this syndrome precludes the performance of valued social roles. At the same time, the CFS sufferer is deprived of the justification of being ill in the light of the ambiguous nature of his or her symptoms. Indeed, the CFS sufferer is deprived of the self-enhancing potential of having an interesting and unique illness by virtue of the trivializing of his or her symptoms by many medical specialists (Clarke and James 2003).

Another contested illness—that is, one for which the diagnostic legitimacy of the disorder is problematic—is fibromyalgia syndrome (Barker 2002). Because the diagnostic legitimacy of fibromyalgia syndrome is problematic, the justification for one's somatic complaints and inability to perform conventional social roles is precluded, with the result that the person's self-evaluation suffers.

Self-enhancing functions in illness—While illness frequently has adverse consequences for self-evaluations, as was suggested above, numerous observations have been made indicating that, under specifiable circumstances, individuals may be attracted to the sick role and enjoy the self-enhancing functions of illness, going so far as to pretend to be ill or at least unconsciously believing that one is ill when this is not the case (factitious illness). Factitious illness may present in any of a number of ways, including Munchausen syndrome, Munchausen by proxy, hypochondria, conversion disorder, somatization, and pain disorder. The benefits derived from factitious illness behavior often relate to the genesis of self-enhancing attitudes and the mitigation of the distress associated with self-rejecting attitudes. Enhanced self-attitudes might eventuate from the attention and caring responses exhibited by significant others in the person's network. The person might also be relieved of onerous responsibilities that he or she fears will not be fulfilled. Thus, the sick role facilitates avoidance of circumstances that would lead to self-perception of failure to perform in salient social roles. Hamilton and Janata (1997) authored a self-enhancement model of factitious illness behavior according to which adoption of the sick role enhances self-esteem and assuages a derogatory self-concept. Three mechanisms were posited through which the enhancement might occur. In the sick role, a person may have the opportunity to demonstrate medical knowledge, might demonstrate uniqueness through presentation with unusual or untreatable symptoms, or might bask in reflected glory through associating with physicians who are themselves highly respected. Consistent with some of these expectations, Hamilton, Deemer, and Janata (2003) reported that patients who were described as

knowledgeable about medical matters and who had unique syndromes evoked more favorable evaluations than patients who were not said to be knowledgeable and who did not have unique syndromes. The expectation that patients were more positively evaluated through association with more prestigious physicians was not supported.

However, a person need not feign illness to enjoy self-enhancing consequences of such illness. Certain kinds of illness serve symbolically to communicate the ownership of certain valued traits. A torn anterior cruciate ligament or a cast upon one's foot—particularly when wearing a ski sweater—suggests athletic risk-taking, or at least engagement with athletics. At the same time, one is afforded the opportunity to present oneself in a praiseworthy light as being able to bear pain, perhaps as a display of “manliness” or (in the case of children) acting like a “grown-up.” Similarly, under circumstances where the individual has endured chronic failure and rejection, whether induced by the disability or some other cause, the disability and its diagnosis may serve to offer justification for the failures and render past rejections as unjust. At the same time, the individual is relieved from the necessity of fulfilling what would ordinarily be regarded as appropriate role expectations in the future, while being offered the self-enhancing hope for the future modifiability of the impairment. Consistent with such expectations, MacMaster, Donovan, and MacIntyre (2002) report that, while self-esteem levels in a control group of children without disabilities remain stable for the period of observation, level of self-esteem manifested a significant increase above prediagnostic levels following the diagnosis of a learning disability.

Where the illness has self-devaluing consequences, the person is motivated to adopt self-enhancing or self-protective responses that will mitigate, forestall, or reverse such outcomes. For example, in the case of disorders that often are not recognized as credible by the public and professional community, as in the instance of CFS or fibromyalgia, the consequent experience of negative self-feelings motivates self-enhancing responses. Unable to abide the self-derogating circumstances of their disvalued and often delegitimized illness status, many sufferers engage in the self-enhancing strategy of evolving a new, more acceptable self:

For many another stage in the process involved in coming to terms with CFS was the acceptance of the newly constructed self.... They talked of becoming new selves—selves that they say they value more than previous selves. They did not seek a return to previous functioning—or a supernormal identity—they did not “settle” for something less than they were before, or even a return to the self before the illness; instead they invented new and, they believed, better selves.... Some emphasized how their values had drastically changed. They began to question what they had assumed to be important previously.... Others emphasized personality changes that resulted from the illness experiences. They talked of how they valued being stronger, standing up for themselves, being more patient and pacing themselves. They talked of feeling more compassion for others and being more confident about who they were. (Clarke and James 2003:1391–92)

Self-enhancing or self-protective responses occur at both the collective and the individual levels. At one level of abstraction, collective responses by sufferers of syndromes that are medically and publicly contested are exemplars of the more general response of those in socially disvalued identities who seek legitimation of these identities through social movements, as these processes are described in the literatures linking self, identity, and social movements (Stryker, Owens, and White 2000). The language of the social movement literature may be easily seen in Barker's (2002) description of the function of self-help literature in legitimating the experiences of sufferers of fibromyalgia:

In conclusion, through real and virtual self-help communities, sufferers shape the boundaries of their illness experience. They share and define symptoms, assess the

merits of competing etiological paradigms and treatment options, make demands for public awareness, fight for public and private funds to advance research and treatment, and support each other by sharing personal struggles and victories. Self-help communities simultaneously give meaning to individual experiences and bind individuals together through diagnoses, symptoms, suffering, and an emerging sense of shared interests. Whether as fibromyalgics, breast cancer survivors, depressives, anorexics, or AIDS survivors, illness identities channel individuals into new subjectivities focused on their illness and its management. (P. 295)

Where the medical disorder is itself implicated in the genesis of self-devaluation, seeking effective treatment constitutes a self-enhancing response. A case in point is improvement in self-esteem among individuals treated for erectile dysfunction (Cappelleri et al. 2005). Where the lower self-esteem was associated with stigma, the improvement in self-esteem might be presumed to be accounted for by the fact that the stigmatizing condition was obviated. Where the causes of the reduced self-esteem were associated with inability to perform valued social roles, the gain in self-esteem may be presumed to be due to the regained ability to perform those roles. Similarly, cognitive behavioral treatment of self-esteem was observed to result in the clinical benefits of increased self-esteem and improved social functioning, perhaps due to decreasing psychotic symptomatology (Hall and Tarrier 2003).

Contingencies for self-referent outcomes—The impact of the disease process on self-referent responses is contingent on a number of circumstances. Being a member of a stigmatized group does not inevitably lead to low self-esteem. As Camp, Finlay, and Lyons (2002) observe:

It seems too crude to suggest that merely being in a stigmatized group leads to low self-esteem. Lower self-esteem might be found only in those for whom the label is central to their self-concept, who perceive a more negative attitude in their community, whose own attitudes to mental illness are more unfavorable, or who have had more direct experience of rejection. Self-esteem might be affected in a variety of ways: by internalizing negative representations of mental illness, by being affected by the response of others in the immediate environment, by unfavorable social or personal comparisons, by the loss of valued roles and relationships (Nicholson et al., 1998; Wright et al., 2000), or by lowered perceptions of personal control (Fife & Wright, 2000). (Pp. 824–25)

Another contingency is normalization of the disorder in the person's immediate environment. Thus, deaf and hearing-impaired individuals who have deaf parents have more favorable self-concepts than individuals with the same disabilities who have parents who can hear. Further, individuals with those disabilities in residential schools seem to have more favorable self-concepts than those who attend public school classes (Obrzut, Maddock, and Lee 1999).

The extent to which disability adversely affects self-esteem is contingent on how others in the environment respond to the person's impairment. Where the disabled person is raised in a home without demonstration of affection, where the person is less involved in school activities, or where the person is more likely to be overprotected, he or she is likely to manifest lower self-esteem and more social isolation later in life (Nosek et al. 2003).

Beanlands and her associates (2003) report data suggesting that intrusiveness of the illness conditions identification with the illness role. The person may be motivated to dissociate from the self-image of being a bone marrow transplant patient to the degree that the illness and its treatment are viewed as intruding upon one's normal activities. Where the

intrusiveness of the illness and its treatment are meaningful (as reflected in distressful feelings), the person defensively rejects identifying with the patient/treatment status, aspiring to a more conventional self-image. In the absence of an association of the inability to perform conventional roles with distressful self-feelings, the person is better able to accept a self-concept as a bone marrow transplant patient, recognizing its association with disruption of normal role activities.

Illness and self-referent outcomes in membership groups—A disability not only adversely affects the self-esteem of sufferers of the disability, but it also affects the self-feelings of members of the disabled person's membership group. Thus, mothers of children with intellectual disabilities manifested lower self-esteem than the mothers of nondisabled children (Argyarakouli and Zafiropoulou 2003), a relationship that is moderated by such variables as family size and cultural stigmatization of the disorder. If the family member is a caregiver and perceives the assistance he or she renders as unreciprocated (whether through self-care or assistance with chores), the caregiver will experience low self-esteem (Clipp and George 1990; Neufeld and Harrison 1995; Reid, Moss, and Hyman 2005).

In addition to the illness of other members of the family, the death of family members has important implications for an individual's self-evaluation and ensuing negative self-feelings. Thus, self-esteem has been reported as a mediator of parental bereavement and children's internalizing symptoms (that is, anxiety and depression) (Haine et al. 2003).

Negative life events may lead to reduced self-esteem by directly devaluing the child (e.g., being criticized or rejected by the surviving parent or caregiver), exposing the child to some self-devaluing stigma (e.g., the arrest of the surviving parent or caregiver), or decreasing opportunities to engage in esteem-enhancing activities (e.g., reduced time spent with friends and in academic activities). (P. 623)

Self-enhancing responses may be evoked by overidentifying with the caregiver role and evoking positive responses from others and from oneself for "selfless" behavior. In some cases the need for such responses is so strong that the caregiver may perpetuate or create the illness in the person for whom he or she is caring (e.g., Munchausen by proxy).

CONCLUSION

I have asserted that the trend in science is to focus on one's own discipline to the exclusion of other disciplines, on one's own subdiscipline to the exclusion of other subdisciplines, and on increasingly narrow areas of interest within one's chosen subdiscipline to the exclusion of other areas of interest. Among the dysfunctional consequences of this situation for the scientific enterprise are the failure to inform and be informed by the products of more inclusive subdisciplines, the unnecessary duplication of effort that results from ignorance of parallel enterprises in other disciplines, and the inability to recognize the relevance of adjacent disciplines for extending and explicating the nomological network that guides research in a particular area.

The reversal of this process and the forestalling of these consequences depends upon the adoption of a theoretical framework that accommodates research in a wide variety of areas, facilitates communication among subdisciplines, and sensitizes the researcher to the relevance of other disciplines for understanding the subject matter of the target discipline. I have offered a theoretical framework centering on self-referent constructs that has served me well in these regards, and I have applied it to the subject matter of medical sociology, using relatively recent studies to illustrate the utility of the framework. While I have focused on individual-level data, more macrosocial levels might be addressed as well. For example, Pfeffer and Fong (2005) illustrated the use of self-enhancement, in the context of

organization theory, to examine generalizations regarding power and influence that might be relevant in studying health care organizations. Also, poor professional self-concept has been implicated in attrition in the nursing profession (Corwin and Hengstberger-Sim 2006).

At this point, motivated by a self-protective need to deflect criticism, I might be wise to suggest that self-referent constructs do not explain everything and that other central organizing constructs might serve the same purpose of integrating current understandings and stimulating further systematic research. Nevertheless, my self-enhancement-motivated commitment to my life-long pursuit of the implication of the self-enhancement motive leads me to persist in the belief that systematically pursuing implications of generalizations regarding self-referent constructs will have most salutary effects on the organization of current understandings and research into the phenomena that constitute the field of medical sociology.

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Biography

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