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Chapter 26
Identity and Illness

Kathryn J. Lively and Carrie L. Smith

Introduction

Over the last several decades, sociological interest in and research on the relationship between illness and identity has flourished. Unlike disease, which refers primarily to physical pathology, illness generally refers to lived experience (Kleinman et al. 1978). The foci of this research have been two-fold: an examination of the public self (an individual’s identity as perceived by others) and the private self (an individual’s identity as perceived by oneself) and how the two interact with and affect each other (Kelly and Millward 2004). Yet, the commonality among the majority of studies focusing on illness and identity is that researchers have usually treated identity as a function of illness – that is, how one’s identity forms or changes as a result of contracting a particular disease or condition. This approach has been represented most successfully by those sociologists who view illness as an identity disruption (e.g., see Charmaz 1993; Karp 1996) and those interested in the relationship among identity, stigma, and illness (e.g., see Link 1987; Link et al. 1991). Recent studies have focused on how individuals strive to maintain their sense of self in spite of illness. Hinojosa et al. (2008), for example, find that veterans who had suffered a stroke were able to maintain a continuous sense of self by drawing upon their religious beliefs and cultural expectations of aging. Likewise, Sanders et al. (2002) find that while people with osteoarthritis do talk about the disruptive effects of the condition on their daily lives, they still manage to view these symptoms as part of their normal lives.

While the field of identity and illness has progressed much beyond the Parsonian framework of the sick role (1951), it has done so, predominantly, with the inclusion of vague insights from symbolic interaction, rather than the incorporation of social psychological theories of identity. In this chapter, we identify new directions of scholarly inquiry in the area of identity and illness through the integration of existing social psychological conceptualizations of identity, identity formation, and identity disconfirmation/verification. Specifically, we highlight the potential contributions of identity theory (generally defined) before discussing in depth three variants: structural symbolic interaction, affect control theory, and identity control theory.

Although the majority of work in this area focuses on diagnosed physical pathologies, some also document the lived experience of individuals whose conditions are still contested. For instance, Barker (2002) examines how self-help literature helps those diagnosed with Fibromyalgia syndrome (FMS) to construct a coherent illness identity. Fibromyalgia, as well as other forms of chronic pain, are particularly difficult for those who have it in that the symptoms associated with the condition are invisible or have no organic cause. In their study of individuals with facial pain, Lennon et al. (1989) point out that because pain cannot be explained biomedically, those who suffer from it are often stigmatized.

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We begin with a brief description of the general trends in identity and health research thus far. We then turn our attention to a set of social psychological theories of identity that have remained all but invisible within the broader discussion of identity and illness and illustrate how these theories have the potential to open up new avenues of research. In contrast to the dominant focus on the negative impacts of illness on the individual (Horwitz 2002), we posit that integrating these theories can provide valuable insight into the development of positive illness identities as well as the ways in which identity may have the ability to ameliorate the negative impact of disease.

We conclude by pointing to new methodological approaches that could be used in future work on identity and illness. Up to this point, most work in this area is qualitative and, in particular, has relied primarily on patients' narratives as a source of data (Bell 2000; Conrad 1990; Pierre 2003). We argue that the inclusion of social psychological theories of identity not only has the potential to open up new theoretical directions, but also methodological directions through the incorporation of complementary – if not alternative – methodologies, such as surveys, experiments, and computer simulations.

General Themes and Frameworks in the Field of Identity and Illness

The Effect of Illness on Identity

It is widely acknowledged that studies of identity and illness had their genesis in Parsons' (1951) theory of the sick role (e.g., see Lawton 2003), which hypothesizes that patients assume a set of rights and obligations that determine behavior once they have been diagnosed with a medical condition. Based on the assumption that illness is a form of dysfunction, Parsons argued that patients should be released from the obligations of other social roles and not held accountable for their actions in order to facilitate their return to health and reintegration into society. In return for these concessions, patients are expected to seek out and cooperate with competent medical professionals. This approach assumes that illness is a temporary condition and that patients desire to be healed.

Later generations of scholars have critiqued Parsons' (1951) theory for, among other things, neglecting the experiences of those with chronic illnesses (e.g., see Crossley 1998; Radley 1994) and for its overly deterministic nature (e.g., see Pierre 2003; Turner 1995). Additionally, given his view of illness as a form of deviance, Parsons has further been criticized for neglecting to incorporate the physical body and its impacts on the illness experience. It is difficult to avoid the reality that illness often brings with it physical aches and pains and limitations, and these physicalities surely impact the individual's sense of self, which is derived, in large part, from the reactions – real or perceived – of others (e.g., see Kelly and Field 1996). For our purposes, the most severe – and warranted – criticism is that with its focus on the "outsider perspective" (Lawton 2003), Parsons failed to acknowledge that patients have agency in constructing their illness experiences and identities and do not simply conform to what physicians, and the larger society, demands of them. In response, many researchers have sought to recover the individual's voice; and, as a result, much of this research draws upon qualitative narratives. As mentioned earlier, these studies also generally focus on the negative impacts of illness, and posit identity changes in response to illness.

A good illustration of this approach is Charmaz's (1983) seminal work on how individuals with chronic illnesses experience a "loss of self." She points out that those with chronic illnesses often face several negative reactions and life situations – from experiencing increased social isolation to being discredited by others. In dealing with these negative reactions and life situations, people's various identities and sense of self may collide with one another, such that a loss of self in one area of their lives might result in a loss of self in another area. Someone who is diagnosed with colon cancer, for example, may no longer be able to fulfill her role as CEO, forcing her to take a temporary, if not permanent, leave of absence. While Charmaz demonstrates that people do have agency in
construing their identities during illness — that is, how people begin to redefine what it means to be a parent or a spouse, while still dealing with their afflictions — her focus is overwhelmingly on how they do so after they become ill.

Charmaz’s (1983) study, based on 73 in-depth interviews with 57 chronically ill individuals living with diseases ranging from diabetes to multiple sclerosis, remains one of the most cited studies in the field of identity and illness and exemplifies the general methodological approach of focusing on patients’ narratives and giving voice to their day-to-day experiences. The value of utilizing qualitative narratives is that researchers are able to better ascertain how individuals define what their illnesses mean, and how they create meaning out of their illness experiences. Charmaz finds that with the exception of those whose physical conditions had improved, her respondents often used a language of loss and constraint to describe their illness experiences. For instance, a man undergoing kidney dialysis stated that he felt “less than human” (p. 173) while an elderly woman felt “badly about being dependent” (p. 188).

Many studies in this genre (e.g., Charmaz 1993; Gordon 1995; Karp 1996; Weitz 1991) draw almost exclusively from traditional symbolic interaction (Blumer 1969; Mead 1934). In one of the earliest statements of symbolic interactionist thought, Mead (1934) posited a reciprocal relationship between self and society — a relationship that has been mirrored in health scholars’ discussions of the private and public self. Mead argued that self shapes society, and vice versa, just as more modern scholars argue for the reciprocal relationship between the public and private selves (e.g., see Kelly and Millward 2004). In his discussion of the self-concept, Rosenberg (1981) argued that the self (that is, the private self) is a product of society, as well as a social force (also see Callero 2003).

In addition to positing a social self, symbolic interaction also assumes that meaning is central to human life (McLeod and Lively 2007). This basic tenet asserts that meaning shapes not only how individuals interpret particular events, others, and their environments, but also themselves (Heise 2002; Smith-Lovin and Heise 1988). These interpretations, in turn, color how individuals respond to events and situations, regardless of the objective reality of the event itself (Charmaz 1980, 1993). In her study on cancer survivor support groups, for instance, Westphal (2004) found that individuals with cancer were encouraged by group leaders and other support group members to adopt specific preferred meanings regarding their current situation. Here, in routine interactions with similar others (Thoits et al. 2000), individuals were urged to view their conditions as acute (instead of chronic) and to see chemotherapy as a necessary evil in their “battle” against disease (instead of as a poison that made them tired, nauseous, and irritable). Although always within the rhetoric of support or “best interests,” members were typically sanctioned when entertaining or promoting beliefs that undermined those that the group deemed desirable.

As the above suggests, one of the most enduring insights of symbolic interaction is that meaning — much like the self — is not static. Instead, meaning is expected to change over time as individuals develop new understandings of their situations (Blumer 1969). New understandings may result from the changing nature of a situation or event (as in the diagnosis of a debilitating or stigmatized disease or condition) or from self-reflection (Callero 2003). They may also arise out of social interactions with real or imagined others (as in getting to know or learning about other people who may share similar life circumstances). As individuals garner more information from the social world, their meaning of themselves may either be reaffirmed or altered, as may their view of the world around them. Further, because the meaning attached to the self tends to structure one’s world view, individuals who see themselves in particular ways are also likely to view their illness or condition in ways that correspond to those self-definitions.  

2Additionally, meanings may also be linked to circumstances that extend beyond the immediate definition of the situation — that is, meanings may also be shaped by broader historical and cultural settings where “unarticulated assumptions about the nature of the person have their origins” (Callero 2003, p. 121).
One well-known example that illustrates the general tenets of symbolic interaction is that of the American Cancer Society's adoption of the term survivor, as opposed to victim. According to this new rhetoric, individuals are expected to see themselves and other cancer patients as potential survivors, and to take a more proactive stance towards their treatment regimens and their overall health. As noted previously, compared to those who see themselves as potential victims or sufferers, potential survivors are expected to develop new meanings about their illness, their treatment, their doctors, and their likelihood of survival that are consistent with their survivor identities (Westphal 2004). However, not all individuals adopt the identity of "survivor." In her study of women who were treated for breast cancer, Kaiser (2008) found that while some women adopt the identity of "survivor," others rejected it because it did not cohere with their illness experience. For some, the threat of a possible recurrence was powerful, while some felt that their illness experience had not been severe enough to warrant their adopting the "survivor" identity.

As the above examples suggest, the idea that individuals strive for cognitive consistency underlies much of symbolic interactionist thought. Cognitive consistency theory posits that individuals are motivated to act in ways, and have thoughts, values, and beliefs, that are consistent with their sense of self (Heise 1979; Stryker 1980). When someone fails to achieve the desired consistency—either in terms of their situation, behaviors, thoughts, attitudes, or beliefs—they experience some form of cognitive dissonance that often manifests itself as an emotional reaction (most typically, distress). According to this perspective, individuals who experience cognitive and/or emotional dissonance will enact behavioral and/or cognitive changes in order to bring their situations, behaviors, thoughts, attitudes, and beliefs back in line with their fundamental sense of self, even if it means surrendering a valued identity (e.g., see Charmaz 1983; Elson 2003; Gordon 1995).

One of the strengths of traditional symbolic interaction (Blumer 1969) as a perspective and a methodology is that it allows researchers to capture the rich complexity of lived experience. Drawing almost exclusively on narrative accounts, symbolic interaction allows scholars to tap into individuals' perceptions, thoughts, and feelings, while taking into account the uniqueness of their particular situation. Indeed, as we pointed out earlier, the majority of studies on identity and illness have privileged patients' narratives, providing us with rich, ethnographic data that highlights patients' voices and perspectives (Bell 2000; Conrad 1990; Pierret 2003). However, while narratives and in-depth interviews may be the best methods to capture and describe the nuances of lived experience, they do not necessarily lend themselves to prediction, or even replication. Indeed, one of the long-standing criticisms of traditional symbolic interaction (Blumer 1969) is its assumption that the social world and, hence, the self, is always in a state of flux or negotiation (Stryker 1980). Such an approach fails to account for the relative stability of society or the self over time, or even across a variety of situations (a point to which we return later).

The Interplay of Illness and Identity (Stigma and Labeling Theory)

One of the more developed lines of inquiry within the study of identity and illness is the internalization of stigma associated with having a particular condition. However, unlike the aforementioned studies—which assume that identity is a function of illness—scholarship on stigma posits a more explicitly reciprocal relationship between the two. In other words, while scholars focusing on the impact of illness and identity generally argue that illness may result in a stigma that affects one's sense of self (Karp 1996), those examining the relationships among stigma, illness, and identity argue that having a stigmatized identity may also result in compensatory behaviors that can influence subsequent health outcomes (Link 1987).
Although the concept has been used in a variety of ways, Goffman (1963) defined stigma as a socially discrediting blemish that may be of the body, of the character, or tribal in nature (e.g., race or ethnicity). Given the general processes of socialization (Mead 1934), most individuals within a society are raised with similar beliefs and attitudes regarding the types of conditions or characteristics that are likely to result in stigma. This is one reason why individuals holding a stigmatized characteristic or trait are likely to have the same beliefs and attitudes towards that trait (and therefore themselves) as those who do not have the trait.

Although all individuals may have some potentially stigmatizing characteristics (or engage in stigmatizing behavior), they will not necessarily be stigmatized until they have been labeled as such. A person with epilepsy, for example, may pass as "normal" until he has a seizure that is witnessed by someone who has the power to label him as such (e.g., a physician, a teacher, or a police officer). Once labeled, however, his status as "an epileptic" is made public and is routinely confirmed vis-à-vis interactions with others, as well as through daily limitations placed on behavior (e.g., the inability to drive a car).^2

While the example above refers to primary deviance (that is, the behavior that gets one labeled to begin with), labeling theory also attempts to explain secondary deviance — that is, the additional deviance people continue to engage in once they have been labeled (Lemert 1999).^3 In this sense, labeling theory views identity not only as a result of the internalization of stigma, but also as a social force that has the ability to influence subsequent feelings, beliefs, and behaviors — both for those who are labeled and those around them (see also Britt and Heise 2000; Taylor 1995).

The labeling process works similarly with individuals who struggle with issues pertaining to mental illness, particularly for those who have been labeled formally. According to the modified labeling theory of mental illness (Link 1987; Link et al. 1989), the negative consequences of psychiatric treatment are rooted in cultural definitions of the "mentally ill." When an individual is diagnosed with a mental illness, cultural ideas about the mentally ill (e.g., incompetent or dangerous) become personally relevant and are transformed into expectations that others will devalue and discriminate against that person (Kroska and Harkness 2006). These negative expectations are associated with such undesirable outcomes as unemployment, low earnings, and feelings of devalorization, even after controlling for differences in psychiatric diagnoses (Link 1987). Further, these expectations are believed to promote behaviors aimed at preventing negative reactions: concealing treatment history, withdrawing from social interaction, and/or educating others about mental illness. Ironically, but perhaps unsurprisingly, both withdrawal and educating others are also linked to additional negative outcomes. The former restricts social networks (Link et al. 1989) and is related positively to both devalorization and unemployment (Link et al. 1991), and the latter increases the positive relationship between stigma beliefs (that is, beliefs that mental patients will suffer discrimination and be devalued) and devalorization (Link et al. 1991). Mirroring predictions from

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^2Note that the term epileptic is a social identity, rather than a condition. Scholars have argued that epilepsy is a deeply discrediting condition because it meets more than one of Goffman’s (1963) characteristics of stigma. Other physical health conditions that are socially discrediting include HIV/AIDS (Fife and Wright 2000), eating disorders (e.g., see Rich 2006), and disability (e.g., see Rose 2006). Again, like epilepsy, each of these conditions contains multiple elements of stigma; specifically, each involves not only the individual’s body, but also, in the minds of many, their character.

^3Also see Schneider and Conrad’s (1983) study on individuals with epilepsy.

^4Secondary deviance is explained primarily in two ways. First, once individuals have been labeled as deviant, most — if not all — of their behaviors are viewed as a manifestation of their deviance. For instance, if individuals have been labeled as having depression, all of their behavior is interpreted to be a result of their mental state, Second, once individuals have been labeled as deviant, they may respond to what they perceive as others’ reactions to them in ways that either inadvertently or intentionally reaffirms their stigmatized identity (Lemert 1999).
classic labeling theory, mental patients' expectation of rejection seems to set in motion a series of actions and reactions that fulfill their original fears.6,7

Focusing less on those who have been labeled by others, Thoits (1985), too, builds upon traditional labeling theory by elaborating the process of self-labeling (also see Taylor 1995). In an attempt to explain why people voluntarily seek counseling (psychiatric or otherwise) in spite of its potential to lead to stigmatization, Thoits (1985) focused her attention on the experience of emotional deviance. Feelings of emotional deviance are likely to occur when individuals become aware (or are made aware) that they are violating emotion norms – that is, norms that tell us what we should feel or how we should express emotions in a particular situation (Hochschild 1979). According to Thoits (1985), self-labeling takes place when individuals come to see themselves as feeling (or expressing) emotion in ways that are not consistent with widely held cultural norms about emotions and seek professional assistance to bring their emotions back in line with cultural expectations.

Notably, individuals who seek out less restrictive forms of treatment voluntarily are less likely to be stigmatized than those who are institutionalized against their will. Thoits (1985) attributes the lesser stigmatization of seeking counseling in outpatient settings to the growing utilization of private counselors throughout the general population. Despite the widespread use of individual counseling, however, there remains a lingering stigma associated with certain types of psychiatric disorders as well as psychiatric treatments that may or may not involve the use of psychotropic drugs (Benkert et al. 1997).

Taken together, studies focusing on stigma, identity, and illness are much better at documenting the reciprocal relationship that exists between identity and illness than those that simply examine the effect of illness on identity. While illness does, indeed, affect identity, the internalization of a stigmatized identity can, in turn, lead individuals to make choices or to engage in behaviors that may subsequently affect health and other health-related outcomes (e.g., see Reidpath et al. 2015). However, where these studies advance our understanding of the relationship between identity and illness, they, too, concentrate only on the negative effects of illness on identity. This pejorative focus may be understandable, however, given their interest in stigmatizing diseases and conditions that are, by definition, undesirable.8 Moreover, while scholars have assumed a more reciprocal relationship between illness and identity once the stigma has occurred, scholars working in this area have failed to address how an individual's identity prior to the illness – or the labeling itself – can play a significant part in how that stigma and/or illness is experienced, negotiated, and acted upon.

The Effect of Identity on Illness

Although the majority of studies have focused on how illness affects identity, this is not to say that scholars have completely ignored how identity has the capacity to affect one's health or experience of disease. In his classic study on biographical disruption, for instance, Bury (1982) finds that those diagnosed with rheumatoid arthritis carefully select specific events in their earlier biographies to

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6Elsewhere, Link and Phelan have identified stigma as a fundamental cause (2001) for mental health disorders.
7Despite the strength of this approach – as well as its intuitive appeal – recent narrative accounts of diagnosis suggest that some seem to experience their conditions as improving upon being labeled. In a personal memoir describing his experience with Asperger's Disease, John Robinson (2007) reports that instead of internalizing the stigma associated with the label, he was reassured by having gained a greater understanding of the thing he had been plagued by – unknown to him – since childhood. His experience with Asperger's – a developmental disorder that leads to social and communicative difficulties – matches those of individuals who suffer from chronic pain and other "invisible" conditions who seek diagnosis as a means of legitimizing their experiences to the outside world.
8Recently, however, social movement scholars have noted that social movement organizations have become more skilled at recasting potentially stigmatized – or otherwise damaged – identities in a more positive light in order to better effect social change (Britt and Heise 2000; Taylor and Van Willigen 1996).
help make meaning out of their illness experience. For instance, one woman recounted her belief that her troubles with rheumatoid arthritis began with her then 7 year-old son’s emergency appendectomy. The stress of that incident, she posited, might have triggered the illness. However, Bury does not theorize a more integrated concept of identity, choosing instead to focus almost entirely on the impact of particular events (also see Richardson et al. 2006; Wilson 2007). Building upon Bury’s work, Williams (1984) proposed the concept of “narrative reconstruction.” In studying how people make sense of their illness, Williams finds that not only do people focus on specific events in their earlier biographies, but they weave elaborate and concise narratives incorporating these events. He argues that these narratives help to reconcile the past and the present for the individual experiencing the illness. While Williams provides a more holistic theorization of how individuals make sense of their illness by drawing upon the pre-illness past, like Bury, he primarily focuses on the impact of specific events and does not examine how pre-illness identity might play a part (also see Alaszewski et al. 2006; Hallowell et al. 2006).

Some scholars – most typically affiliated with departments of psychology or schools of public health – have also begun to address the so-called “buffering” effects of identity. Specifically, they address how a strong identity might help mitigate the impact of illness. For instance, in their study of African-American men, Wester et al. (2006) find that particular aspects of racial identity attitudes helped to mediate the relationship between gender role conflict and psychological distress. Other studies have also examined how racial and/or ethnic identities play a role in mediating the impact of racial/ethnic discrimination on individuals’ health (e.g., see Brown and Wallace 2001; Gee et al. 2007). Many of these studies, however, limit their conceptualization of self to the use of personality markers, such as mastery, self-esteem, or self-efficacy, as proxies for identity (e.g., Ohm and Aronson 2006; Tijerina 2006). While these approaches provide valuable insight into the protective nature of particular aspects of identity on the experience of illness, such one-dimensional measures tap into a limited and static understanding of the self (McLeod and Lively 2007). Moreover, these variable-based measures imply that the self is something inherent to the individual and, therefore, asocial – assumptions that are at odds with insights gained from social psychological theories. Just as the first group of studies fails to address the independent effects of identity on health, this third group fails to consider the social, dynamic, and interdependent aspects of the self that may ameliorate or exacerbate the experience of illness.

To summarize, the extant literature in this area has generally taken three approaches toward the study of identity and illness: focusing on the ways in which illness affects identity, the interplay between the two, and, somewhat less successfully, how identity has the ability to influence one’s experience of disease and other debilitating conditions. With the exception of those studies based on the modified labeling theory of mental illness (Link 1987), the majority of this work has drawn only on vague insights from symbolic interaction, largely eschewing more developed social psychological theories of identity, which posit a more dynamic, proactive, social self that may lead individuals to make different choices regarding their health and illness and, subsequently, to different health outcomes. In the following sections, we will introduce identity theory (Stryker and Burke 2000), in more general terms, before turning our attention to three related, yet distinct theoretical perspectives: structural symbolic interaction (Stryker 1980), affect control theory (Heise 1979), and identity control theory (Burke 1991). Despite their similarities, each of these theories offers unique contributions that may further enrich our understanding of the relationship between identity and health.

Identity Theory

One of the strengths of symbolic interaction is its ability to capture the dynamic nature not only of reality, but also of the self. In contrast, many people (both sociologists and laypersons) tend to view the self as enduring or stable. In an attempt to explain this contradiction, various forms of identity theory were developed. Generally speaking, identity theory (Stryker and Burke 2000) focuses on
how social structure influences individuals’ identities and behaviors, as well as the role that individuals play in sustaining both the social structure and the normative order in which they are embedded. From this perspective, actors develop their identities from the social positions or roles they occupy within the social structure. Eventually, they come to derive meanings and normative behavior from these roles.

Social psychologists differentiate between different types of identities. Within sociology, the most common of these are “role identities,” although some scholars also study “social identities” (Hogg 2003) and “person identities” (Stets and Burke 1996). A role identity is the set of self-meanings an individual internalizes from his or her position within the larger social structure (McCall and Simmons 1978). Individuals derive meaning about the self and their surroundings – as well as behavior – by adopting role positions. As such, these positions shape the self in important ways and also serve to tie the individual to the very social structure from which the social roles originated.

Keeping this general framework of identity theory in mind, we now turn to three specific theories: structural symbolic interaction, affect control theory, and identity control theory. We argue that insights from these theories have the potential to open up new theoretical and methodological directions in the field of identity and illness. In the following discussion, we provide an elementary introduction to each of these perspectives and explicate their usefulness to the study of health and well-being.

**Structural Symbolic Interaction**

As noted above, structural symbolic interaction posits that the self stems largely from the larger social structure in which one is embedded, drawing our attention to the ways in which individuals’ positions within the social structure impact behavior. According to this perspective, the self is made up primarily from the combination of role identities that the individual holds. Although there are several hundred social roles available to any given person at any given time (Heise 2006), Stryker (1980) argues that one’s sense of self is typically comprised of a much smaller set of social roles or role identities. Indeed, the handful of role identities to which individuals are most strongly committed and are most salient make up one’s identity hierarchy. Those identities at the top of the hierarchy are the ones to which the individual is most highly committed. Commitment, in this sense, refers to the number of social relations that one would lose if he were to abandon or lose a particular social role. Saliency refers to one’s affective attachment (or the emotional rewards) that one has to a particular role. Saliency, for the most part, is believed to stem from commitment (Callero 1985; Stryker 1980). If a worker decides to exit the work role by seeking disability, for example, it may be more difficult if she believes that doing so will also risk her role of wife or, if she is her children’s primary financial provider, her role as breadwinner. If the majority of her friendships are also dependent upon her role as worker, the decision may be even more difficult, for she runs the risk not only of losing the emotionally satisfying relationships with her husband and her children, but also with her peer group (also see Ebaugh 1988).

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*“Social identities” refer to identities that are derived from group membership (e.g., female or Asian-American), whereas “person identities” refer to personal characteristics or attributes that describe a particular person across social roles (e.g., intelligent, compassionate, competitive). Indeed, Affect Control Theory (Heise 1979) treats “person identities” as attributes that have the ability to moderate role identities, instead of as identities in their own right.*
According to Stryker (1980), individuals tend to hold some role identities in higher esteem than others. A role identity that is deeply embedded in one's social networks – that is, there are many relationships dependent upon one's occupancy – and has some degree of emotional payoff is likely to be more salient than those roles that are not deeply embedded or emotionally rewarding.

Structural symbolic interaction assumes that individuals are especially motivated to act in ways that maintain their most highly committed and salient social roles. Given that social roles can be thought of as a bundled set of rights and obligations that exist between role partners (Heiss 1981; Stryker and Statham 1985), actors are expected to act in accordance with their rights and obligations. If they fail to do so, they can expect to be sanctioned by their role partner(s). When individuals are no longer able to meet the demands of the role, they may voluntarily leave the role or, at the very least, reduce its importance to their sense of self.10

When a role identity is particularly salient, Stryker (1980) suggests that individuals may find themselves engaging in the behavior associated with the identity even in situations where it is not appropriate. They may also purposely seek out events where they can enact that role without social sanction, as well as seek out people who support that role. For example, someone who is wedded to his patient identity may immerse himself in traditional treatments or seek out friends who are supportive, if not sympathetic, to his plight and distance himself from those who are not (Charmaz 1980).11

Additionally, however, individuals may eschew roles associated with their condition altogether, putting their energy into maintaining an identity – or identities – that have little to do with being a patient. It may also be that potential patients (or potential incumbents of the patient role) may choose to concentrate their energies on identities that have very little to do with illness. For example, someone who suffers from chronic lower back pain may not be highly committed to his role as a pain sufferer, although he may suffer a tremendous amount of pain on a daily basis. Instead, he may be more committed to his roles as attorney, father, or athlete – all of which may be fundamentally at odds with the patient role. Further, if athlete is his most salient role (in terms of emotional payoff), he may eschew the rights and obligations of the patient role – or the sick role – in lieu of those associated with the more favored role of athlete. That is, he may seek out health care providers (e.g., a chiropractor versus a surgeon) who promote exercise versus bed rest. Indeed, numerous studies reveal that patients tend to seek out, and cooperate with, health care providers who, in some way or another, tell them what they want to hear (Lock and Kaufert 1998; Steinberg and Baxter 1998). However, when it is no longer possible for him to fulfill his role-related obligations, he may have no choice but to rearrange or otherwise alter his identity hierarchy.

Despite the flexibility of structural symbolic interaction and its ability to predict behavior across a broad spectrum of individuals, this approach has remained virtually invisible among those who study the relationship between health and identity. Indeed, to date, the most influential discussion

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10In his account of his journey toward becoming a quadriplegic, anthropologist Robert Murphy (1990) discusses how his condition affected his ability to conduct fieldwork. As he pointed out, anthropologists garner status and prestige through their field work. In an effort to maintain some status within his chosen field, he turned to writing anthropology textbooks, even though he knew that such an activity was relatively devalued within his discipline.

11Recently psychologists have also become more interested in identity hierarchies, as they seem to operate like cognitive schemas. Self-schemas refer to cognitive filters that develop in the brain over time which affect the ways in which individuals attend to, store, and retrieve – in this case – self-referential information (Kilstrom and Cantor 1984; Markus 1977; also see Linville and Carlston 1994). To the degree that identity hierarchies operate similar to schemas, it may also be that individuals who hold an illness identity that is maintained within their significant social networks are more likely to notice, attend to, and remember information, encounters, and incidents that support their view of themselves and of their situation (Morgan and Schwalbe 1990). This suggests that someone for whom the illness identity is particularly salient may pay more attention to his or her aches and pains than those for whom the identity is not particularly salient. This is not to say that individuals willfully choose to process some information and ignore others; rather, their identity provides filters that operate at a more subconscious level.
of social roles in the health literature comes not from structural symbolic interaction, per se, but rather role theory and structural functionalism. Similar to structural symbolic interaction, role theory—the theory on which the sick-role (Parsons 1951) is based—assumes that individual behavior is largely dependent upon individuals’ social roles, their role sets, and their role repertoires. Simply put, role theory assumes that once you are in a role, your behavior is, for the most part, determined by that role. Unlike structural symbolic interaction, however, role theory fails to explain how or why individuals adhere to particular roles and not others. Nor does it adequately explain variability within similar roles, or why it is that people tend to act similarly across varying roles.\(^1\)

In an attempt to bridge the fluidity of symbolic interaction and the rigidity of role theory, Stryker and Statham (1985) have argued that structural symbolic interaction is based on the notion of role-making, as opposed to role-taking. According to this perspective, role-making refers to the give and take that exists between any given set of role-partners in a particular social interaction or network that explains the wide variability in the performance of particular social roles. For instance, some patients may be more involved in their treatment than others, allowing—or causing—their health care provider to be less authoritarian, just as some doctors may be emotionally engaged, thereby encouraging a more personal relationship with their patients. Alternately, some physicians may stay firmly behind the wall of affective neutrality, encouraging their clients to be less engaged in the establishment of care.

Taking a slightly different approach to explain the variability with which people approach, adopt, or enact certain roles, Callero (1994) argues that roles should be conceptualized not only as a set of rights and obligations that determine individual behavior (Merton 1957), but also as resources that individuals seek to acquire for their anticipated benefits. From this perspective, roles can be thought of as resources that individuals actively pursue in order to obtain access to symbolic, cultural, social, and material capital (Callero 1994; also see McLeod and Lively 2003). When an individual adopts—or maintains—a role such as patient, for example, she not only benefits from the increased access to resources associated with the role (e.g., the sympathy or releases from certain obligations, such as employment or domestic labor, associated with being ill), but she also acquires access to the others associated with the role. The social connections attached to roles grant individuals access to information networks that could potentially benefit them through material, emotional, cultural, or symbolic gains—thus acting as another means through which an individual may increase one’s human capital. When individuals self-select into particular roles in order to achieve certain benefits or to avoid potential costs, they are, in a sense, exercising their own personal control and power (also see Callero 2003). Thus, roles are not only utilized to define the self, guide behavior, and buffer against life stress, but also to achieve desired ends (Callero 1994). In the context of identity and illness, this means that while the objective realities of individuals who experience the same disease may be similar, their subjective experiences (i.e., illness) may be different depending on the roles they chose to enact and maintain throughout their illness.\(^2\) Unfortunately, however, this assertion remains virtually untested among those studying identity and illness.

To date, most studies of identity and health take their starting point from when the individual can no longer work around his or her condition or disease and is already in the position of having to

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\(^1\)Another insight that can be gleaned from these theories is the importance of considering actors’ social networks. To date, scholars have become increasingly interested in the role that one’s social networks have on a variety of health related behaviors, including the utilization of health care services (Pescosolido 1996, 2006), agreement to generic testing and other forms of screenings (Husaini et al. 2001; Levy-Storims and Wallace 2003), and adherence to treatment regimens (Westphal 2004). According to a more network centered perspective, our social networks help influence our understanding of a particular situation; subsequently these understandings also affect future behaviors.

\(^2\)While we recognize that some diseases are debilitating and may, to some degree, act as master statuses (Hughes 1945), there remain individuals who chose to invest in other role identities despite overwhelming odds. For instance, in a recent study of mothers who have HIV/AIDS, Wilson (2007) found that her respondents continue to cling to the mother identity and emphasize their need to survive and protect their children. Typically, however, individuals who are able to maintain alternate roles in the face of devastating illnesses or physical conditions tend to have considerable economic, cultural, and social capital at their disposal.
abandon emotionally salient and committed roles such as a breadwinner or coach (Bury 1982; Charmaz 1980; Karp 1996; Williams 1984). Indeed, these are the experiences on which numerous narrative studies and patient memoirs are based. Before individuals reach this point, however, they may make decisions that are based less on their physical conditions and more on their subjective identities and desires. These decisions may or may not affect their eventual health outcomes. Given that this supposition has yet to be empirically tested, it may be worthwhile to examine individuals’ identity hierarchies at the time of diagnosis, track how these hierarchies change, and how they affect individuals’ decision making processes regarding their condition over time.

To conclude, structural symbolic interaction and recent conceptualizations of social roles have the potential to open up new theoretical directions for those studying identity and illness. In taking account of individuals’ pre-existing identities, we are further able to examine the differential ways in which individuals handle and make decisions about their health. Further, incorporating insights from structural symbolic interaction also helps locate the contexts in which individuals use pre-existing identities to help alleviate the negative impacts of illness.

**Affect Control Theory**

Moving away from the notion of identity hierarchies, affect control theory (Heise 1979, 2006) focuses on the internal and behavioral processes an individual undertakes in regulating and maintaining an identity (also see Burke and Cast 1997). Unlike other theories of identity, which are primarily cognitive, affect control theory relies largely on sentiment structures to predict behavior. Sentiments, according to Heise (2006), are culturally shared affective meanings that individuals hold regarding elements of the social world. Specifically, affect control theorists are interested in the relationship between the *fundamental sentiments* that individuals hold generally and the *transient sentiments* that arise in situated interaction – that is, during a particular encounter between social actors.

Generally speaking, affect control theory is based on the premise that individuals are motivated to act in ways that keep their transient sentiments in line with their fundamental sentiments. When transient and fundamental sentiments are at odds, individuals are expected to act in ways that bring them closer together. According to Heise (2006), when individuals are *able* to confirm sentiments about their current identity, they are in essence actualizing their sense of self. When they are *unable* to confirm sentiments about their current identity, however, they experience inauthenticity that they resolve by enacting compensating identities or reframing the situation cognitively.14

Based on dozens of cross-cultural studies of affective meaning (Osgood et al. 1975), affect control theory assumes that the sentiments of people everywhere vary along the three dimensions of meaning: Evaluation, Potency, and Activity.15 The theory also assumes that people who share a culture also

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14In experimental settings, individuals are more likely to alter behavior – or their meaning of a behavior – before attempting to alter (or redefine) their own social identity or the identity of their interaction partner (Nelson 2006).

15Sentiments are measured through disaggregating the elements of social interactions – that is, role identities, behaviors, attributes, emotions, and settings – into three fundamental dimensions of affective meaning: Evaluation (how good or bad something is), Potency (how powerful or powerless), and Activation (how lively or quiet). These three aspects are usually referred to as EPA; and most affect control theorists assign them values ranging from approximately 4.0 to 4.0. As these values suggest, the three aspects of sentiments – Evaluation, Potency, and Activity – are matters of degree: E, P, and A values can be greater or less, in either a positive or negative direction. For example, physician has an EPA of 2.01, 1.67, -0.10, whereas a nurse has an EPA of 1.65, 0.93, 0.34, and a patient, 0.90, -0.69, -1.05, which suggests – not surprisingly – that in any given interaction, individuals who see themselves as patients are more likely to listen to or obey physicians than they are to adhere to the demands of nurses, whom they view as relatively less good and less powerful.
share sentiments about interactional elements within that culture, such as role identities, behaviors, settings, emotions, and attributes. In the USA, for example, Americans tend to view children as being fundamentally very good (in terms of Evaluation), fairly weak (in terms of Potency), and fairly active (in terms of Activation). However, in a situation when a child does something bad (such as kicking an infant, who is also viewed as very good, fairly weak, and fairly active), we construct a transient sentiment regarding that particular child, based on the combination of his identity as a child, his (very bad and fairly powerful) behavior, the equally good, weak, and active identity of the infant, and the setting in which the interaction occurred.16

The difference between one’s fundamental sentiments that comprise the interaction and the transient sentiments that a particular interaction produces is referred to as deflection. Affect control theory, like symbolic interaction, assumes that individuals are motivated to confirm their fundamental sentiments and, thus, to minimize deflection. When deflection cannot be reduced through behavior alone (that is, the offending child cries, thus signaling remorse for his action and reducing his power in the situation in such a way that compensates for his previous powerful action against the infant), elements of the situation may have to be redefined (that is, the child is relabeled as a delinquent or the kick is redefined as an accident or as playing). A delinquent who kicks an infant or a child who plays with an infant seems much more likely an occurrence.

In addition to maintaining their own fundamental identities, affect control theory also assumes that people are also similarly motivated to maintain the identities of their interaction partners (Heise 2006). In other words, when interaction partners’ identities are disconfirmed, actors are expected to act in ways to reset the balance. In the medical context, for example, this suggests that patients who view physicians as very good, very powerful, and somewhat inactive should act in ways that confirm their sentiments regarding the physician identity — meaning that they would be more likely to seek out medical attention and obey directives. Patients who view physicians with less esteem, however, would probably be less likely to seek out or adhere to medical advice because they are — even if only at the subconscious level — confirming their sentiments regarding the “negative,” and potentially “powerless” and “inactive” identity of their health care provider who they may view as either a quack, or in the case of a younger physician, an upstart. According to affect control theory, it would not be unexpected for actors to disagree with, disparage, or ignore those whose identities are viewed as significantly worse, weaker, and less active than their own. From this perspective, knowing how different populations view physicians may help us to understand why some patients comply with physicians’ orders, while others do not. It may also help to predict patients’ reactions to different types of health care providers, given that different types of providers tend to be viewed differently (e.g., competent healer versus new-age quack).

Further, affect control theory has a predictive capacity that moves beyond other theories of identity. In order to specify the mathematical underpinning of the theory, Heise and colleagues have developed a computer simulation program, INTERACT, that allows researchers to simulate social interactions by entering in discrete elements of a social interaction (and their concomitant EPA values) and combining them to create transient sentiments. Using the EPA structures as data and the mathematical models that have been derived from affect control theory (Heise 1979, 2006;

16Although affect control theory assumes that the majority of sentiments within a culture are commonly shared, scholars have nonetheless documented some subcultural variations. Most subcultural differences in sentiments exist as a result of differences in identities or behaviors that are associated with one group and not another (Heise 2006). For example, Smith-Lovin and Douglass (1992) reported that members of a liberal gay church had more positive meanings attached to identities such as homosexual and behaviors such as sodomy than members of a fundamentalist church. Heise (2006) argues that 80 percent of people’s affective sentiments come from the influence that the dominant culture wields, and the remaining percentage stems from personal experiences. Smith and colleagues (Smith and Francis 2005; Smith et al. 2001) have also found subtle, yet significant variations in the sentiment structures of Japanese and US samples.
Smith-Lovin 1987, 1990; Smith-Lovin and Heise 1988), INTERACT allows researchers to model interactions, not only from the perspective of the first actor (who may see herself as a competent physician who is in the act of instructing an uninformed patient), but also from the perspective of the second actor (who may see the situation from an entirely different perspective: insensitive know-it-all talks down to competent professional.) INTERACT, as well as Affect Control Theory, reminds us of the importance of considering the perspectives of both (or all) actors within a given situation. Because of their differential perceptions, the actions that one actor may take in order to reduce deflection may be at odds with the prescribed steps of their interaction partner. That individuals may have different definitions of situations, which may result in incongruous behaviors, is not new; indeed, it is the stuff from which television sit-coms are born. While the mismatch of meaning can be humorous in a comedic setting, it can be disastrous in a medical context.

To date, there have only been a handful of studies that have applied insights from affect control theory towards the study of health and identity. Although all these speak of issues of mental illness, they have implications for physical health as well. Drawing on the experience of individuals entering into social support and grief management for those who were recently divorced or widowed, Francis (1997) found that support group leaders changed participants’ emotional responses to loss by altering their underlying social identities. For instance, when individuals came in distraught over their divorce, the group leader would attempt to lower the member’s evaluation of their spouse in terms of their relative goodness, powerfulness, and activation. They would also attempt to increase the relative goodness of the member. Similarly, widows or widowers—especially caregivers—who believed that they had failed their spouse, were encouraged to see the spouse’s behavior (e.g., dying) as intentional, thereby reframing their death as a choice to leave or as a form of abandonment. By viewing the spouse’s behavior as conscious and, therefore, significantly more negative, more powerful, and more active, the aggrieved spouse was able to see him or herself, as well as the deceased, in a different light. The transformation of identities (that arose predominantly from the reconceptualization of the behavior) positioned surviving spouses to deal more effectively with not only their guilt, but also their grief.18

Focusing more on sentiment structures than the transformation of social identities, Kroska and Harkness (2006) introduced the concept of stigma sentiments in order to test Link’s modified labeling theory of mental illness (see earlier discussion). Stigma sentiments are the culturally held sentiments regarding individuals with mental illness. Based on surveys from four distinct populations that tapped not only into stigma sentiments, but also self-appraisals (“myself as I really am”) and reflected self-appraisals (“myself as others see me”), Kroska and Harkness (2006) found that the self-appraisals and reflected self-appraisals of the mentally ill patients were closer to that of role identity of person with mental illness than those of non-patients.19 Further, mentally ill patients’ self-appraisals and reflected self-appraisals were also more positively associated with those of three other negative and potentially stigmatizing identities (e.g., loser, outcast, and reject) than non-patients. These findings are consistent with the modified labeling theory of mental illness (Link 1987), in that they, too, suggest that patients who have been diagnosed with mental illness do indeed come to see the negatives associated with mental illness as self-relevant.

17In order to use INTERACT, available at http://www.indiana.edu/~socpsy/ACT/interact.htm, one must put all interactions into the format of actor-behavior-object. Using advanced settings, the researcher can also choose personal attributes (e.g., opinionated, lazy, friendly), as well as the settings in which the interaction is likely to occur (e.g., a hospital, a clinic, a bar).

18Perhaps not surprisingly, individuals who attended the grief support group for widows and widowers were less inclined to accept a blatant negative reconceptualization of their deceased spouse’s identity than those individuals who had lost a spouse to abandonment or divorce.

19The non-patient samples included both network members of the mentally ill as well as college students from a nearby state university.
Although one could argue that their findings merely replicate Link’s (1987) already well-documented results, Kroska and Harkness (2006) argue that stigma sentiments may, in fact, be a superior measure of mental health stigma than the stigma beliefs (Link 1987). Unlike stigma beliefs, which are based on a relatively lengthy scale of historically and socially contextualized statements that may capture the assumptions of mental health researchers rather than the actual experiences of patients (e.g., “Most people would willingly accept a former mental patient as a close friend”; Link 1987), stigma sentiments are historically and socially context-free. They are also easier to collect – requiring only three simple ratings along the dimensions of Evaluation, Potency, and Activation – and are both highly comparable and reliable across cultures.

Although stigma sentiments have only been recently introduced to the study of mental health, they provide an intriguing opportunity for health researchers to understand how the onset and progression of disease may influence the effects of illness on various aspects of identity – particularly self-appraisals and reflected self-appraisals. Given Kroska and Harkness’ (2006) purpose of testing modified labeling theory, it is not surprising that they failed to also address how these new (or altered) self-meanings may also impact individual choices related to disease, if not subsequent outcomes. Drawing on insight from affect control theory – that is, that individuals tend to create events that confirm their sentiments (Heise 2006) – it is likely that behaviors and outcomes will be affectively consistent with self-meanings. To date, however, there has been very little, if any, data collected on such a phenomena. Future studies would do well to collect self-appraisals from patients or those laboring under various diseases or conditions and – at least in the case of stigmatized conditions – self-reflected appraisals. Not only could researchers examine differences between patients and non-patients, following Kroska and Harkness (2006), but they could also follow changes in patients’ self-meanings over time.

Identity Control Theory

Despite considerable overlap with ideas from structural symbolic interaction (Stryker 1980), affect control theory (Heise 1979, 2006; Smith-Lovin and Heise 1988), and identity theory more generally (Thoits 1983, 1986), identity control theory focuses on the more internal – as opposed to the behavioral – processes an individual undertakes in regulating and maintaining an identity (Burke 2005). In the identity control model, an individual controls her perception of the situational meanings via a feedback loop in which she strives to match situational inputs (i.e., how she perceives herself in the situation) with her identity standard (the set of meanings she holds for a particular identity, such as wife, student, or employee). Unlike affect control theory, which relies on fundamental sentiments held in common at the cultural level, identity control theory relies on identity standards that are collected directly from the individuals being studied. The goal of the identity control process is to bring the situational inputs into alignment with the identity standard (Burke and Cast 1997). Much like individuals who perceive an incongruence between fundamental sentiments and events are expected to alter one or more elements of the interaction in order to reduce deflection (Heise 1979, 2006), individuals who perceive an incongruence between situational inputs and their identity standards are expected to alter their behavior and/or perceptions until congruence between the situational inputs and the identity standard are achieved.20

20 As do other theories of identity (Heise 1979, 2006; Stryker 1980), identity control posits that if an individual’s restorative strategies fail to produce a correspondence between situational input and the identity standard, the identity standard itself may change (Burke and Cast 1997).
Scholars interested in health have not capitalized on identity control theory as much as they have on the other theories outlined above. Granberg’s (2006) recent scholarship on sustained weight loss may represent the most successful application of identity control theory, at least in conjunction with the theory of possible selves (Markus and Nurius 1986; Markus and Ruvolo 1989) and narrative psychology. Specifically, she examined how individuals who experience significant and planned weight loss negotiate this self-imposed challenge to self and identity. Granberg’s (2006) work extends the scope of identity control theory in important and significant ways. First, “possible selves” do not refer to whom individuals see themselves as currently, but rather how they could possibly be at some future time. According to Markus and Nurius (1986), the theory of possible selves focuses on gaps between who we are and who we might be, and links such discrepancies directly to the pursuit of self-relevant goals (Markus and Ruvolo 1989). In Granberg’s study, many of the respondents’ possible selves were based on what they thought their lives would be like upon reaching their weight loss goal or, in some cases, being found sexually attractive or buying a certain sized dress.

Second, prior to Granberg’s (2006) study, identity theories have been considered to be most relevant to formal social roles, such as patient, invalid, doctor, etc., and to processes that promote stability and coherence in individuals’ self-concepts. Therefore, identity theory has typically not been used to explore informal roles (or physical conditions), nor has it been applied to instances of self change. Unlike traditional applications of identity control theory that focus almost entirely on formal social roles and stability (Burke and Cast 1997), Granberg’s work reveals that informal roles, such as “fat” or “thin,” when invoked in social interactions, also influence thoughts, behaviors, and strategies. Moreover, they not only inform individuals’ choices about maintenance, but they also motivate decisions and behaviors regarding continued self-change.

Third, Granberg shows that individuals’ narratives about obesity, like those used in earlier accounts of identity and more formal illness (e.g., Bury 1982; Charmaz 1993), refer to stories used by individuals to relate their experiences in such a way that they incorporate an additional message or moral story (Orbuch 1997). They are also an important means through which the excitement generated by the hoped-for possible selves or the disappointment resulting from a failure of self-verification can be made comprehensible not only to the self, but also to others (Granberg 2006; also see Bruner 2002; Gergen 1994; Hyden 1997).21

In melding these three theoretical traditions, Granberg (2006) suggests that identifying the processes through which people resolve unmet expectations (about what they thought their lives would be like post-weight loss) can explain the very high rates of failure of weight loss as well as informing theoretical understandings of identity formation and maintenance. For instance, while individuals who are dissatisfied with their weight loss may be more inclined to gain the weight back, the successful “losers” in Granberg’s study tended to either engage in behavioral strategies (e.g., exercise more or lower their goal weight) or reframe their desired self (e.g., from being sexy to being healthy).22

While her focus is on issues of obesity and weight loss, Granberg’s (2006) observations may have implications for other forms of disease or other health-related conditions, especially since possible selves can incorporate any domain of self-conception, such as role identities (e.g., victim), personal attributes (e.g., disabled), or physical characteristics (e.g., obesity). Moreover, although

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21Insights such as these may also be useful in furthering our understanding of other forms of self-change that involves the physical self — that is, the body (for recent examples, see Davis 1995; Gagne and Tewksbury 1999; Phelan and Hunt 1998; Preves 2001).

22Although obesity has not been fully accepted as a disease in the traditional sense, it is a physical condition that undoubtedly impacts health and contributes to other diseases, such as diabetes, hypertension, high-blood pressure, bulimia, etc. Gaining insight into the cognitive barriers to weight-loss, then, has important implications for a variety of health related dilemmas.
Granberg's (2006) analysis dealt only with possible selves that are positive, possible selves can also be negative (e.g., invalid) or represent conditions that individuals would prefer to avoid (e.g., incontinence). Future research in this area would do well to address how individuals use identity control processes when facing a wider array of health challenges that may, or may not, lead to the genesis of negative, or deteriorating, possible selves.

Conclusion

In this chapter, we have argued that a more thorough inclusion of social psychological theories of identity has the potential to remedy current oversights in the field of identity and illness. In particular, by taking into account people's identities before they become ill, we can examine how existing identities may not only shape individuals' subjective experience of their illnesses, but also their choices, behaviors, and, potentially, their outcomes. Although identity theories such as those we have discussed here have been used in a variety of contexts, from predicting blood donations (Callero 1985) to trial sentencing (Robinson et al. 1994), only rarely have they been incorporated into studies relating to illness (for exceptions, see Francis 1997; Granberg 2006; Kroska and Harkness 2006).

Structural symbolic interaction, affect control theory, and identity control theory all operate on the premise that individuals are motivated to protect (or maintain) their fundamental sense of self (but see Granberg 2006). For Stryker (1980), this means maintaining the role identities to which they are highly committed and find the most salient. For Heise (1979) and Burke (1991), however, it means creating (or perceiving) events that match their senses of self. While scholars have examined how illness impacts an individual's identity, we argue that fully incorporating these theories can contribute towards a more sophisticated and nuanced theory of the relationship between identity and illness. Furthermore, we believe that incorporating the theoretical insights from social psychological theories of identity would also assist researchers and possibly practitioners in understanding why it is that some seem more willing to succumb to disease, while others do not.

As noted previously, structural symbolic interaction (Stryker 1980) reminds us that individuals are motivated to maintain highly valued identities. When applied to medical research this suggests that those studying the relationship between identity and illness might benefit from paying closer attention to individuals' preferred social identities prior to and immediately following a diagnosis, as well as during treatment and, if applicable, throughout recovery. Because one's social role identities are closely tied to affect, cognition, and behavior, it is likely that individuals' outcomes may vary by the degree to which they embrace or reject the patient role, either surrendering or retaining other valued social roles in the process.

Similarly, affect control theory (Heise 1979, 2006) suggests that individuals are motivated to maintain their fundamental affective sentiments regarding their sense of self, others, and even settings where situated interactions are likely to occur. When individuals' fundamental sentiments are not matched by situated interactions, they may engage in behavioral or cognitive strategies to rectify these discrepancies as a means to avoid dissonant feelings. Again, when applied to the study of health and illness, it is possible that some groups of individuals may have different fundamental sentiments about what it means to be a patient, an invalid, or a physician. Additionally, they may also differ in terms of their understanding of hospitals and the type of activities that are likely to occur there. Taken together, these insights suggest that a more nuanced understanding of individuals' sentiments regarding social roles, behaviors, and settings within the medical context might shed light on why certain types of people may be more or less likely to seek out, receive, and adhere to medical care. Further, affect control theorists have also shown how important it is to truly understand and consider individuals' definition of the situation in the course of situated interactions (see Robinson et al. 1994). If scholars had access to such definitions, they would be better positioned...
to not only understand an individual's choices and motivations, but also to predict behaviors and develop successful interventions (again, see Francis 1997).

Finally, identity control theory (Burke 2005) also argues that individuals are motivated to maintain their preferred self-identities. Drawing on these insights, as well as Markus and Nurius' (1986) discussion of possible selves, Granberg (2006) showed that individuals are not only motivated to maintain their preferred self-identities as they are now, but also to reach identities that they may imagine in their future. Although Granberg's study is limited to positive possible selves, it stands to reason that some individuals may also be motivated to avoid negative possible selves. A post-menopausal cancer survivor, for example, may avoid taking prescribed hormone replacement drugs because of her fear of developing breast cancer, leaving herself open to a greater risk of heart disease and stroke. Insights like these would not only improve scholars' understanding of the decisions that individuals make, but could also lead to the development of important interventions within the field and practice of medicine.

Despite their roots in traditional symbolic interaction (Blumer 1969), the empirical applications of identity theory rely most commonly on quantitative methods. Indeed, part of Stryker's (1980) justification for a more structural perspective on identity was to move scholars away from traditional symbolic interaction's reliance on qualitative data and shift them towards survey methods that would result in more efficient data collection and greater replicability and generalizability. Notably, the two control theories (Heise 1979; Burke 1991) tend to utilize an even broader range of methodologies that includes not only ethnography and surveys, but also computer simulations and experiments. While we are by no means proposing to supplant qualitative methods, we argue that the introduction of complementary methods and data sources to the study of illness and identity would better allow scholars to not only ascertain the generalizability of their findings, but also more readily link their work to broader questions within sociology. For instance, by quantifying the insights garnered from narrative accounts or other forms of ethnographic research (e.g., creating identity hierarchies, collecting affective sentiments, etc.), researchers would be better positioned to understand the ways in which individuals' self-meanings—particularly those associated with health, illness, and well-being—may be influenced by the larger social structures in which they are embedded. Indeed, drawing on insights from social structure and personality (see McLeod and Lively 2003 for a recent review)—and from social stratification more generally—it may be that potential shifts in individuals' identities that may arise from, or perhaps even buffer, an illness or other debilitating condition, are affected by broader factors such as race, class, gender, or sexuality. They may also be influenced by the social characteristics of friends, families, schools, or even neighborhoods. Further, the use of more highly structured data, in conjunction with the rich details that only narrative methods can provide, may also grant scholars the ability to more easily make comparisons not only between groups, but also within groups. It may also allow researchers to more efficiently and effectively track changes over time. Such strategies have the potential not only to deepen our appreciation of the effects of illness on identity and vice versa, but also to promote an inherently more sociological approach towards the study of identity and illness.

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