Getting Well: Impression Management as Stroke Rehabilitation*

Steven J. Gold
University of California, Berkeley

ABSTRACT: Participant observation, interview and photographic data reveal how stroke victims are taught impression management skills to cope with the physical limitations and sick role status brought on by their ailment. Their rehabilitation process is collective, intentional and seeks to have stroke victims redefined as normal, healthy individuals. This analysis focuses on the group's work to demedicalize the social definition of their condition.

Illness and Deviance

A shared concern of the many forms of phenomenological sociology is the relation between individual actors and the values, norms and patterns of behavior of a social group. Phenomenologists argue that individuals learn, adjust to, recreate and change norms and structures by way of social processes. In the process of interacting in groups they adopt the norms of the group and society. Working within this tradition, sociologists have studied marijuana smokers (Becker, 1963), strangers to a society (Schutz, 1944), mental patients (Goffman, 1967) and transsexuals (Garfinkel, 1967) to explore the relationship between individuals whose behavior is in some way remote from collective values, and the society which upholds those values.

In all of these studies, the authors describe the process through which actors become aware of their distance from behavioral norms and take special actions because of this awareness. For example, transsexual Agnes (Garfinkel, 1967) creates a flawlessly female self-characterization to counter any challenges to her identity. In a similar vein, Goffman notes that mental inmates recognize and try to support the norm of privacy. Where attendants violate patients' privacy, they embarrass their keepers with intimate comments about dandruff, shaving cuts and style of dress (Goffman, 1967:68). In these studies, bearers of stigma are reported to have a unique understanding

*I would like to acknowledge Arlie Hochschild for her assistance in guiding this paper toward publication. For reprint requests, write: Department of Sociology, University of California, Berkeley, Berkeley, CA 94720.

of what constitutes being socially normal. Who knows more about acting straight than one who must avoid being detected as stoned (Becker, 1963)? Because they are not normal, deviants must master activities of impression management.

Since Durkheim's *Division of Labor in Society,* social theorists have noted that norms support certain actions while discouraging and punishing others. Drawing on the Durkheimian tradition, Parsons (1951) and Foucault (1965, 1980) have shown that social groups use definitions of health and illness as forms of social control. Recently, students of society have noted a tendency to apply medical definitions to behavior not previously regarded as a matter of health or illness. In Western societies, illness is defined by the highly legitimate and value-neutral scientific institution of medicine. When deviant behavior other than illness is labeled and managed as a medical problem, it is done at least in part, in order to avoid acknowledging the inherently moral issues of identifying and treating deviant individuals (Zola, 1972, Conrad and Schneider, 1980). This phenomenon has been labeled the "medicalization of deviance."

Interestingly, a value-free medical definition has been both sought and rejected by "deviant" groups in their attempts to contend with coercive social norms. For example, largely through the efforts of Alcoholics Anonymous, alcoholism is now seen as a sickness and not a crime or personal weakness as it once was (Conrad and Schneider, 1980:108). Whereas gay rights advocates waged a successful campaign to have the American Psychiatric Association remove homosexuality from its list of psychiatric conditions (Conrad and Schneider, 1980:208), Alcoholics Anonymous members sought a medical definition in order to reduce the moral stigma. Gays, by contrast, worked to demedicalize and hence legitimate their lifestyle.

This article explores the response of stroke victims to various competing social definitions of their deviance. A stroke victim is wrenched from his or her original status and must relearn rules of self presentation despite the effects of a physical disability. Stroke victims are treated in an organized, collective manner in hospitals and rehabilitation centers. Much of their rehabilitation involves learning to display a socially acceptable image of wellness.

Methods

Data were collected during a period of nine months of fieldwork as a volunteer in the Stroke Rehabilitation Center. As one of the few male volunteers, my duties at the center were most often "heavy" jobs such

as furniture mover, physical therapy aide, and male attendant. In addition to attending the center, I also visited stroke victims in nursing homes, a local hospital and in their homes to gain access to a diverse sample. Data were gathered through participant observation, formal and informal interviews, examination of the center's files and photography.

Photos (cover, #1, #2) offer a glimpse of the center environment and patient activities. Photography did not commence until I had been at the center for one month in order to avoid my being seen solely as a photographer by the center's members. Because I photographed frequently, little attention was paid to my taking "candid" photos which did not focus on specific individuals (cover, #1, 2). Posed portraits (#3-5) were taken only with the subject's permission. While sociologists are urged to shun reactivity, photographers often make use of their relationship with subjects (Becker, 1974:19). My capacity as a member of the center is reflected in the naturalness of the expressions in the photos.

The General Experience of Stroke

To understand the experience of the stroke victim, one must know a little about strokes. A stroke or "CVA" (cerebral vascular accident) is a blockage in the blood vessels which supply oxygen to the brain. The loss of blood to the brain may cause temporary or permanent brain damage, resulting in an impairment of the body part controlled by that portion of the brain. The results of stroke vary in intensity and extent of recovery. The outcomes depend on a number of factors including the area of the brain affected, the physical condition of the afflicted individual and the type of treatment. A stroke victim may lose the use of an arm and leg, the control of facial muscles, the ability to form sentences, or there may be no obvious effects. While stroke is commonly seen as an ailment of the aged, persons of any age can be subject to it. The average age of participants at the stroke center is about 60.[1] Stroke may occur spontaneously or be brought on by physical trauma. When stroke results from non-traumatic causes, it is often painless and usually described as a twinge or numbness, followed by a loss of sensation in the affected area. (American Heart Association, 1981b).

The physical effects of stroke, such as impairment of communication and movement, vary more than the emotional reactions. Feelings of depression, isolation and frustration are common. Mood changes are frequent. Self-care and social presentation behaviors, which were previously taken for granted, may become difficult or impossible.

Recent stroke victims are often hospitalized. Following examination, surgery is performed on some individuals to aid rehabilitation or reduce the chances of another stroke. Doctors may also prescribe bed rest, physical, speech or psychological therapy, a special diet or anti-convulsive drugs.

As a result of medical treatment, recent stroke victims see themselves as occupying the sick role (Parsons, 1951, 1958, Freidson, 1970). The sick role implies that the stroke victim is exempt from social responsibilities, such as making a living or caring for children, as long as he or she defines being sick as an undesirable and temporary state. The sick role is exemplified by the stroke victim trying to get well and cooperating with the efforts of others to get him or her well. To deviate legitimately, one must avoid forming groups and making claims on the basis of illness as a permanent, legitimate role.

In this way, sick individuals are spared the stigma of social deviance; society also insures that it does not reinforce deviance by too far removing those who are sick. The sick role claims that the concern and supportive care provided by the high status doctor reflect society's concern for the patient. This undercuts alienation and motivates recovery.

While the real condition of stroke victims seldom conforms precisely to the Parsonian ideal type, the sick role does approximate their status during the early stages of the stroke experience. During this time, medical treatment can assure the patient and family that they are well cared for. Exemption from obligations allows the stroke victim to avoid discrediting him or herself because of reduced ability to function. Because the sick role is not a demanding one for a person who feels sick, little effort is required for impression management during this period.

Stroke, however, is a chronic rather than acute ailment, one which cannot be "cured" by the techniques of scientific medicine. As noted by Davis (1963), recent victims of chronic disabilities often have difficulty in understanding the long-term duration of their condition. At first, the sick role is adopted. Later, when it becomes evident that there is no cure, individuals must learn to accept stroke as a life-long condition. Unfortunately, treatment staff are often unwilling or unable to make clear the likelihood and extent of recovery. The sick role is inadequate, yet no new identity is readily available. In this way, stroke victims are prevented from having a clear basis upon which to express an interactional self. Many stroke victims first arrive at the Stroke Rehabilition Center in this state of identity confusion.

1

The "Ideology of Therapy"

The Stroke Rehabilitation Center creates and uses an "ideology of therapy." This philosophy is determined by the Center's director, but other staff and participants make significant contributions as well. The director is a charismatic woman in her mid-forties, the wife of a prominent community physician. Trained in physical therapy, Jeannie relies on her effervescent charm as much as her professional knowledge in running the center. She trots about the center addressing the patients, staff and volunteers with cheery greetings and pep talks. She also lends a careful ear to those facing difficulty. Jeannie sometimes flirts with male participants and teases females in order to help spread the high spirits and good humor. She frequently reminds staff and patients that it is their center.

While the director is vital to the center's "ideology of therapy," other members participate in numerous ways. Special phrases which describe the center, its members and the work of rehabilitation are

frequently repeated in casual talk and on ceremonial occasions. Stories of successful rehabilitation are told by staff as testimonials of what stroke victims can and do accomplish.[2] The tales of Mabel's great improvements in speech, Herman's weight loss and positive attitude and Bab's storytelling skills and nine grandchildren are retold, so that all the people in the center can take pride in the group's accomplishments. Participants able to contribute to the center's ideology through their own achievements or suggestions are seen as making progress in rehabilitation. This is especially so for patients who are unable to speak. Their accomplishments are recalled by others, who thus literally speak for a person who cannot speak for him or herself.

The collective orientation of the stroke center contrasts with the traditional hospital, where firmer lines of authority are maintained and patients are seldom encouraged to contribute to the ideology of their rehabilitation. Official information about the center is explicit in defining the central thrust of the rehabilitation process as getting the patient out of the sick role by "mainstreaming" (that is, getting the patient into the mainstream of life).

My interviews indicate that new stroke victims most often see their physical condition as influenced by two events: the physical effects of the stroke itself and the experience of medical treatment.[3] At the center, the sick role, acquired through these two events is rejected through the process of "reframing" (Goffman, 1974). Reframing means teaching stroke victims to project an alert, controlled and responsive self-image. Stroke victims must thereby reject the components of the sick role which imply deviance or absence of wellness.

The stroke center teaches stroke victims that they must fulfill personal obligations and are personally responsible for their own care. They must make a claim of legitimacy by and for stroke victims as a group and they cannot see their condition as a purely negative one. For example, the center's staff consciously uses the active term "participant" instead of the passive term "patient." According to the Parsonian sick role, a patient is supposed to be emotionally attached to his or her doctor. At the stroke center, participants often denigrate their physicians and give credit for their recovery to the center's more attentive physical therapists.

While stroke victims would like to appear and feel well, this is often quite difficult for members of my sample, considering their physical and social position as elderly, disabled and low-income persons. In the stroke center, rehabilitation is accomplished by teaching the participant to redefine stroke from a life-shattering medical ailment to a conquerable inconvenience. For example, one man had a stroke, and

2

for several years before coming to the center claimed to have "given up." During this time, he refused to participate in rehabilitation activities and blamed his stroke on an accident caused by improper care in the hospital: "I stayed in bed and ignored my wife and son." Finally, a neighbor began to visit him, convincing him to *work* towards rehabilitation. When he began to attend the Stroke Rehabilitation Center, he was highly motivated and made rapid progress. "In the center, I used my stubbornness. I am not embarrassed when I talk to people now." According to the center's definition, rehabilitation has occurred when someone who has experienced a stroke is seen and sees him or herself as "a whole, well person" within the center.[4]

According to staff and participants, to accomplish rehabilitation one must rely on inner strength. Inner strength consists of classic Anglo-American character traits such as determination, courage, ability to work hard, concern for others, stoicism, a sense of humor, devotion to family and hope for the future. Inner strength is an excellent tool for accomplishing stroke rehabilitation, because it can be applied by any person, regardless of physical disability. One participant exemplified inner strength when he described his motivations for living alone, even though he was rather severely disabled. (A choice to live alone was made by several participants.) "It's the fighting to live alone that keeps me going. I could move in with my daughter, but the soft life is no good. I'd just sit around."

The stroke center emphasizes the therapeutic value of a positive outlook. Displays of cheerfulness, cooperation, outward orientation, and desire to work diligently towards rehabilitation are the means to achieve wellness.

Many seemingly small and mundane actions are treated as expressions of serious progress toward rehabilitation. These include: smiling; giving greetings; making or actively listening to small talk; demonstrating commitment to difficult, boring or apparently useless therapy activities; expressing gratitude to the center; submitting good-naturedly to teasing; displays of affection; adjustment of clothing; answering personal questions; and being photographed and scrutinized by other participants and staff. These all are heavily rewarded within the center. Such rewards include acceptance by the center's participants and staff, encouragement, personal friendship, favors, gifts and, perhaps most important, an institutionally-based image of "I am doing my best and so I am a well person."

To insure success, the ideology-makers of the center maintain that virtually every activity at the stroke center has value in providing

3

participants with therapy and lessons of independence. Even such common activities as the scheduling of daily events and the passing of time in itself are seen as therapeutic. Following a schedule teaches punctuality and responsibility.

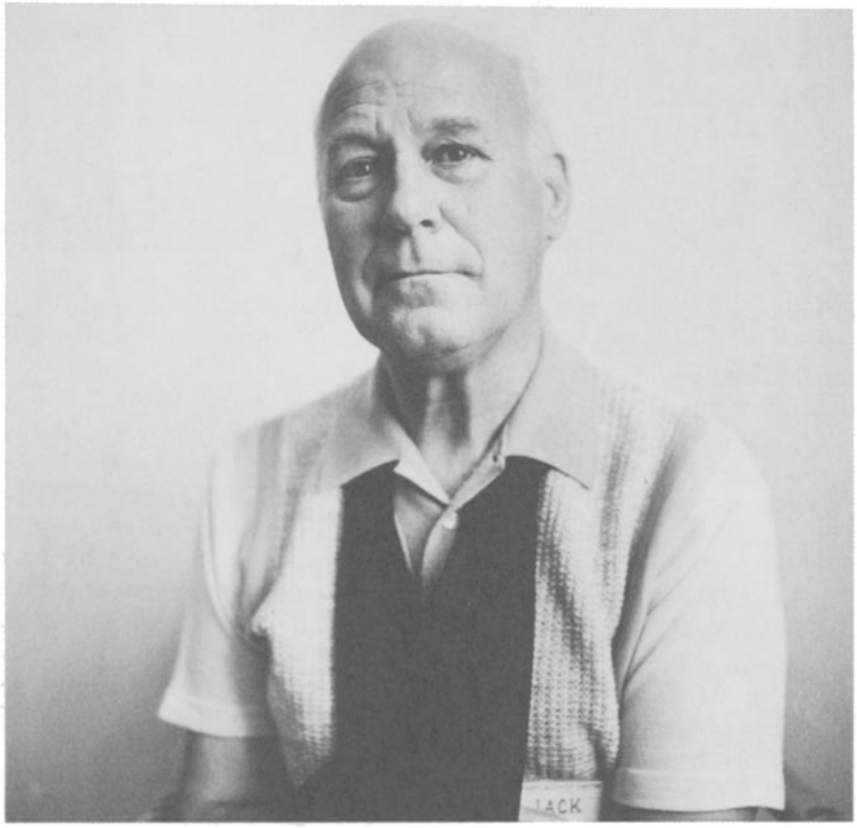
Criteria of Wellness

In order to explore the way one presents him or herself as a well and interactively competent person, I have developed a list of "criteria of wellness." These include behaviors which were specifically encouraged or condemned in the day-to-day life of the Stroke Rehabilitation Center. Participants who were able to display many positive behaviors and few negative ones were seen as exemplary and making excellent

progress. The greater the difficulty in displaying such behaviors, the greater the positive evaluation received by that participant. Because many of these behaviors are expressed visually, photographs were helpful in discovering them. Eight categories are included in the list. While there is some overlap among the criteria, each relates to an important area of interactional competence which must be mastered in order to project an image of self which is well. These include: (1) Time orientation, (2) attention span, (3) body control, (4) participation, (5) appearance, (6) knowledge, (7) sharing group values and (8) emotions.

Time Orientation. Time is an important factor in the stroke rehabilitation process (Roth, 1963). To be seen as well in the center, a participant must be able to sense and participate in the daily timing of the center's activities as well as the longer-term flow of the rehabilitation process. The quality and quantity of behavioral displays of alertness, attention and participation require an ability to sense

4



5

socially appropriate timing. In addition, the ideology of therapy of the center is rooted in a kind of Protestant work ethic, whereby participants are expected to accept the idea that effort expended over a period of time (that is, work) will yield some recovery.

Attention Span. Stroke victims must display sufficient attention to and comprehension of therapy activities, lectures and conversations. Excessive attention, such as focusing on the "hippie" appearance of a volunteer, is frowned upon by staff as "inappropriate" attention.

Body Control. Body control is an important way of demonstrating wellness at the center. Because many of the participants suffer rather severe physical infirmities, standards of body control appropriate to larger society are not applied. However, complete lack of body control is considered inappropriate behavior. For example, limp arms or legs are restrained by slings or braces. In the center, an important issue of body control is the ability to use the bathroom by oneself. Several

participants who are unable to do so are accompanied to the center by family members or personal attendants, thus freeing the staff of this responsibility.

Participation. If a stroke patient refuses to participate in several activities at the center over a period of time, he or she will be asked to leave. Generally, participants are permitted to refuse certain activities, but if they "come around" and begin to take part, they are rewarded.

Appearance. Appearance is an important tool in the management of wellness. This is illustrated by the degree of visual impression management in the posed group of photos (#3-5). Because patients may be limited in their ability to move or speak, their appearance takes on major importance for expressing personal competence. Clothing is a helpful prop for maintaining appearances at the center. Slightly dressy attire is favored for men, and women participants are complimented for wearing colorful outfits. Jeannie, the director, sets an example by always wearing dresses, make-up and jewelry.

Knowledge. In order to be seen as well, participants are expected to command knowledge of the center's members, ideology and their own daily program. The latter is encouraged by pinning a schedule on their shirtfront. Additional expertise in activities such as table-tennis, crafts or lobbying on behalf of the center is rewarded as an indication of wellness.

Sharing Group Values. The ability to demonstrate that one shares the center's values as well as American middle-class values is vital to appearing well. At the same time, the center's ideology tolerates individualistic coping styles.

Emotions. The display of situationally appropriate emotions is considered vital to the learning of wellness. Emotions of cheeriness, pride and enthusiasm are valued, while excessive displays of depression or anger are discouraged. Emotion work (Hochschild, 1979) training for stroke victims is especially important because the physiological effects of the ailment can alter one's emotional state (Fowler and Fordyce, n. d.:28).

The process by which stroke victims are rewarded with an identity contingent on their display of certain behaviors and outlooks is an illustration of Goffman's (1967) model of society as a system of exchanges of deference and demeanor. Conformity with rules, such as the criteria of wellness, or commitment to activities of rehabilitation, yields not only rehabilitation from stroke, but further confirms a well self. Thus, small pleasantries become infused with much more meaning

than they might be given in other settings. "The gestures which we sometimes call empty are perhaps the fullest things of all" (Goffman, 1967:91).

Displays of cheer, effort and cooperation within the center also have an economic motivation, that is, they are criteria of the center's wellness. The center, as a new and marginally funded institution, desires additional support. When local officials visit the center and see the busy and optimistic environment, it is hoped that they will be impressed and provide additional money.

Photographs yield further insight into the way participants display wellness. As noted in the criteria of wellness, because many stroke victims are limited in their ability to move and speak, visual displays are an especially important means of communication in the center. In examining portraits of participants (#3-5), I was struck by the uniformity in style of self-presentation. The participants were from different backgrounds, ages, and sexes. They had a variety of different disabilities from stroke and different opinions of me as a photographer. Yet, their expressions, postures and focus of attention seem quite similar.

The similarity of poses can be seen as a reflection of the values and orientations of the center in which they were taken. Many aspects of the participant's demeanor in photos reveal the "optimistic but firm" outlook which is the theme of rehabilitation activities. For example, in the portraits, backs are straight, chin is forward, corners of the mouth are turned up and there is eye contact. Frowns, avoidance of eye contact or smiles are all absent. In general, the portraits reveal a controlled, focused, energetic and communicative outlook. I call this the "standing tall" posture. Standing tall is the center's motto and appears along with a picture of a tall redwood tree on name tags and other locations throughout the center.

The photos allow participants an ideal medium to show wellness. With the photographer's cooperation, an expression which took only seconds to display is frozen and becomes permanent evidence of the strength of character of its subject. In this way, a photograph becomes a tool of impression management and captures an idealized typification of self, available to be referred to at any time.[5]

Complex Framing

While displays and demeanors such as those shown in the posed portraits might offer conformity to the ideology of the center, it should be noted that such displays might not be felt at all times by those

offering them. Or, if sincerely displayed, such actions might be "enriched" with personal as well as institution-defined communication. Such actions yield appropriate demeanor and, at the same time, express personal statements of resentment, irony or autonomy. While individualistic behavior has a potential to disrupt the social organization of the center, it is tolerated and even encouraged, as long as it is not too openly hostile.

Taking a "you rascal you" attitude, the ideology makers of the center deem seemingly antisocial actions wholesome and spirited signs of any well American's character. One example of such behavior is an ironic "shit-eating grin." A participant with this contemptuous smile is seen as making an effort to show a positive outlook, while at the same time expressing disgust toward his or her own situation of disability. One person carried this ironic frame too far. He would often smile and say "shit, shit, it's all bullshit!" On one occasion, this brought a young female volunteer to tears. Staff members comforted the girl, telling her that this man had had a particularly bad life since his stroke.

Another means of displaying both individual and institutional meaning in the center occurs in the choice of clothing. Some persons attend the center regularly attired in garments which violate basic values of rehabilitation. One man wears cowboy boots with heels which make balance training therapy difficult. Another affects mirrored sunglasses which limit eye contact and so hinder the interpersonal communication valued by the center. Like other displays of individual autonomy within the center, these were accepted as allowable transgressions because the "violators" had demonstrated their embrace of the center's ideology in other ways. As mentioned previously, minor violations were tolerated as individual coping styles.

In addition to dealing with the participants' expression of individual as well as institutional meanings, the center also has to adjust to events which have the potential to undermine the center's claims regarding the abilities of stroke victims to become well. Falls, seizures and fits of crying occur unpredictably. These threaten all stroke victims working toward rehabilitation because such events seem to demand sick role treatment. The center counters these occurences in a manner not unlike its treatment of the physical disabilities of stroke. They are defined as routine, controllable and nonthreatening. Seizures are considered a normal part of the healing process. When a participant is afflicted, the center's physical therapists place him or her in a prone position and calmly observe the patient's condition. This prevents complications from going unnoticed and constitutes a

display made by the staff for the participants' benefit. No effort is made to call for outside help and activities within the center go on as usual.

Falls receive similar treatment. The staff ignore the fact that falls can result in injury and that they signify helplessness. Instead, the fallen participant's desire to be active and independent (the cause of the fall) is endorsed. Crying, as a potential threat to the cheery and productive atmosphere of the center, is reframed in several ways. First, crying is often defined as a physiological rather than emotional by-product of stroke in medical literature (Fowler and Fordyce, n. d.:28). Second, according to the center's staff, stroke victims, like all people, become frustrated, depressed and angry. Crying is a means of expressing this. Third, by taking a group therapy approach, crying can be defined as a legitimate form of valued communication. The crying person is then comforted by the staff, so demonstrating the supportive and understanding environment which exists. By reframing potential threats, the center is able to strengthen its ideology of rehabilitation.

Conclusion

The physical event of undergoing a stroke and its medical treatment encourage the stroke victim to see him or herself within the sick role. However, the chronic nature of stroke and the inability of doctors to provide a cure soon make the sick role dysfunctional for both stroke victim and medical treatment staff. While the sick role is inappropriate, physical disabilities and uncertainty prevent the afflicted individual from presenting him or herself as well.

In offering rehabilitation, the Stroke Rehabilitation Center gives participants an opportunity to alter the relationship between sick role status and the social norms and institutions which define them as sick. The center's socially based, concrete and attainable criteria of wellness, provide individuals with the means to abandon the sick role and make a legitimate claim on the definition of themselves as well persons. By demedicalizing stroke in a social setting, the center allows participants to claim wellness. Once stroke victims can make a claim on wellness, the physical symptoms which initially implied the existence of a "sick role self" now become inconveniences. At least within the center, these are managed through styles of interaction.

Reference Notes

1. According to the American Heart Association, despite the fact that strokes can occur in persons of any age, six out of seven strokes occur in persons over 65 (American Heart Association, 1981:10).

2. Stroke literature often mentions the achievements of stroke victims. Freese (1980:11-12) points out that FDR, Churchill, Walt Whitman, George Frederick Handel and Louis Pasteur all made major accomplishments after their strokes.
3. In addition, stroke victims sometimes mentioned family members' reactions and their own past health history as important in coloring the way they saw their ailment. Patients who experienced stroke through traumatic onset generally do not separate the stroke from the injury which brought it on.
4. Due to less tolerant standards of wellness, even fully rehabilitated stroke victims might be seen as sick in other settings.
5. In *Gender Advertisements,* Goffman (1979) notes how an executive will have a portrait of himself taken at the height of his manly prowess, perhaps having just shot a deer, and will display this photo in his office as evidence of this part of his identity.

References

American Heart Association
1981a Strokes: A Guide for the Family.
1981b An Older Person's Guide to Cardiovascular Health.
Becker, Howard S.
1963 Outsiders. New York: The Free Press.
1974 "Photography and sociology." Studies in the Anthropology of Visual Communication 1: 3-26.
Conrad, Peter and Joseph Schneider
1980 Deviance and Medicalization. St. Louis: Mosby.
Davis, Fred
1963 Passage Through Crisis. Indianapolis: Bobbs-Merrill.
Durkheim, Emile
1933 The Division of Labor in Society. New York: The Free Press.
Emerson, Joan P.
1970 "Behavior in private places: Sustaining definitions of reality in gynecological examinations." Pp. 74-93 in Hans Peter Drietzel (ed.), Recent Sociology No.2. New York: Macmillan.
Foucault, Michel
1965 Madness and Civilization. New York: Vintage.
1980 History of Sexuality. New York: Vintage.
Fowler, R. S. and Fordyce, W. E.
n. d. Stroke: Why do They Behave That Way. Dallas: American Heart Association.
Freese, Dr. Arthur S.
1980 Stroke: The New Hope and the New Help. New York: Random House.
Freidson, Elliot
1970 The Profession of Medicine. New York: Harper and Row.
Garfinkel, Harold
1967 Studies in Ethnomethodology. Englewood Cliffs, N. J.: Prentice Hall.
Goffman, Erving
1959 The Presentation of Self in Everyday Life. Garden City: Doubleday Anchor.
1963 Stigma. Englewood Cliffs, N. J.: Prentice Hall.
1967 Interaction Ritual. New York: Harper Colophon.
1974 Frame Analysis. New York: Harper Colophon.
1979 Gender Advertisements. New York: Harper Colophon.
Hochschild, Arlie R.
1979 "Emotion work, feeling rules and social structure." American Journal of Sociology 84: 551-75.
Parsons, Talcott
1951 The Social System. New York: The Free Press.

1958 "Definitions of health and illness in the light of American values and social structure." In E. Gartley Jaco (ed.), Patients, Physicians and Illness. New York: The Free Press.

Roth, Julius

1963 Timetables. Indianapolis: Bobbs-Merrill.

Schutz, Alfred

1944 "The stranger: An essay in social psychology." American Journal of Sociology 49: 499-507.

Zola, Irving K.

1972 "Medicine as an institution of social control." Sociological Review 20: 487-504.