Pergamon

Soc. Sci. Med. Vol. 44, No. 9, pp. 1357–1365, 1997

PII: S0277-9536(96)00301-2
0277-9536/97 $17.00 + 0.00

THE IMPACT OF ANOMIA AS A FACTOR IN A DEMAND RESOURCE MODEL OF HEALTH

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Abstract—The particular aim of the present study was to explore the interrelations between the construct of anomia, conceptualized as internal health demand or resource, and self-reported ill-health in the framework of a demand resource model. The four main constructs of this model were considered as recursive causal levels: (1) socio-economic data, (2) external resources/demands, (3) internal resources/demands, and (4) ill-health. Study statistics comprised graphical models to reveal the relations between variables using the statistical program DIGRAM designed for discrete graphical models. This method of data analysis permits a focus on the link between anomia and the other three levels. The function of anomia as an intermediate data level which might prove to be an intervening variable can be evaluated. A total of 440 subjects of a random community sample were included in the final analysis. In the framework of a demand resource model, it was possible to confirm that the construct of anomia plays a key role in health outcome. Graphical models showed that a low degree of anomia is related to high psychological quality of life and few psychosomatic symptoms on the one hand, and to good social integration and emotional support, a low amount of daily hassles and high educational level on the other hand. As an overall conclusion, it can be stated that the evaluation by the graphical modeling procedure permits a good fit of theory with methods. © 1997 Elsevier Science Ltd

Key words—anomia, demand resource model, of health, graphical models

INTRODUCTION

The aim of the paper is to examine the interrelations between socio-economic data, external demands/resources, the internal demand or resource of anomia and self-reported ill-health in a community sample. The study reported in this paper relies on the basic assumption that human health depends on demands and resources of the internal and external environment. Therefore, health is conceptualized in the framework of a demand/resource model (Lazarus and Folkman, 1984; Antonovsky, 1987).

In the past two decades, perspectives regarding the concept of health have changed from a pathogenic to a salutogenic model (Antonovsky, 1979). This health concept is based on the assumption that an individual is permanently faced with various kinds of stressors during his/her life. Stressors can be described as demands emanating from the internal and external environment of a person. Antonovsky's model seeks to answer the question how one can stay healthy or recover from an illness in spite of the universal presence of stressors. This shift of perspective has a major impact on health concepts.

Modern concepts of health derive either from systems or action theories. Thus, health is embedded in most complex dynamic systems. As population health research involves associations of many complex levels and types of influences affecting health, its soundness is widely determined by the range of theories and methods being used. Its potential arises from the theory and the method used to analyze multiple associations (Dean, 1993). Specific exchange processes between individuals and their environment, between cognitive and emotional processes and individual strategies of coping are assumed to be essential for health. It is assumed that the character of health has to be seen in the context of systemic feedback processes.

Mussmann *et al.* (1993) define health as "... a transactionally produced condition of a dynamic balance between the individual, his/her autonomous potential of self-organization as well as of self-restoration and his/her social and economic environment. This balance depends upon the availability and use of health-protective and health-restoring factors in the individual and in the environment which can be defined as internal and external resources" (p. 9). They represent resources which are essential in coping with strain (Lazarus and Folkman, 1984), a factor which tends to have negative effects in the salutogenic process.

In this broad view, the individual's health is determined by several systems, such as the organic, psychological and social. Therefore, health results from the capability of the organism to regulate its own behavior and its physiology. The exchange of information on all levels of organization, from the simple molecular level to the level of social and cultural interactions (Noack, 1987; Weiner, 1990, 1991) plays a crucial role in this process.

In accordance with other authors (Breitwieser *et al.*, 1990), we assume that developing and maintaining positive health requires good personal, environmental and economical conditions as well as a usable infrastructure of everyday life. Health is the product of a successful interaction between the individual and the environment, that is, with coping and changing.

Figure 1 shows a demand resource model of health including the levels of the macro-environment, the micro-environment and the individual him/herself with their respective resources and demands as variables influencing health. The health status of an individual at a particular point in time is assumed to be the result of complex person–environment transactions.

In the present study the construct of anomia is considered as a central demand or resource of health. Durkheim (1933, 1952) first employed the concept of *anomie*. He refers to the pivotal task of society to take the lead of moral power and authority. Exceptional circumstances may lead to sharp transitions in society. In this situation, society might be incapable of regulating the individual's passions. In such crises, society loses the power, authority and effectiveness to guide human behavior and action. According to Durkheim, this means a state of *anomie*. His definition includes two main aspects, first the ineffectiveness of society's regulative power in abrupt transitions, and second the permanent lack of social rules.

Merton (1938), studying deviant behavior, picked up the concept of *anomie*. Subsequently it became widespread in sociological theory. The construct of *anomie* describes a state of lacking social orientation combined with the deinstitutionalization of relevant social and cultural means and norms. Possible consequences are uncertainty as to the substance and legitimacy of social norms in situations of social interaction. This again can cause frustration, social dissociation, social disintegration and psychic maladjustment. Merton pointed out in particular a situation in which cultural goals and institutionally prescribed means and norms of striving towards these goals are dissociated.

Srole (1956) developed a scale to assess the individual's degree of *anomia* and introduced it as a new term (Srole *et al.*, 1978). He uses social malintegration and interpersonal alienation as synonyms and is fully aware that both Durkheim's and Merton's conception of *anomie* relates to the state of the society and not to the individual's state (Deflem, 1989; Mestrovic and Glassner, 1983). His scale for measuring the individual's degree of *anomia* consists of five items and was used to explore the association between *anomia* and a rejective orientation toward outgroups.

Another approach was used by Jilek (1977) who introduced the concept of *anomic depression* to explore the interrelation between the socio-cultural situation of Coast Salish Indians and a specific type of mental illness as well, as in another study, culture-bound syndromes" (Jilek and Jilek-Aall, 1985).

In the study presented in this paper the individual's degree of *anomia* was assessed and considered as an internal demand or resource of health in the sense of Srole, whereas a low degree of *anomia* is assumed to be a health protecting factor. This construct is interpreted like comparable concepts, e.g. Antonovsky's (1987) sense of coherence or Kobasa's (Kobasa *et al.*, 1982) hardiness.

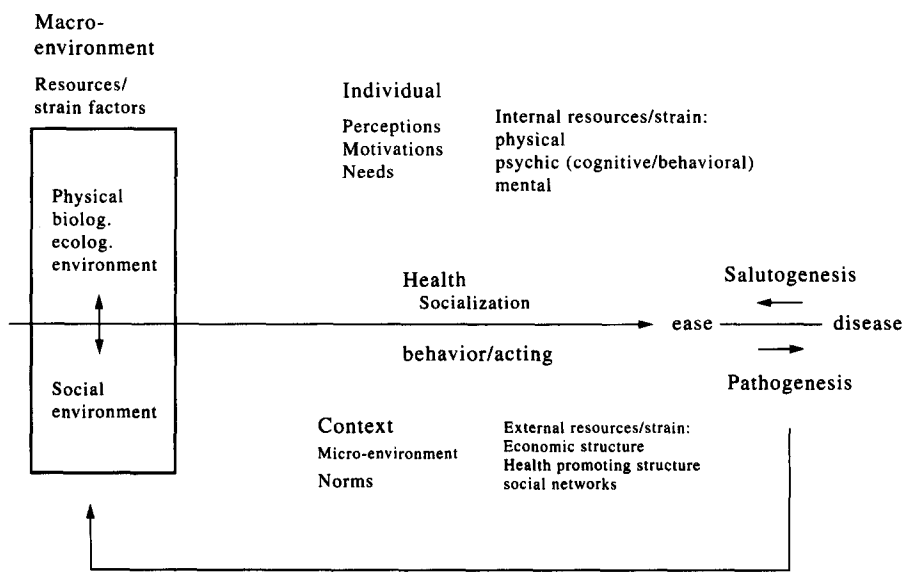

Fig. 1. A demand resource model of health.