# Chapter 3
# Social Construction and Health

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Social construction represents a major theme in sociology. Ever since Berger and Luckman (1967) suggested that some of our most taken-for-granted assumptions about society are embedded in specific "realities", sociologists, across the board, have been interested in such processes and applied them to a wide array of topics. Social constructs are viewed as the by-products of countless human choices, rather than laws that result from divine will or nature. This approach stands in contrast to essentialism that considers specific phenomena as inherent and transhistorical essences independent of human actions and decisions (Burr 1995). The theoretical contributions of medical sociologists within this perspective are shaped by the development of medical sociology itself. Early on, Strauss (1957) pointed out the inherent tension between sociologists *in* medicine and sociologists *of* medicine. The former generally collaborate closely with medical doctors to solve practical problems in medicine, but the latter are committed to use issues of health, illness, and healing as a window to help us understand larger sociological questions. Increasingly, sociologists are interested in questions that simultaneously advance sociological theory and have implications for the well-being of populations and individuals. Not surprisingly, these questions often center on how social and cultural factors matter for the way in which we understand and respond to biological processes.

In many ways, issues of health, illness, and healing offer particularly interesting insights into our understanding of the social construction of reality. While almost all aspects of human society, from the largest organizational features to the smallest routine interactions are continually (re)constructed, our health has an "objective" biological component that individuals and societies respond to. A useful distinction emerged between disease (the biological condition) and illness (the

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social meaning of the condition), highlighting the importance of understanding every issue related to health and illness as shaped by biological as well as social factors (Eisenberg 1977). It is the case that social and cultural factors impact virtually every question that medical sociologists are interested in, including, how we understand the biological abnormalities in our bodies, how we respond to illness, how we interact with medical professionals, and how we deliver our health care. All these processes have been created and recreated in human interaction over an extended period of time. Consequently, issues of health, illness, and healing offer us an opportunity to examine the interplay of the biological and the social in our lives.

Although notions of social constructions are evident in the earliest sociological writings (e.g. Durkheim, Mannheim, and Thomas), the approach took off as a major theoretical perspective both in sociology and medical sociology in the 1960s. One strand of research emerged from those scholars interested in understanding the role of deviance in society. They pointed out the lack of a universal law guiding what is abnormal or deviant; rather, certain social behaviors become defined in such a way within a particular social context. Inevitably, this definition has a strong association with power, namely certain individuals and groups have the power to label the behavior of other individuals and groups as weird, criminal, deviant, or sick (Becker 1963; Conrad and Schneider 1992; Spector and Kitsuse 1977; Zola 1972). This was also a time where major sociological thinkers were considering how issues related to health, illness, and healing do not represent an actual reality. As an example, Goffman (1961, 1963) pointed out how the "moral career" involves both biological conditions as well as social experiences; Freidson (1970) illustrated how illness and disease are socially constructed in his important book on the *Profession of Medicine*, and Foucault (1965, 1973) showed how the medical profession, through its powerful position, was able to label what was normal and abnormal. Together, this early work has inspired a large body of work in medical sociology, nicely captured by Conrad and Barker (2010: S69) as illustrating "how illness is shaped by social interactions, shared cultural traditions, shifting frameworks of knowledge, and relations of power."

Given the centrality of social construction within the sociology of health, illness, and healing, it would be impossible to count all the different ways in which medical sociologists engage with the approach. Consequently, I focus on a few major areas where important contributions have been made and consider: (1) The cultural meanings of illness; (2) The distinction between the normal and the abnormal; (3) How illness responses are embedded in the community; and (4) How medical knowledge itself is impacted by social factors. I then discuss the strengths and weaknesses of the approach and consider future directions that highlight how our world of health and illness is simultaneously impacted by biological realities, cultural traditions, historical trajectories, and institutional arrangements. To illustrate that point, I draw on a cross-national perspective and consider how it can increase our understanding of health, illness, and healing.

## The Cultural Meanings of Illness

Historically, illnesses have represented reality to most people. They represent abnormal variations in our bodies and our responses are often considered rational and even the only way to respond. This reality has become so taken for granted that we fail to notice that it is embedded in specific social contexts and ideologies. Even in cases when there are biological abnormalities, there are social and cultural meanings attached to them. These meanings help us make sense of the illness and have consequences on patients and health care. As an example, Sontag (1978) argued that negative metaphorical meanings of cancer, as evil or repressive, are common in our society and significantly impact those afflicted with the disease. In many ways, the cultural understanding of cancer ‘and particularly breast cancer’ has been altered through the survivor movement, which at first glance appears to be a positive development, as it empowers those suffering from it. However, research has shown that many women alter the meaning of survivorship or reject it all together. In particular, the “positive” survivor discourse alienates women who struggle with the threat of recurrence, who feel their cancer experience was not severe enough to merit this title, or who prefer to grapple with the disease more privately (Kaiser 2008).

Although all illnesses have a cultural component, those with stigma attached to them illustrate this point particularly well. The concept of stigma, originally formulated by Goffman (1963) is an attribute that, according to prevailing social norms, is deeply discrediting, marks a person as tainted, and allows the target to be denigrated. Sociologists have pointed out several illnesses frequently stigmatized in societies, including epilepsy, cancer, mental illness, HIV/AIDS, and sexually transmitted diseases (Conrad and Barker 2010). Link and Phelan (2001) define stigma as the co-occurrence of its components: labeling, stereotyping, separation, status loss, and discrimination, and suggest that power must be exercised for stigmatization to take place. Many children, even before entering first grade have notions about what it means to be crazy and have ideas about what “those” people are like. These ideas have been created and recreated in social interaction, but have become an inherent part of our cultural context, helping us to make sense of individuals who behave a strange way. However, what is considered strange is not equally determined across social groups as those in more powerful positions have greater power to define what constitutes such behavior.

The difference between illnesses that carry high versus low levels of stigma illustrates that there is nothing inherent in some conditions that naturally leads to stigma. Comparison across different types of physical and mental illness shows this clearly. It would seem that individuals and societies should view all types of cancer in a similar way, yet research has indicated that while some stigma may be associated with all types of cancer (Muzzin et al. 1994), those diagnosed with lung cancer experience particularly high levels of stigma, as the disease is strongly associated with smoking and therefore caused by the individuals in many people’s minds. This does, however, not apply exclusively to smokers but non-smokers felt stigmatized in the same way (Chapple et al. 2004). And while mental illnesses are more likely to be stigmatized in general, some mental illnesses carry more stigma than others. For example, individuals are more likely to hold negative attitudes toward those with schizophrenia as compared to depression, and a key explanation is the link between violent behavior and schizophrenia (Martin et al. 2000). This difference across disorders has even been observed amongst children; for example, Americans are more likely to be willing to have a child with depression in the same class as their child, as compared to ADHD. Yet, the reverse happens when they are asked whether they would want their child to be friends with a hypothetical child with depression or ADHD (Martin et al. 2007).

History can serve as a powerful tool to better understand how meaning is created and recreated in social interaction. Research has shown that the meanings of behavior change over time and, in the US today, few would regard some illnesses of the past in such a way. For example, masturbation was once considered as an illness, as well as Drapetomani: a condition described by American physician Samuel A. Cartwright as a mental illness causing black slaves to flee captivity. The example that is perhaps best known is homosexuality—included in the Diagnosis and Statistical Manual (DSM) of the American Psychiatric Association (APA) as a disorder until 1973. It was removed largely due to efforts of the gay rights movement and general changes in the landscape of norms surrounding human rights issues. Despite the strong sentiment that homosexuality was not a disease, the APA refused to completely eliminate it and created a new disease, ego-dystonic homosexuality. Rather than considering all homosexuality as an illness, the disease was now limited to those who had homosexual feelings but wanted to be heterosexual. It was not until 1986 that homosexuality was completely removed from the DSM as a potential illness (Conrad and Schneider 1992). These examples show that, in some cases, the label of an illness is closely related to the overarching cultural and political landscape of a society and, in many cases, has a moral component where more powerful groups view the behavior of less powerful groups as immoral and as something that society needs to respond to and control.

## What is Normal and Abnormal?

Tracing back to the 1960s and 1970s, sociologists have been interested in understanding how particular social behaviors become defined as deviant, especially within the subfields of criminology and medical sociology. These scholars pointed out that there was nothing inherently wrong in many of the behaviors we consider deviant; rather, these behaviors represent deviations from the social norms that guide our everyday life, and in particular deviate from the norms that more powerful groups consider important. Early on, Szasz (1961) argued that mental illnesses were nothing but a myth, as such “illness” lacked the characteristics that we normally require from illnesses—most importantly some form of biological deviation. He argued that mental illnesses simply represented problems in living and in some way reflect a normal response to an abnormal world. Within sociology, Scheff

(1966) was the first to articulate the link between labeling and mental illness, arguing that we all, at one point or another, engage in deviant behavior. What matters is that some people become labeled as deviant whereas others are able to avoid the label. He points out that being mentally ill is in essence a social role and once the label is applied, others expect certain behavior from the "sick" individual that continues to perform as expected of him or her. Rosenhan's (1973) study of *Being Sane in Insane Place* clearly illustrates the difficulties in distinguishing between the normal and the abnormal. In this study, eight pseudo-patients attempted to be admitted to a mental hospital with symptoms of schizophrenia, which proved successful in all cases. Upon admission, they acted like they normally would, yet were hospitalized for 7–52 days and all released with schizophrenia in remission. In addition, their behavior (e.g. taking notes) was interpreted as a reflection of the illness within the hospital walls. This highlights the inadequacy of the psychiatric diagnosis system, raising question of how we can distinguish between the normal and the abnormal.

Social constructionism and labeling quickly came under attack when some argued that mental illness did, in fact, represent real illness (Gove 1970). This resulted in heated debates both on the role of labeling as steering an individual into treatment as well as whether the causes of rejection were associated with labeling and stigma or simply a response to the symptoms themselves (Gove 1975; Scheff 1974). The opposing views clash on the understanding of what mental illness is, particularly whether there is a reality to such illness beyond the label. To consolidate the two view points, Link and his colleagues offered their modified labeling theory, using insights from the original labeling theory, but not arguing that labeling is a direct cause of mental illness (Link 1982, 1987; Link et al. 1989). In this view, stereotypes of mental illnesses play a powerful role in limiting the opportunities of those experiencing mental illness, both concretely through a direct rejection but also more indirectly, since there is a general agreement that those experiencing mental illness are different from others. Specifically, they are often viewed as less reliable, less capable, and/or more dangerous than the average individual. Consequently, individuals who have been diagnosed with mental illness are confronted by the reality that the label of mental illness is now a part of them, resulting in a fear of rejection in a wide array of personal and professional situations. Regardless of what such labels play in causing mental illness in society, it is clear that they continue to have important consequences for those living with mental illness, especially as many people have strong notions about what the mentally ill are like, even before they get to know someone who has experienced such illness.

Closely related to the labeling perspective are notions of medicalization. Similar to labeling, this perspective focuses on how some individuals and groups in society have the power to define and respond to "abnormal" behavior of other groups, often with less power. The key difference between the two perspectives is the focus of medicalization theories on the role of medicine as an institution of social control, holding power to define what is normal and what is abnormal. More specifically, the concept refers to a process in which medical authority has to a large degree replaced religious and legal authority systems (Conrad and

Schneider 1992; Zola 1972) as the main agent with power to define and respond to deviant behavior. Social behaviors previously defined as a sin or as a crime are increasingly defined as an illness and the sinner and the criminal have been replaced by the patient. This trend has happened across a large number of conditions, ranging from abnormal behavior and processes, to normal biological processes, to potential risk factors for disease and has been so large-scale that it has been labeled as one of the major social transformations in advanced, industrialized nations (Clarke et al. 2003).

It is important to consider that theories of medicalization are ultimately theories of power, specifically, who has the power to define, describe, and respond to variations in social behaviors, emotions, and feelings. In the original formulation, the power largely resided with the medical profession itself (Conrad 1992), but as societies have changed other powerful agents of medicalization have emerged, including the pharmaceutical industry, consumers, and managed care (Conrad and Leiter 2004). Countless examples from past research illustrate how power shapes our definitions of what is abnormal. For instance, historically, societies were more likely to medicalize women's problems. Of course, we might consider that women are simply in more need to be fixed with medical innovations, but an more plausible explanation is that an historically male-dominated medical profession tended to view issues pertaining to women as problematic. For example, the APA decided to include pre-menstrual syndrome (PMS) as a psychiatric disorder in its manual in 1986, which potentially meant that all women could have a mental illness. Regardless of whether PMS is real or not, the inclusion clearly corresponds to the cultural position of women in society and the meaning associated with the gender roles attached to men and women (Figert 1996).

More recently, it is clear that the pharmaceutical industry impacts how we think about what is normal and abnormal. When GloxoSmithKline was ready to introduce Paxil to the market in the 1990s, the company faced the problem of not having enough potential buyers. While severe anxiety has long been known as a disabling condition, marketing to that limited population would not have been a particularly profitable endeavor. Instead, GlaxoSmithKline came up with the strategy of simultaneously marketing milder versions of the condition and the drug to treat it. The ads implied that everyone who experiences any kind of anxiety throughout the day may, in fact, suffer from seasonal anxiety disorder and/or general anxiety disorder. Although the drug company was later charged for inappropriate and misleading marketing, the fact remains that both disorders are now a part of our social landscape (Moynihan and Cassels 2005).

In sum, regardless of whether we approach the definitions of normality and abnormality through the perspective of labeling or medicalization, sociologists argue that definitions of what constitutes normal behavior is, at least in part, constructed within a specific social context with a specific power structure, where some groups have the power to define and others have little power to resist the definitions forced upon them.

## Illness Responses Embedded in Cultural Context

Just as illness is often viewed from a pure biological standpoint, responses to illness are often considered logical responses to abnormal biological processes. That is, individuals consider their choices and make informed decisions based on these choices when they get sick. Yet, this is only a partial account as individuals look for clues about what is going on with them and what is most appropriate to do within their social environment. Decisions about responses are embedded in the social networks of individuals and fall in line with the cultural norms and expectations followed by those that matter to us (Olafsdottir and Pescosolido 2009; Pescosolido 1992).

Across disciplines, scholars have been concerned with the role of culture in responses to illness. Anthropologists have long highlighted that cultural beliefs impact what is perceived as an appropriate reaction to illness (Kleinman 1980). They view culture as "located in the realm of expectations, values, ideas, and belief systems" (Jayasuriya 1992: 41). In order to understand how people use services, psychologists have developed models conceptualizing health beliefs or intentions as important predictors of use (Fishbein and Ajzen 1975; Rosenstock 1966) and sociologists have focused on predisposing characteristics, such as race and gender, as proxies for cultural influences on utilization (Andersen 1968, 1995). As far back as the 1960s, sociologists illustrated that the beliefs of the group mattered for illness behavior. In an early study, Kadushin (1966) identified a social circle of *friends and supporters of psychotherapy*. The individuals belonging to this group shared certain characteristics, including being more likely to know someone who had been in therapy, asking for a referral as well as being more likely to go to plays, concerts, and museums. He argues that those belonging to this circle are more likely to go to psychotherapy, not necessarily because they have more problems that require the attention of a therapist, but because they exist in a social context that encourages such a solution.

The social environment matters for what we do when we encounter illness in general, but it is particularly important when we encounter mental illness. The Network-Episode Model (NEM), originally proposed in 1991, is designed to better capture the experience of seeking treatment for mental illness. The NEM views help seeking behavior as a phenomenon assigned meaning within social networks. The model originally highlighted the dynamics of the illness career and the importance of social networks in shaping health care outcomes. Social interactions give the initial sources of normative meaning and individual reactions (Pescosolido 1992, 2011). In the earlier conceptualization it was illustrated that individuals experience multiple pathways to mental health treatment, falling into the three broad categories of: (1) choice; (2) coercion; and (3) muddling through. The first two may be self-explanatory, individuals choose to enter treatment because they recognize a problem or they are forced into treatment because those around them recognize a problem. The category of muddling through is less clear and refers to individuals who neither actively seek out treatment nor actively reject it, they simply somehow end up in treatment (Pescosolido et al. 1998a). These different trajectories illustrate that the interpretation of symptoms and what should be done about them is embedded in the community where both the individual experiencing the problem and those around him/her attempt to make sense of what is going on.

It is established that social networks matter for what we do when we encounter illness, yet research has found contradictory results. Some have shown that they accelerate entry into mental health treatment (Kadushin 1966; McKinlay 1972), while others show that they delay or deter use of such services (Horwitz 1977). To better understand how social networks matter, the Network Episode Model highlights not only the importance of the size and structure of social networks, but also the cultural context of the networks themselves. That is, to fully understand how and why social networks matter, we must understand the ideas, beliefs, and values that individuals connected through networks hold about issues of health, illness and healing. To test this idea, Pescosolido and colleagues (1998b) looked at the impact of large social networks on utilization of mental health services in Puerto Rico and found that larger networks delayed or deterred help-seeking. This finding can only be understood through knowledge of the cultural context of Puerto Rico. The population consists of lower-class individuals of an ethnic minority, characteristics often related to less positive views about mental health services. Therefore, it is not surprising that knowing many individuals that hold such attitudes and beliefs results in a lower likelihood of entering services, as treatment is not considered a logical response to the situation.

Despite these early insights about the importance of the cultural context to understand illness behavior, researchers have only recently begun to unpack what culture means within utilization research. While this has long been of interest to medical sociologists, they usually focus on major social categories (e.g. race/ethnicity) as proxies for culture. Here, researchers point to language as a “carrier of culture” (Bernal et al. 1995) and argue that ethnicity and language, at least in part, capture cultural characteristics (Takeuchi et al. 1999). For example, language and cultural issues of “face” predict utilization for Filipino Americans (Gong et al. 2003) and adherence to Asian cultural values decreases likelihood of using counseling (Kim and Omizo 2003; Lau and Takeuchi 2001). While this research has provided us with important insights into how culture shapes responses to illness, it does not take into account the larger cultural systems that impact such responses.

In response and following the “cultural turn” in sociology, researchers have reframed the key theoretical and methodological issues in health care utilization research (Olafsdottir and Pescosolido 2009; Pescosolido 2011; Pescosolido and Olafsdottir 2010). We argue that individuals use cultural maps to make sense of their health care choices and that we need to consider whole cultural systems of beliefs, attitudes, and values to understand how and why individuals use or do not use services. Individuals mentally evoke different options when they are faced, directly (self) or indirectly (others), with a health problem. While some have multiple locations on their maps (e.g. counselor, medical, doctor and psychiatrist), others have few, or even only one (e.g. doctor). The concept of cultural mapping identifies cultural boundaries by showing how individuals discriminate between different providers in the medical marketplace. The focus has therefore shifted from simply understanding whether individuals endorse particular provider to how they discriminate across culturally “legitimate” sources of care (Olafsdottir and Pescosolido 2009).

Thinking about the relationship between culture and illness responses in this way shows that individuals endorse multiple options simultaneously as would be expected by the Network Episode Model. However, they also clearly discriminate among them and they do so based on cultural attitudes, their evaluation of the situation, and occasionally on their social location. As an example, how serious the situation is perceived does not only provide a clue that treatment is needed, but it results in discrimination where the mental health system is preferred over the general medical system. Counseling may represent the clearest line on the public′s cultural map. When situations are attributed to stressful circumstances, Americans prefer counselors over other options. Finally, the public draws a clear line if violence is anticipated, endorsing psychiatrists over doctors and counselors, and they express the rare cultural preference for hospitalization over visits to psychiatrist when the person may be dangerous toward others (Olafsdottir and Pescosolido 2009).

To conclude, sociologists have been interested in responses to illness for at least the past 60 years and have powerfully demonstrated that culture matters for what we do when we encounter physical and especially mental abnormalities. Our responses are therefore not based on a notion of the “correct” response to illness but are shaped in the community and influenced by the cultural context of those communities.

## The Social Construction of Medical Knowledge

A final theme considered is the social construction of knowledge. Again, it is possible to consider medical knowledge to be neutral and simply reflecting reality. Along those lines, changes in how we think about health and illness as well as treatment simply reflect scientific processes, and if they change over time it is because we know more now than we did in the past. However, when these statements are examined through a critical lens, it becomes clear that this is far from the truth. Just as the world is socially constructed, so is the world of medical knowledge. Freidson (1970) was probably the first medical sociologist to articulate how medical knowledge is embedded within particular social and political context (Conrad and Barker 2010). He showed how the medical profession has a set of assumptions about what illness is, partly reflecting biological realities but also the social world. There are multiple interpretations of illness and professional understandings are often at odds with lay understanding of illness. By acknowledging the existence of multiple knowledge systems, it is possible to consider that our definitions of health and illness have components that may have less to do with scientific norms than with various cultural and political agendas.

While medical and lay diagnosis represent two different knowledge system, both have an important impact on how knowledge about health and illness is constructed (Olafsdottir and Pescosolido 2011). Lay impressions of illness are embedded in a broader social context, and rather than representing a concrete disease experience, they allow individuals to make sense of deviations from usual health status in themselves and others (Freidson 1970; Olafsdottir and Pescosolido 2009; Pescosolido 1992, 2011). Or as Jutel (2010: 1084) notes, the lay counterpart represents a first step in whether individuals cast "life's experiences as medical in nature". The consideration of lay beliefs allows for an understanding of how medical knowledge is constructed, both formally within the medical system as well as informally in the community. This is particularly important, as lay beliefs may vary systematically from professional scripts and categorizations of physical and mental illness. For example, research has shown that cancer beliefs held by African American women, regarding effectiveness of treatment, are significantly different than those held by physicians (Gregg and Curry 1994). Feminist scholars have also pointed out how medical realities are shaped by the fact that only one gender has historically had power to define what is normal or abnormal. They suggest that medical discourses and practices may have more to do with existing gender norms than biological realities (Clarke 1998; Ehrenreich and English 1978; Lorber 1997). For example, ideas about women's "proper" place in society are clearly a part of the medical discourse on various health "problems" associated with women, including pregnancy, PMS, childbirth, and menopause (Conrad and Barker 2010).

The notion of gender stereotypes has been found to have profound impact in medical care, resulting in inferior treatment for women when they encounter certain illnesses. McKinlay (1996) provides a powerful example here by showing that the "fact" that women did not experience heart disease until menopause was accepted knowledge within the medical community. He showed that gender differences in heart disease were an artifact of incorrect medical observations. The symptoms that heart disease produced among women were different than in men, leading to a dismissal of it as the explanation and instead attributing the symptoms to stomach problems or even emotional problems. As a consequence of this medical practice, the rates that doctors use to guide their diagnosis process were based on wrong assumptions that then resulted in a wrong diagnosis that continued to support the socially constructed gender rates. Using the sociological imagination, McKinlay changed how medicine viewed gender differences in heart disease by distinguishing between the personal trouble of an individual woman being misdiagnosed and a social issue where we witnessed thousands of women being systematically misdiagnosed due to socially constructed rates that were, at least in part, grounded in a gendered ideology related to medicine where the male body was traditionally viewed as the norm and the female body as deviation from the normal.

More recently, scholars at the intersection of medical sociology and science studies have pointed out the relationship between medical knowledge and the social context in which it is embedded (Conrad and Barker 2010). They point out that our notions of biological disease or biomedical evidence are negotiated and interpreted within a specific social context (Joyce 2008; Timmermans 2007). More specifically, it has been pointed out that the mid-1980s witnessed the birth of a new paradigm, where an inclusion of previously excluded groups (e.g. based on gender and/or race) became important in any medical research. This represented change in medical thinking away from the assumption that it is possible to understand all bodies in the same manner, highlighting the possibility of different disease processes and treatment outcomes across major fault lines in society. While certainly an important step forward, Epstein (2007) shows that this inclusion has the unintended consequence of grounding social categories even more firmly as rooted in biological differences. Through an examination of the process of how this happened, he is able to show that the knowledge that is produced about race and gender has as much to do with social and political conflicts and negotiations, as true differences based on biology.

In sum, studies on medical knowledge illustrate that the construction of such knowledge is embedded within specific social context where certain groups have power to define what is an illness and how it should be treated, whereas other groups are largely or exclusively the subject of the medical gaze (Foucault 1973). Importantly, they underscore that different knowledge systems often clash in the interpretation of disease which has implications for how we understand and respond to health problems in societies.

## The Strengths and Weaknesses of Social Constructionism

As a conceptual framework, social constructionism has made important contributions to our understanding of health and illness and it provides an important counterpoint to the largely deterministic approach that medicine has toward disease and illness (Conrad and Baker 2010). While processes of rationality and scientific advancement have provided important contributions to human lives through the past centuries, they have been coupled with a darker side that often goes unnoticed, simply because we have taken for granted that medical innovations represent neutral knowledge and progress for mankind. Yet, we have evidence that some of the major advancement in human health during the 19th century had as much to do with improvements in social conditions, as with innovations in medicine (McKeown 1979; McKinlay 1981). History, however, has often been constructed in a way that gives more credit to medicine and has resulted in a view of medicine as neutral, and medical doctors as scientists committed to solve mysteries related to health and illness.

It can be argued that this has become even more important as the medical landscape has changed. Earlier, it was largely the medical profession who held the power to define and respond to issues of health and illness, although of course the lay referral system has always been an important force shaping people's ideas (Freidson 1970). This was also an era where health problems were less complex and physicians frequently responded to acute, infectious diseases using medical solutions proven effective. Two changes have made it even more important to understand how our ideas about health and illness are embedded within a specific social context. First, there are more stakeholders that attempt to impact our understanding of what health problems are, many who have direct interest in making us believe that our experiences are problematic in one way or another. The pharmaceutical companies provide a key example. Just as the medical profession was simply providing us with better solutions to the physical problems of the past, many view the pharmaceutical companies as simply providing us with better solutions to a wide array of physical and mental health problems. The perspective of social construction helps us understand that while the pharmaceutical companies provide medicine that improve health, they also have a direct interest in selling more of their medication, which shapes the reality that they are invested in protecting and even in some cases creating. Second, the potential health problems that we currently suffer from are more complex than ever before, and some have argued that everything is a potential disease in modern societies. This reality makes a counterpoint to the medical/pharmaceutical perspective more crucial than ever before.

Finally, if sociologists are successful in getting their points through to policymakers, we can improve policymaking in the health care field. Conrad and Baker (2010) illustrate how each domain of the cultural meaning of illness, the illness experience as socially constructed, and medical knowledge as constructed has important policy implications. For example, it can make policymakers realize that the “facts” that are presented to them do not present a concrete reality or even the “best” reality. It remains true that the stakeholders in the health field do not hold equal power in the policy process and claims by some are taken more seriously than others. Medical doctors have often been able to put their perspective forward as the way the world really is, often ignoring the perspective of other professions involved in the same jurisdiction as well as the important perspective of those who are suffering. In addition, an understanding of the world as socially constructed allows us to envision a reality where issues of health, illness, and healing can be understood differently. It is possible to individualize various “problems,” but it is equally possible to view them as a reflection of a larger social problem. For example, we can view the existence of ADHD as a reflection of that some kids are flawed, as bad kids or biologically damaged product, or we can view our school system as flawed in ways that does not allow all children to succeed within the classroom. The way in which this is constructed clearly guides policies on this particular issue and has more general implications.

With every strength comes a weakness and as powerful the perspective of social construction is, it is not without limitations. The most general is perhaps the issue of why we should care that the world is socially constructed? What have we learned if we do not move further to understand and explain how it impacts the actual life of individuals and broader social processes, such as inequality? Within sociology, we are often content to show that certain phenomenon are socially constructed, but fail to address why and how it matters. As an example, numerous studies have provided important insights into how and why particular conditions were medicalized and pointed out the specific forces involved in the medicalization process, but less is known about how this matters for individuals and societies. For example, is medicalization likely to increase or decrease health inequalities? Does medicalization reduce stigma of mental illness? Insights from research that are not particularly focused on social construction can provide some cues into how this may matter. For example, the perspective of fundamental causes of health disparities shows us that those who have more resources can repeatedly transfer them into better health outcomes and services (Link and Phelan 1995). This is partly due to their capabilities of taking advantage of medical solutions as they become available. Yet, as highlighted by medicalization scholars, the process is not always one that results in better health for individuals. An attempt to link together medicalization and health inequalities and outcomes would provide a strong statement for how the construction of what constitutes a health problem has an impact on key outcomes of interest to sociologists.

Similarly, it is possible to consider whether the way in which mental health problems are constructed matter for individuals experiencing such problems. In contrast to the psychiatric perspective, sociology has the power to unveil how our understanding of mental health problems does not simply follow a scientific process, but is embedded in a particular context where interests play as large of a role (Kirk and Kutchins 1992). As a result, we know that certain professions may have more investment in highlighting the biological and/or genetic approach to mental illness. But we also know that many mental health problems are rooted in the social environment and the public endorses a wide array of social, biological, and individual causes of mental illness (Martin et al. 2000). While it is important to understand the multiple understandings of mental illness across professionals and the lay public, as well as how these understandings are shaped by interest, we also want to know how these attributes translate into the lives of individuals. An important study by Phelan (2005) provides evidence that public understanding of what mental illness is matters for stigma. In particular, those individuals who believe that mental illness are caused by genes are more likely to stigmatize the sibling of the individual, indicating that such attribution may move us away from a model where something is not only problematic with the individual experiencing mental illness, but also close family members. Research that pushes us to not only show that many of our taken-for-granted assumptions are viewed in such a way because a particular group of individuals have believed them for a long time but that they have consequences for individuals and societies, are all the more powerful than research that simply points out that a wide array of things we take for granted are socially constructed.

Finally, while the perspective of social construction provides an important correction to biological essentialism, it is important that we do not embrace a similarly narrow social essentialism. The debate of nature versus nurture has largely been settled with many agreeing that we need to think about nature and nurture as complementary (Pescosolido et al. 2008), yet some sociologists are skeptical of too close a collaboration with medical doctors and natural scientists focusing on biological roots of illness. While understandable, this standpoint can be dangerous to the field of medical sociology, as cutting-edge research across multiple fields (e.g. medicine, sociology, public health) shows that a large proportion of the dominant illnesses are rooted simultaneously in social, psychological, and biological factors. This provides a unique opportunity as those interested in health and illness from a biological standpoint cannot ignore the importance of social factors, but without direct participation we allow them to trivialize it and rely on faulty measures, as their training is not in understanding the social world. As a consequence, it is important for sociologists to step up to the plate and continue to show the power of social factors in shaping our understandings of health, illness, and healing. Current realities do not allow us to do that from a pure social constructionist standpoint, rather we must take into account current knowledge about the complex realities of health and illness in advanced, industrialized nations, such as the United States.

## Illustrating Social Construction: The Power of Cross-National Comparisons

As originally pointed out by Berger and Luckman (1967), the way in which societies are organized and social life is understood quickly becomes a part of who the individual is and how he or she understands the world. That is, even though certain actions and decisions by individuals originally determine how we understand a wide array of social phenomenon and how we provide and organize major social institutions (e.g. education, health care, correctional facilities), this "reality" becomes taken for granted overtime in a way that any other understanding or arrangements seem impossible. While there are many ways to illustrate that other realities are possible, a cross-national perspective is especially powerful in showing how ideas and responses within one cultural context appear strange or even impossible in another cultural context. Yet, individuals happily go about their daily business in both contexts, never wondering if the world could somehow be better, or even different. Issues of health, illness, and healing are no exception as they simultaneously reflect biological and scientific realities and cultural adaptations and understandings.

A cross-national perspective clearly illustrates the power of cultural meanings of illness and perhaps especially mental illness. Depression can serve as an example here, as one of the conditions that has greatly increased in prevalence overtime and has been declared as one of the leading global causes of disability (Murray and Lopez 1996). This development can partly be explained as Western, biomedical criteria (especially DSM III) are applied to multiple contexts. Therefore, new understandings of depression within a context may have more to do with how mental health is understood within a specific scientific community, as compared to changes where a larger proportion of the population across countries is biologically vulnerable to depression. Here, Lutz (1985) has pointed out that Western psychologists often view the failure to look for happiness as a symptom of depression, yet the desire for happiness is not natural, but a culturally constructed goal. Similarly, Kleinman and Good (1985) argue that a universal experience of depression is unfounded. While some work has indicated that ideas about depression (and other illnesses) travel across national boundaries, research focusing on how global biomedical models of illness are adopted, rejected or modified at the local level can give us insights into the relationship between medical knowledge and cultural understandings of illness.

What is considered normal and abnormal is different across groups and places within a single society, but a comparison across nations can illustrate this even more profoundly. For example, we can ask whether specific social behaviors and emotions are constructed in the same manner across societies and attempt to explain the variations in understanding across nations. In addition, a cross-national perspective adds to our understanding of labeling and stigma by considering how these processes may operate similarly or differently across context. For example, Olafsdottir (2011) shows that the cultural images associated with mental illness vary systematically across the U.S., Germany, and Iceland. As expected, and often discussed, the overarching picture provided in the U.S. is that individuals experiencing mental illness are dangerous and to be feared. A single society examination may lead to the conclusion that mental health problems are strongly embedded in a culture of fear, yet the analysis from the other two countries shows a different picture. At least partly reflecting the social organization of welfare, the Icelandic context illustrates a culture of solidarity, where mental illness is social in nature and it is the responsibility of society to do something about them both in terms of providing solutions as well as creating society that is more beneficial to mental health. Similarly, the German context is embedded in a specific historical trajectory where the events of World War II have constructed a careful discourse that avoids blame making and highlights the importance of learning from history and never go back to the cruel realities of that period.

Turning to responses to illness, not surprisingly they are embedded within a specific cultural context. An examination of public attitudes in countries that all adhere to similar biomedical understanding of schizophrenia shows that public responses vary, both in terms of lay recognition of schizophrenia as well as appropriate responses. The public, in this sample of advanced, industrialized nations, largely recognizes schizophrenia as mental illness in general, but not schizophrenia in particular and the level of recognition varies drastically (Olafsdottir and Pescosolido 2011). Similarly, there is a cultural variation in what the public believes should be done about the problem and how effective treatment would be. Importantly, cross-national differences do not only reflect different responses in terms of what individuals do when they encounter illness, but also in what kind of treatment is provided and importantly paid for. Sociologists have pointed out how changes in the reimbursement system within the U.S., impacts what choices are available to doctors when they treat patients (McKinlay 1996) and this is likely to be even more prominent when examined in a cross-national perspective. Research focusing on what kind of treatments are provided and reimbursed across different societies, in addition to an understanding of how individuals use services and conceptualize the problem, has the potential to add to our understanding of the relationship between culture and responses to illness.

Finally, there is a relationship between culture and medical knowledge. The obvious differences are across what often is labeled as alternative and scientific medicine, but even among nations that adhere to the same biomedical model, differences are observed. As an example, how frequently women are expected to have a cervical cytology varies across countries, as do norms of whether screening for prostate cancer represent a useful strategy to improve men's health at the population level. Of course, it can be argued that countries with more extensive screening are doing a better job, yet that does not translate into population health. In many cases, screening is more frequent in the United States, where health outcomes are still lagging behind most advanced, industrialized nations. And contrasting the United States and Japan, where the latter would have a greater reliance of alternative sources of care, reveals that the Japanese do better on various health outcomes, including life expectancy, that are among the highest in the world. Research that can trace how the cultural context of medical knowledge varies across context, with an attention of how it matters for the health profile of populations is especially valuable to understand the social realities of medicine and how medical knowledge does not merely reflect superior scientific knowledge.

## Conclusion

Sociology has an important role in providing a counterpoint to the predominant biological and medical approaches to health and illness. As this chapter has illustrated, the social matters for virtually every aspect of health, illness, and healing. Our understandings of illness and responses are embedded in the community and knowledge is created by individuals with specific background, orientation, and interest, highlighting that social factors play not simply a complementary, but a critical role. This role has perhaps never been more important, as the disease profile of societies has become more complex and it is clear that it is impossible to respond to health problems without a serious consideration of how they are embedded within specific cultural contexts. In addition, sociologists have brought issues such as power and interest to the forefront of how we understand and respond to health problems, acknowledging the important role that medicine and the pharmaceutical industry play in responding to illness, while pointing out the dangers associated with too much reliance on professions and corporations, that in the end, have enormous gains associated with a specific understanding of health and illness in contemporary societies. Consequently, the sociological imagination that allows us to connect the society to the individual has perhaps never been more important and holds a power to provide a crucial counterpoint to the biological approach, often assuming that there is a concrete "reality" to our illness and responses to it.

## References

Andersen, R. (1968). *Behavioral model of families' use of health services. Center for Health Administration*. Chicago: University of Chicago.

Andersen, R. (1995). Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health and Social Behavior, 36*, 1–10.

Becker, H. (1963). *Outsiders: Studies in the sociology of deviance.* New York: Free Press.

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. Garden City: Doubleday.

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: issues for the cultural adaptation and development of psychosocial treatments with hispanics. *Journal of Abnormal Child Psychology, 23*, 67–82.

Burr, V. (1995). *Social constructionism*. New York: Routledge.

Chapple, A., Ziebland, S., & McPherson, A. (2004). Stigma, shame, and blame experienced by patients with lung cancer: qualitative study. *BMJ,*. doi:10.1136/bmj.38111.639734.7C. (published 11 June 2004).

Clarke, A. E. (1998). *Disciplining reproduction: Modernity, American life sciences, and "The Problems of Sex"*. Berkeley: University of California Press.

Clarke, A. E., Mamo, L., Fishman, J. R., Shim, J. K., & Fosket, J. R. (2003). Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review, 68*, 161–194.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18*, 209–232.

Conrad, P., & Barker, K. K. (2010). The social construction of illness: key insights and policy implications. *Journal of Health and Social Behavior, 51*, S50–S79.

Conrad, P., & Leiter, V. (2004). Medicalization, markets and consumers. *Journal of Health and Social Behavior, 45*, 158–176.

Conrad, P., & Schneider, J. W. (1992). *Deviance and medicalization: From badness to sickness*. Philadelphia: Temple University Press.

Ehrenreich, B., & English, D. (1978). *For her own good: 150 Years of the experts' advice to women*. Garden City: Doubleday.

Eisenberg, L. (1977). Disease and illness: distinctions between professional and popular ideas of sickness. *Culture, Medicine and Psychiatry, 1*, 9–23.

Epstein, S. (2007). *Inclusion: The politics of difference in medical research*. Chicago: The University of Chicago Press.

Figert, A. E. (1996). *Women and the ownership of PMS: The structuring of a psychiatric disorder*. Hawthorne: Aldine De Gruyter.

Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research*. Reading: Addison-Wesley.

Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason*. New York: Pantheon Books.

Foucault, Michel. (1973). *The birth of the clinic: An archaeology of medical perception*. New York: Vintage Books.

Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge*. New York: Harper & Row.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Garden City: Doubleday.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice Hall.

Gong, F., Gage, S.-J., & Tacada, L. A. (2003). Help-seeking behavior among Filipino Americans: a cultural analysis of face and language. *Journal of Community Psychology, 31*, 469–488.

Gove, W. R. (1970). Societal reactions as an explanation of mental illness: an evaluation. *American Sociological Review, 35*, 873–884.

Gove, W. R. (1975). Labeling and mental illness. In W. Gove (Ed.), *The labeling of deviance: Evaluating a perspective* (pp. 35–81). Halsted: New York.

Gregg, J., & Curry, R. H. (1994). Explanatory models for cancer among African-American women at two Atlanta neighborhood health centers: the implications for a cancer screening program. *Social Science and Medicine, 39*, 519–526.

Horwitz, A. (1977). Social networks and pathways to psychiatric treatment. *Social Forces, 56*, 86–105.

Jayasuriya, L. (1992). The Problematic of culture and identity in social functioning. *Journal of Multicultural Social Work, 2*, 37–58.

Joyce, K. (2008). *Magnetic appeal: MRI and the myth of transparency*. Ithaca: Cornell University Press.

Jutel, A. (2010). Framing disease: the example of female hypoactive sexual desire disorder. *Social Science and Medicine, 70*, 1084–1090.

Kadushin, C. (1966). The friends and supporters of psychotherapy: on social circles in urban life. *American Sociological Review, 31*, 786–802.

Kaiser, K. (2008). The meaning of the survivor identity for women with breast cancer. *Social Science and Medicine, 67*, 79–87.

Kim, B. S. K., & Omizo, M. M. (2003). Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counselor. *The Counseling Psychologist, 31*, 343–361.

Kirk, S. A., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. New York: Aldine de Gruyter.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley: University of California Press.

Kleinman, A., & Good, B. J. (Eds.). (1985). *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*. Berkeley: University of California Press.

Lau, A., & Takeuchi, D. T. (2001). Cultural values in helpseeking for child behavior problems: value orientation, affective responding, and severity appraisals among Chinese American parents. *Journal of Community Psychology, 29*, 675–692.

Link, Bruce G. (1982). Mental patient status, work, and income: an examination of the effects of a psychiatric label. *American Sociological Review, 47*, 202–215.

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: an assessment of the effects of expectations of rejection. *American Sociological Review, 52*, 96–112.

Link, B. G., & Phelan, J. C. (1995). Social conditions as fundamental causes of diseases. *Journal of Health and Social Behavior*, *36*(*Extra issue*):80–94.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385.

Link, B. G., Cullen, F. T., Struening, E., Shrout, P., & Dohrenwend, B. P. (1989). A modified labeling theory approach in the area of mental disorders: an empirical assessment. *American Sociological Review, 54*, 400–423.

Lorber, J. (1997). *Gender and the social construction of illness*. Thousand Oaks: Sage.

Lutz, C. (1985). Depression and the translation of emotional worlds. In A. Kleinman & B. J. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. 63–100). Berkeley: University of California Press.

Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of fear and loathing: the role of ‘disturbing behavior’, labels, and causal attributions in shaping public attitudes toward persons with mental illness. *Journal of Health and Social Behavior, 41*, 208–223.

Martin, J. K., Pescosolido, B. A., Olafsdottir, S., & McLeod, J. D. (2007). The construction of fear: Americans’ preferences for social distance from children and adolescents with mental health problems. *Journal of Health and Social Behavior, 48*, 50–67.

McKeown, T. (1979). *The role of medicine: Dream, mirage, or nemesis?*. Princeton: Princeton University Press.

McKinlay, J. B. (1972). Some approaches and problems in the study of the use of services—an overview. *Journal of Health and Social Behavior, 13*, 115–152.

McKinlay J. B. (1981). Refocusing upstream. In P. Conrad and R. Kern (Eds.), *The sociology of health and illness*. New York: St. Martin’s Press.

McKinlay, J. B. (1996). Some contributions from the social system to gender inequalities in heart disease. *Journal of Health and Social Behavior, 37*, 1–26.

Moynihan, R., & Cassels, A. (2005). *Selling sickness: How the World’s biggest pharmaceutical companies are turing us all into patients*. New York: Nation Books.

Murray, C. J. L., & Lopez, A. D. (Eds.). (1996). *The global burden of disease*. Cambridge: World Health Organization.

Muzzin, L. J., Anderson, N. J., Figueredo, A. T., & Gudelis, S. O. (1994). The experience of cancer. *Social Science and Medicine, 38*, 1201–1208.

Olafsdottir, S. (2011). Medicalization and mental health: the critique of medical expansion, and a consideration of how National States, markets, and citizens matter. In D. Pilgrim, A. Rogers, & B. A. Pescosolido (Eds.), *The SAGE handbook of mental health and illness* (pp. 239–260). London: Sage Publications.

Olafsdottir, S., & Pescosolido, B. A. (2009). Drawing the line: the cultural cartography of utilization recommendations for mental health problems. *Journal of Health and Social Behavior, 50*, 228–244.

Olafsdottir, S., & Pescosolido, B. A. (2011). Constructing illness: how the public in eight western Nations responds to a clinical description of Schizophrenia. *Social Science and Medicine, 73*, 929–938.

Pescosolido, B. A. (1992). Beyond rational choice: the social dynamics of how people seek help. *American Journal of Sociology, 97*, 1096–1138.

Pescosolido, B. A. (2011). Organizing the sociological landscape for the next decades of health and health care research: the network episode model III-R as cartographic subfield guide. In B. A. Pescosolido, J. K. Martin, J. D. McLeod, & A. Rogers (Eds.), *Handbook of the sociology of health, illness, and healing: A blueprint for the 21st century* (pp. 39–66). New York: Springer.

Pescosolido, B., & Olafsdottir, S. (2010). The cultural turn in sociology: can it help us resolve an age-old problem in understanding decision-making for health care? *Sociological Forum, 25*, 655–676.

Pescosolido, B. A., Brooks-Gardner, C., & Lubell, K. M. (1998a). How people get into mental health services: stories of choice, coercion and 'muddling through' from 'first-timers'. *Social Science and Medicine, 46*, 275–286.

Pescosolido, B. A., Wright, E. R., Alegria, M., & Vera, M. (1998b). Social networks and patterns of use among the poor with mental health problems in Puerto Rico. *Medical Care, 36*, 1057–1072.

Pescosolido, B. A., Perry, B. L., Scott Long, J., Martin, J. K., Nurnberger, J. I., Jr, & Hesselbrock, V. (2008). Under the influence of genetics: how transdisciplinarity leads us to rethink social pathways to illness. *American Journal of Sociology, 114*, S171–S201.

Phelan, J. C. (2005). Geneticization of deviant behavior and consequences for stigma: the case of mental illness. *Journal of Health and Social Behavior, 46*, 307–322.

Rosenhan, D. L. (1973). On being sane in insane places. *Science, 179*, 250–258.

Rosenstock, I. M. (1966). Why people use health services. *Milbank Memorial Fund Quarterly, 44*, 94–106.

Scheff, T. J. (1966). *Being mentally ill: A sociological theory*. Chicago: Aldine Publishing Company.

Scheff, T. J. (1974).W The labeling theory of mental illness. *American Sociological Review, 39*, 444–452.

Sontag, S. (1978). *Illness as a metaphor*. New York: Farrar, Straus and Giroux.

Spector, M., & Kitsuse, J. (1977). *Constructing social problems*. Menlo Park: Cummings.

Straus, R. (1957). The nature and status of medical sociology. *American Sociological Review, 22*, 200–204.

Szasz, T. S. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York: Dell Publishing Company.

Takeuchi, D. T., Edwina, S. U., & Maramba, G. (1999). Cultural diversity and mental health treatment. In A. V. Horwitz and T. L. Scheid (Eds.), *The sociology of mental health and illness* (pp. 550–565). Cambridge: Cambridge University Press.

Timmermans, S. (2007). *Postmortem: How medical examiners explain suspicious deaths*. Chicago: The University of Chicago Press.

Zola, I. K. (1972). Medicine as an institution of social control. *Sociological Review, 20*, 487–504.