



Sociology of health and illness:  
A map of the field

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**3 topics (an incomplete 'map'):**

1. Disease, illness, the sick role, stigma
2. Biomedical versus sociological models
3. Theoretical approaches to studying social reality:  
social-structural, constructionism, critical theory,  
discourse / the 'linguistic turn', structuration theory

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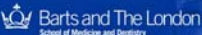
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**TOPIC 1:**  
**Disease, illness, the sick role, stigma**

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## Health

- Absence of disease?
- Body and mind working properly?
- "A state of complete physical, mental and social wellbeing" (WHO)?
- Links with youth / beauty / sport / sex / etc?



## Illness

- **Illness:** the subjective experience of ill health
- **Disease:** medically defined pathology
- **Sick role:** The rights and obligations associated with being ill

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## Health (Mildred Blaxter)

*"...illness is a kind of rest, when you can be free of your everyday burdens. For me, illness is breaking off from social life, from life outside and social obligations"*  
(age / gender unknown)

*"What is health? That is a silly question!"*  
(driver aged 39)

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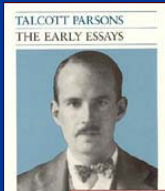
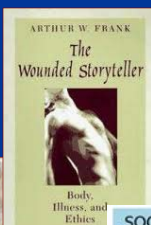

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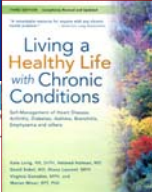




## The evolving notion of the 'sick role'

**SOCIOLOGY OF**  
*Sociology of Health & Illness Vol. 31 No. 3 2011*  
doi: 10.1017/S1446788711000184

**Review article**  
**Health-related stigma**  
**Graham Scambler**  
*Centre for Sociological Theory and Research on Health, UCL, London*

**Abstract** The concept of stigma, denoting relations of shame, has a long ancestry and has from the earliest times been associated with deviations from the 'normal' including, in various times and places, deviations from normative prescriptions of acceptable states of being for self and others. This paper dwells on modern social conceptions of affect, emotional and behavioural deviance, stigma, and



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## Talcott Parsons

(a 'structuralist-functionalist' sociologist – see later)



Table 4-1: The sick role as originally proposed by Talcott Parsons!

Patient:		Doctor:	
Social obligations	Rights	Social obligations	Rights

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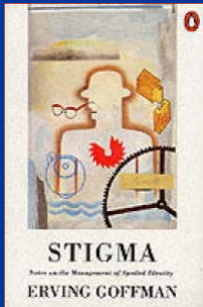
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## Goffman on illness

(a 'constructionist' or 'symbolic interactionist' sociologist – see later)



- The self is actively constructed by the individual to others
- Illness as 'spoiled identity', interferes with ability to present the self
- Stigma = social process characterised by exclusion, rejection, blame or devaluation relating to a health condition, medically unwarranted
- Deviance = behaviour which fails to fulfil the institutionally defined expectations of the person's role

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## Illness as narrative

Corbin & Strauss: Chronic illness as biographical disruption.

'Self management' => rebuilding spoiled identity



Frank: The illness narrative is a moral story of heroic struggle  
*"The wounded storyteller is a moral witness, re-enchanting a disenchanting world."*

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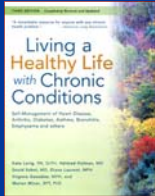
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## The sick role in chronic illness

The later Parsons (1950s): Sick role modified to include continuing to function socially / economically



The 'expert patient' (Lorig): empowered, informed, manages own illness, stays active in society, doesn't 'go sick' except during flare-ups

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## 'Stigma' revisited



Stigma as 'spoiled identity' ('personal tragedy') assumes an individual or interpersonal issue, amenable to education

There is also an institutional dimension to stigma e.g. in relation to inaccessible workplaces / discriminatory practices

*"Stigma operates at the intersection between culture, power and difference"*

The sick body is less able to do some tasks. 'Expert patient' framing may put new pressures on the sick and transmute stigma into 'deviance' (i.e. not following norms)

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## TOPIC 2: Biomedical versus sociological models of health and illness

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## What is a model / theory?

*"Theories act as lenses through which we investigate the social world; some bring to our attention problems of inequity, while others bring forth issues of lived experience. In other words, theories enable researchers to view questions of health and illness from different perspectives."*

Fernando de Maio

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## Biomedical model: assumptions

1. Disease is an objective, morally neutral label
2. Disease (deviation from normal biological functioning) is explained by biological mechanisms
3. Disease causation is biologically specific (e.g. germ theory): Pathogen → lesion → symptom
4. Diseases are 'generic' and managed by biological mechanisms
5. Medicine is scientifically neutral
6. Elimination of disease depends on biomedical advances

Audience participation time: what do YOU think?

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## Biomedical model: criticisms

1. What is 'normality'? Not clear-cut, actually!
2. Reductionist: not everything can be explained at the biological level (=> 'biopsychosocial' model)
3. Disease processes versus illness states:
  - illness strongly influenced by social / cultural factors
  - many 'diseases' defy classification
4. Medicine is NOT scientifically neutral!
5. Elimination of disease depends on social advances as much as [more than?] biomedical

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## Sociological models: examples of assumptions

1. Illness is a *subjective* label (e.g. 'hyperactivity') and has a *moral* dimension (e.g. being high 'deviant')
2. Illness has a *political* dimension: industry is powerful and gains from it
3. Both illness and disease have complex aetiology, including *social determinants* e.g. environmental, social, economic, educational, cultural etc.
4. 'Illness' is what you call hyperactivity if you want the doctor to deal with it; 'bad classroom behaviour' is what you call it if you want the teacher to deal with it

Audience participation time: what do YOU think?

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## Sociological models: examples of criticisms

1. Purely 'sociological' explanations work better for some conditions than others. 'Hyperactivity' might be a subjective category, morally loaded and with political connotations, but many illnesses (e.g. cystic fibrosis) have much stronger *objective* elements.
2. If we take the 'social determinants' argument too far, we end up concluding that individuals have no responsibility for their unhealthy behaviours (e.g. we say that smoking is 'caused' by people's position in the social hierarchy) – and this leads to fatalist conclusions

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**Biomedical framing:**  
Diabetes as [diagnosing and managing] disease

**Sociological framing:**  
Diabetes as [getting on with life despite] illness

We often need a both-and view of disease/illness, not either-or

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### TOPIC 3:

**Theoretical approaches to studying social reality: Social-structural, constructionism, critical theory, discourse / linguistic turn, structuration**

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## Ways of seeing the social world

### SOCIAL-STRUCTURALISM

- Societies are 'objective realities', either harmonious and benign ('functionalist' framing) or containing inherent conflicts (e.g. Marxist or feminist framings)

### CONSTRUCTIONISM

- We *construct* social reality, bringing phenomena into being by our words and actions

### CRITICAL THEORY

- Assumes 'all is not as it appears'; e.g. questions the neutrality / objectivity / power claims of medicine

### LANGUAGE / DISCOURSE

- The key role of language in shaping social relations

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## Social structuralist approaches: society as objective reality [1]

### PARSONS' FUNCTIONALIST VIEW

- Institutions in society (e.g. the economic system, medicine, the judicial system) have emerged to perform particular functions which keep society stable
- The system of medicine has emerged, broadly speaking, to meet society's needs (=> essentially unproblematic)
- Doctors doing their job and patients complying with medical advice stabilise society by reducing the problem of 'deviant' illness

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## Social structuralist approaches: society as objective reality [2]

CONFLICT THEORY [= CRITICAL STRUCTURALISM, POLITICAL ECONOMY] e.g. MARXISM, FEMINISM

- Social institutions serve the interests of powerful groups who have a vested interest in maintaining the status quo
- Disease and illness have social / economic / political causes (capitalism, gender oppression), leading to inequalities in disease rates and health outcomes
- To reduce health inequalities we need to address the root causes of oppression, raise consciousness, challenge the status quo (and ?? break the professions' power)

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## Constructionist approaches: society as socially produced

- Social institutions (e.g. medicine) along with social norms, attitudes, values, behaviours and beliefs are *socially produced* rather than naturally given or determined
- We (patients, doctors etc) are socialised into certain patterns of thinking and behaving
- Social processes create systems of ideas and practices about themes/topics that vary in different settings and at different times

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## Example of a constructionist approach

SYMBOLIC INTERACTIONISM (GOFFMAN)

- *"People construct understandings of themselves and of others out of experiences they have and the situations they find themselves in. These understandings have consequences in turn for the way in which people act, and the manner in which others react to them."*  
Aggleton 'Health' 1990, p91
- i.e. the social identities we possess are influenced by the reactions of others (e.g. I am a powerful doctor because my patients treat me like a powerful person and confer respect upon me)

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## Medicalisation: socially constructed and serving vested interests?

Medicalisation is...

- The process by which a health-related condition comes to be defined and treated as 'medical'
- The process by which aspects of everyday life become medical issues => doctors / health professionals come to engage with, study and treat these
- Involves changes in social attitudes and terminology
- May accompany (and/or be driven by) the availability of tests or treatments => profit for pharma or ICT industry

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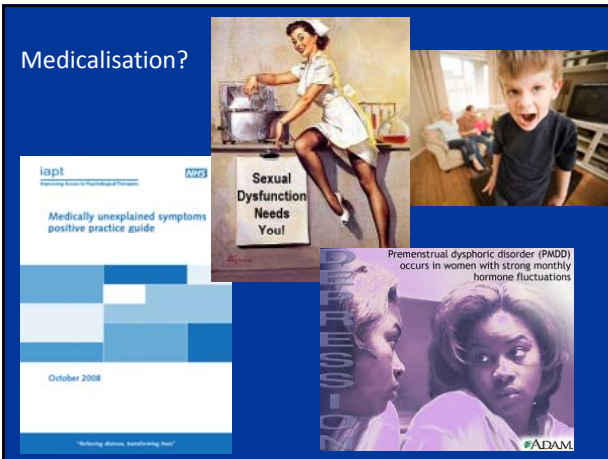
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## Medicalisation?



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## Critical theory

- Asks questions about (e.g.) neutrality/objectivity of medicine, use of technology, directions of science
- **Ideology:** A system of shared beliefs that legitimise particular norms and values at the same time they claim and appear to be based on empirical truths
- Ideologies transform power (potential influence) into authority (legitimate control)
- E.g. ideology of 'empowerment' transforms doctors' assumptions about the 'proper' behavior of patients into a series of research strategies, research results, and potentially coercive interventions

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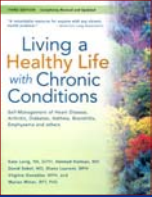
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Conventional ('functionalist') view



**SOCIAL SCIENCE & MEDICINE**  
ELSEVIER

Social Science & Medicine 60 (2007) 1299–1309  
www.elsevier.com/locate/socmed

**The 'expert patient': empowerment or medical dominance? The case of weight loss, pharmaceutical drugs and the Internet**

N.J. Fox\*, K.J. Ward, A.J. O'Rourke  
University of Sheffield, Health, Regent Court, 19 Regent St, Sheffield S1 4DA, UK  
Available online 11 September 2006

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**Abstract**

Do 'informed' or 'expert' patients challenge dominant traditions in biomedicine or simply adapt these as conventional ways of thinking about body shape and size, illness and health? This paper examines this question in relation to the use of the weight-loss drug Xenical by participants in an Internet forum for obese and overweight people. Ethnographic and interview data from the forum provides evidence that participants share information and support each other as they use Xenical, and in the process emerge as 'expert patients' in relation to their body shape and its treatment. However, it is argued that while an 'expert patient' can be perceived as desirable, enabling the democratisation of healthcare, it can also be constraining. The exchanges between the users in the forum perpetuate a biomedical model of overweight as a condition to be overcome. The discussion critically considers a number of options for the development of the expert patient, including the emergence of an 'informed consumer'.

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Keywords: Consumer; Expert patient; Internet; Medical model; Xenical; Weight loss

View informed by constructionism and critical theory: The so-called 'empowered' patient is not really empowered at all – she has been medicalised and is 'consuming' health

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### Discourse and the 'linguistic turn' (moving critical theory into a 'postmodern' phase)

- There is a growing interest in the role of language in constituting and maintaining the social order
- Discourse = the way we speak and represent phenomena, which reflects where power-knowledge is located in society
- e.g. 'The medical gaze' (Foucault)
  - defines the human body and mind as an object of study
  - places emphasis on abstracted 'facts' and marginalises the human being to whom those 'facts' relate
  - establishes a relationship of power (doctor > patient)

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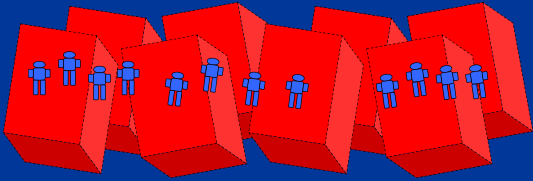
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### Structuration theory

People live in society. They reproduce social structures through their actions. The human agent is not a 'cultural dope' but chooses whether to follow or resist social norms and expectations. Social structures create possibilities, but they also limit the possible.




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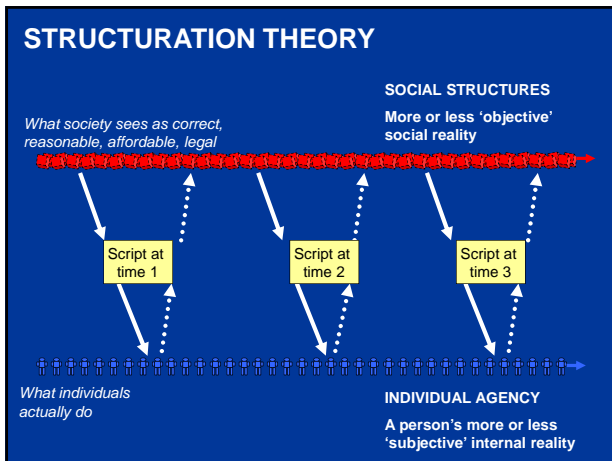
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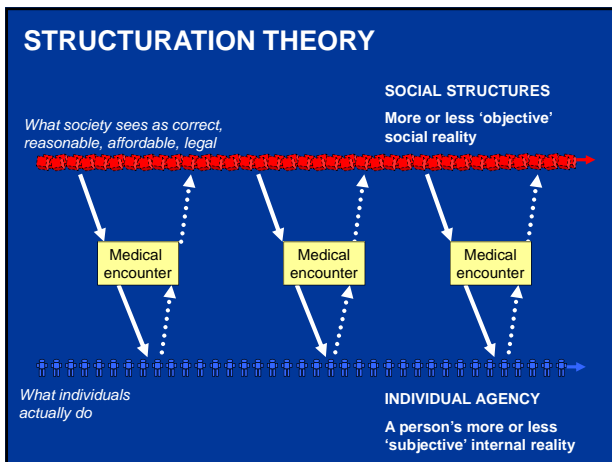
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To be continued...

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