The social origin of the illness experience – an outline of problems

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Abstract

Introduction and objective. The main research objective is a study of social influences on the processes of experiencing illness in the sociological meaning of the term 'illness experience' focusing attention on the subjective activity inspired by being ill, taking into account interpretive (meaning-making) activity. The goal of the analysis is to specify 'social actors' jointly creating the phenomena of 'illness' and 'being ill', taking into consideration the evolution of the position of medical sociology on this issue.

Brief description of the state of knowledge. The ways of experiencing illness in contemporary society, including processes of creating the meanings of the phenomena of 'illness' and 'being ill', are the outcome of not only the application of biomedical knowledge, but are also parallelly a sociocultural 'construct' in the sense that they are under the impact of social and cultural influences. In the sociology of illness experience it is pointed out that illness experience develops in connection with experiencing somatic discomfort, this process occurring in the context of influences of culture, society and socially accepted norms and values. These relationships are interpreted by the sociological, interactionist model which presents illness as a 'social construct'.

Conclusions. Sociological studies on the social construction of 'illness' and 'being ill' construct a model of these phenomena, complementary to the biomedical model, conducive to the validation of the patient's perspective in the processes of medical treatment, and to the humanization of the naturalistically oriented, biomedical approach to illness, i.e. to adjust it more accurately to typically human needs manifesting themselves in the situation of being ill.

Key words

medical sociology, sociology of illness, sociology of illness experience, social constructionism

INTRODUCTION AND OBJECTIVE

Problems of the social construction of illness in the research field of medical sociology. Discussions on the achievements of medical sociology, which were carried out in the US on the 50th anniversary of the discipline's institutionalization in that country (this took place on account of the setting up in 1959 of the *Medical Sociology Section* within the *American Sociological Association*, and the establishment of the *Journal of Health and Social Behavior)*, recognized the description of social construction of the illness phenomenon as one of major accomplishments of the subdiscipline. It was placed on the high – 5th – position on the list of eleven leading research areas of medical sociology [1]. In this way, representatives of medical sociology significantly enhanced the status of the sociomedical approach that makes reference to the assumptions of social constructionism. Its principal thesis says that the ways of defining and understanding the phenomenon of 'illness' in contemporary society are the outcome not only of the application of biomedical knowledge, but at the same time they are a sociocultural 'construct' in the sense that they are also the resultant of social and cultural influences. Sarah Nettleton, an opinion-forming representative of medical sociology, also recognizes the social-constructionist approach as one of the most important theoretical orientations in the subdiscipline [2], while Phil

Brown accords to this approach a high status of '*a central organizing theme in medical sociology*' [3]. When seeking justification for the positions referred to, which affirm the problems of social construction of illness in the research field of medical sociology, Brown emphasizes that this type of analytical approach can be treated as the common denominator of many sociological investigations concerning diverse social influences on the phenomena of 'health', 'illness' and 'treatment'. This approach, Brown believes, is present in many publications, even when their authors do not directly refer to this theoretical tradition [3]. It should be also stressed that the social-constructionist approach developed in sociology first of all in the context of studies on social problems: there is no doubt that 'health' and 'illness' belong to this category of problems [3]. Analyzing 'illness' and 'being ill' as sociocultural constructs has also a noteworthy cognitive and applicative aspect because it emphasizes the sick person's perspective, thereby broadening and complementing the biomedical naturalistic approach that places emphasis on the biological dimension of these phenomena, accessible to cognition by using the instruments of biomedicine, and in this way contributing to its humanization [cf. 4]. Not without significance are also the practical implications of this approach in social policy, consisting in the socioculturally determined meanings that society gives to the phenomena of 'illness' and 'being ill' impact on the ways of practically coping with these problems. This question is investigated by sociomedical studies on the medicalization of social life, which emphasize that the consequence of defining originally non-medical problems as part of the biomedical paradigm is that medicine assumes responsibility for them [1, 4].

The forgoing inspirations initiated a research task aimed at a synthetic recapitulation of the position of medical sociology on the social and cultural creation (constructing) of the phenomenon of 'illness.' The use of the term 'illness', interpreted in social health science as an 'experience-near' category [5] in the role of the central analytical category in the present study signals that the presented article will be concerned with the processes of the social constructing of illness experience. The analysis will seek to specify 'social actors' creating/constructing the phenomenon of 'illness' in its 'experiential' aspect, taking into account the chronology of changing views on this issue in medical sociology. The analysis of the social construction of the 'illness' phenomenon is an element of presenting in the AAEM the basic analytical categories and the achievements of the sociology of health, illness and medicine [6, 7].

'ILLNESS' AS A SOCIALLY CONSTRUCTED PHENOMENON

Ways of applying the social-constructionist approach to the phenomenon of 'illness'. The profile of the journal allows the author to omit a detailed analysis of the origin and assumptions of the '*social constructionism*' trend; the article will therefore confine itself to indicating the main, selected programme assumptions of this theoretical sociological approach. It became established in sociological thought owing to the study by P. L. Berger and T. Luckman, *The Social Construction of Reality. A Treatise on the Sociology of Knowledge* [8]. In this approach, society is perceived as '*a product of human activity*' and as a phenomenon '*being produced by its participants*' [9]. The leading thesis of 'social constructionism' states that '*what human beings at any moment hold to be <real> in social experience is itself a social creation (…)*' [9]. When applying the assumptions of '*social constructionism*' to the 'illness' phenomenon, it should be first explained that in this case one cannot reasonably refer to the radical version of this trend that might suggest that the phenomenon of 'illness' is completely 'socially constructed', and there are no objective, biological foundations of illness and being ill [10]. It is legitimate, however, to use the moderate version of '*social constructionism*', which – as interpreted by M. Blaxter – points out that illness (in most cases) is an objective phenomenon that can be grasped by means of biomedical instruments (abnormal cancerous tissue, myocardial necrosis, etc.), which, at the same time, is a 'social construct' in the sense that society and culture impact the ways of communicating, labeling, and categorizing the states of non-health, by both medicine [10] and lay people, i.e. ordinary people who are not medical professionals [see 11]. This statement indicates two main analytical trends in sociomedical studies on the social construction of the 'illness' phenomenon. One focuses on problems of 'social construction of medical knowledge': it investigates *inter alia* the issues of the sociology of medical diagnosis and related problems concerning the medicalization of social life. The subject of analyses conducted in the other trend – in reference to the theses of symbolic interactionism – is the 'social construction of illness', with emphasis on the question of the social construction of illness experience [3]. This theme will be the subject of in-depth analysis in the next, main part of this study, so now we need to pause for a

moment to consider the question of the 'social construction of medical knowledge'. Medical practice is based on strictly codified labeling of the organic pathology of the human organism and its (pathology's) manifestations. The essence of medical diagnosis in the sociological interpretation consists in labeling the set of symptoms and signs identified in a medical examination with the right label, i.e. in giving them a name [12]. Naming and classifying of non-health states (to be exact: diagnosing of diseases) is the activity that is 'in the centre' of medical science and practice [12]. This process, B. Uramowska-Żyto suggests, '*comprises the whole science and art of medicine*' [13]. As A. C. Twaddle and R. M. Hessler point out, medicine is based on the assumption that '*the experience of non-health can be objectified. That is, it can be treated as an objective reality that exists independently of human thought or will (…). It is real and can be observed, classified, explained, and acted on*' [12]. What is significant from the perspective of this analysis is the observable historical variability of medical systems of naming and classification of diseases, which is the basis of determining the historical and sociocultural relativity of (some) medical diagnoses. This problem is analyzed by medical sociology within the trend of studies on the medicalization of social life, which emphasizes that what is regarded as illness in medicine may change. An example of analysis with such a profile is the study by Virginia W. Chang and Nicholas A. Christakis which describes the evolution of medical concepts of obesity [14]. Sociocultural relativity of labeling the states of non-health in medicine is clearly observable in particular regarding the health problems that do not have a clear organic background noticeable at the level of daily medical practice [2, 10]. This applies *inter alia* to functional health disorders, defined in medical sociology with the name of '*uncertain illnesses*' [15] (however, it must be added that neurobiology continues to identify biomedical bases of diseases belonging to this category).

The author deliberately confines himself only to pointing out the selected problem of social impacts on the processes of creating medical diagnostic categories, because this question was the subject of a number of exhaustive analyses conducted in the stream of sociological research on the medicalization of social life. Within its framework, sociologists stress that medicine '*constructs, or redefines, aspects of normal life as medical problems*' [2], and they also identify sociocultural mechanism that inspire this process, focusing special attention on present-day '*shifting engines of medicalization*'. One of more recent phenomena, which is the focus of sociologists' attention in this context, is the activity of social movements demanding that specific health problems be included in (or exclude from) the medical nosological system [16, 17]. On the basis of the achievements of medical sociology, one could formulate a thesis that the 'illness' phenomenon, also in the biomedical dimension within the medical competence area, defined with the term '*disease*', can be interpreted in terms of a social construct in the sense that society and culture (at least in some cases) influence the medical ways of labeling and categorizing pathologies of human health.

The importance of the anti-psychiatric trend in the development of the concept of illness as a social construct. Sarah Nettleton sees the beginnings of the social-constructionist approach in medical sociology in the trend of criticism of medicine, which developed in Western countries in the 1960s and 1970s [2]. It discussed *inter alia*

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the iatrogenic effects of doctors' actions (the Thalidomide affair) [18], challenged the dominant role of medicine in influencing health indicators in society [19], and pointed out the 'oppressive' aspects of medical, especially psychiatric, practice. An example of this type of considerations is E. Goffman's 1961 study *Asylums,* based on qualitative investigations at St. Elizabeth's Hospital – a federal institution in Washington, DC, in which the mental hospital was defined as a 'total institution'; at the same time, emphasis was placed on the anti-therapeutic distortion of the doctor-patient relationship taking place under such circumstances, and on the negative results of hospital treatment consisting in the degradation of personal identities of mental patients ('institutionalism') [20]. The critical trend towards psychiatry also drew attention to the adverse social results of labeling individuals by means of psychiatric diagnosis, emphasizing that this produced a stigmatizing social response [21]. In such a context, far-reaching, radical views were also articulated, delegitimizing the rudiments of psychiatry and suggesting that mental illnesses are a construct created by psychiatrists in order to exercise social control of individuals exhibiting deviant behaviours (*inter alia* T. Szasz promoted the view that a mental illness is a myth) [2; 21]. At this point, it would be in order to clarify that these kinds of radical theses with definitely anti-psychiatric overtones, attempting to challenge the medical concept of mental illness, should not be attributed exclusively to sociologists. Anne Rogers and David Pilgrim emphasize that sociologists were not the dominant group in the field of anti-psychiatric reflection, a significant portion of leading representatives of anti-psychiatry being dissident psychiatrists (including Ronald Laing, David Cooper, Thomas Szasz and Franco Basaglia) [22], which means that the theses of anti-psychiatry are largely of a self-opposing nature, deriving from within the discipline. At the same time, the above-mentioned authors stress that the views challenging the foundations of psychiatric theory and practice were the object of sociologists' attention and constitute an important inspiration (but not the only one) for sociological research on the social aspects of mental disorders, in particular on the problems of deviation and social control [22]. It must be stressed that mental disorders have always been (and still are) a particularly convenient area making it possible to apply and verify the labeling theory and the (related) interpretive concept of deviation formulated *inter alia* by Howard Becker in the well-known 1963 study *Outsiders* [23]. These two concepts underline the critical importance of social reaction in creating deviation, and suggest that deviation is not an immanent (qualitative) characteristic of a person or behavior, but stems from how an act (feature, attribute, etc.) is socially perceived and interpreted [23]. These theses became the starting point for a number of sociological investigations, also conducted at present on, for example, the stigmatization of persons with mental disorders in society, and pointing to the social impacts on the ways of experiencing mental illnesses.

To sum up, the anti-psychiatric trend was an important inspiration for the development of sociological studies on the social construction of illness. The views articulated here also played an important role of a different kind, consisting in the humanization of relationships between the mentally ill persons (or formerly ill persons) and both medicine and society. For example, E. Goffman's concept of total institution contributed to the humanistic reform of psychiatric hospital treatment (to its de-institutionalization and development of

community-based forms of care), while the trend in which negative, social consequences of psychiatric diagnosis were accentuated, inspired a number of studies, also conducted nowadays on social attitudes towards persons with diagnosed mental disorders. It should be added that nowadays this theme of anti-psychiatric reflection has an interesting counterbalance/complement in the form of sociology of diagnosis, in the field of which, on the basis of qualitative studies based on the opinions of patients, many constructive social functions of diagnosis have been described, *inter alia* the reduction of uncertainty implied by the experience of non-health, social legitimacy of suffering, opening access to medical help (the administrative function of medical diagnosis), structuring of patients' contacts with the medical system, or opening the possibilities of performing the social role of the sick person and taking advantage of the privileges associated with it, etc. [24].

'Illness' as a socially constructed phenomenon from the perspective of American interactionists. Thinking about illness in terms of a social construct, inspired by the achievements of anti-psychiatry, found extended continuation in medical sociology in the period of the latter's development, which followed after the decline of the domination of the structural-functional theory in this field. First, however, it was necessary to apply the labeling theory to somatic illnesses, i.e. to bring this question outside the problem scope of mental disorders. This was achieved by Eliot Freidson [25] – one of the leading representatives of the postwar sociological 'Chicago School' and a leading advocate of the patient's perspective in medical sociology [26, 27]. This change took place in the broader context of the evolution of the object of sociomedical research in the 1970s and 1980s, which consisted in the departure from the problems of mental disorders for the sociomedical problems of chronic somatic illnesses. (The inspiration and marker of this change was the publication in 1975 of the study by A. L. Strauss and B. G Glaser *Chronic illness and the quality of life* [28]).

An application of the labeling theory to somatic illnesses was E. Freidson's work *Profession of Medicine,* with Part Three being characteristically titled *The social construction of illness* [29]. The book contains the basic assumptions of Eliot Freidson's '*sociology of illness*' and is justifiably treated as the starting point for sociological inquiries into the social construction of the phenomenon of '*illness*' [30]. We shall stop for a moment at its principal theses. Freidson treats illness as '*a social concept*', seeking the essence of the social problems of illness in how it is defined. He says that: '*the social reality of illness*' is created by the medical profession [29], which means that '*(…) medicine has the authority to label one person's complaint an illness and another's complaint not, medicine may be said to be engaged in the creation of illness as a social state which a human being may assume* (emphasis by E. Freidson)' [29]. As Freidson writes: '*being the authority on what illness <really> is, medicine creates the social possibilities for acting sick. In this sense, medicine's monopoly includes the right to create illness as an official social role*' [29]. One can easily see the analogy between Freidson's propositions and the theses formulated in the anti-psychiatric trend, the difference being, however, that Freidson is preoccupied with the problems of illnesses in general, including somatic ones. (Incidentally, Uta Gerhardt points to the references of Eliot Freidson's analyses to the

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writings of Thomas Szasz, one of the major representatives of anti-psychiatry [31]). When commenting on Freidson's theses it should be emphasized that the object of his interest was the ways of applying medical knowledge and their social context. Such a position is represented by S. Nettleton, who believes that Eliot Freidson was preoccupied first of all with the question of '*social nature of medical practice*' [2, 32]. Freidson, therefore, did not relativize biomedical knowledge *per se*, he only accentuated the social aspects (or specifically: social consequences) of its applications [2], consisting *inter alia* in opening access to the possibility of performing the social role of the sick person.

The object of Eliot Freidson's analyses were also the parallel processes of social creation of the '*illness*' phenomenon within the '*lay system*', i.e. outside of the field of institutional medicine. This problem is covered by the concept of the '*lay referral system*', well-established in health sciences since the 1970s, accentuating the social context of presenting (or not) the problems of non-health in the field of professional medical care [29, 33]. When analyzing '*the events that occur during the history of a complaint*' [33] Freidson pointed out that (in most cases) they comprise references to the non-medical frame of reference that involve the use of help (consultation) of the treating layperson. As Freidson writes: '*the doctor is but one consultant of many, and the patient often arrives at his office only after having exhausted a whole network of less formal consultants*' [33]. Consultations with another layperson serve to formulate an interpretation of the problem of non-health, the consequence of which will be to take specific measures, and in the course of these institutional medicine will be referred to (or not) [33]. Freidson therefore treated illness as a phenomenon constructed in the processes of social interpretation and social action, taking place both in institutional medicine and within the '*lay system*', which means that in his approach illness is not only a 'professional construct' but also 'a lay one'.

An important stage in the evolution of thinking of illness in terms of 'a social construct' is associated with the contribution of Anselm Strauss and his collaborators, who documented the active participation of patients in creating the processes of being chronically ill [28, 34]. In the studies by this circle of scholars, the role of the central analytical category was assigned to the category of 'work' applied to manifold, including social and identity-related, consequences of being chronically ill (we are dealing here with the sociological understanding of the concept of 'illness experience' in terms of subjective actions inspired by being ill). It is pointed out here that the process of chronic illness examined in a socio-temporal perspective ('a trajectory of illness') is also created by actions ('work') of the ill persons [28, 34, 35] that are oriented not only towards coping with the effects of illness in the area of daily life, but also towards reconstructing one's own 'self' and personal biography [36], emphasis being placed on the fact that the ill person's actions are strongly determined by the specificity of his/her social context, including social interactions occurring in it. We shall cite now *in extenso* the definition by J. Corbin and A. Strauss of the analytical category of '*work*', in the light of which this concept refers to '*a set of tasks performed by an individual or a couple, alone or in conjunction with others, to carry out a plan of action designed to manage one or more aspects of the illness and the lives of ill people and their partners*' [35]. Therefore, we can clearly see that the performance of tasks implied

by chronic illness in daily life takes place in the context of social interactions. When referring to this question, Corbin and Strauss use the term '*articulation*', which accentuates agreements between social actors concerning '*the actions necessary for carrying out the work, as conceived by the participants to it*' [37]. This determines the effective carrying out of the work implied by illness by the team of persons involved (not only by the sick person but also by his close family/friends). Work on the illness and its effects is therefore perceived here as a '*coordinated, collective act*' [37]. Having made these remarks, we can better understand the important thesis of symbolic interactionism, applied by A. Strauss in the sociology of illness, that '*work rests on interaction*' [37]. Social interactions that condition the making of 'agreements' on actions undertaken by individual actors from 'the stage of chronic illness' are an indispensable condition for the efficacy of work on illness, but they (the interactions) are also under its influence because collective actions implied by illness shape the social interactions of the sick person.

To sum up, the interactionist approach to illness, advanced in the studies by Eliot Freidson and Anselm Strauss, accentuates that the sick 'negotiate' their social status, both with other lay people (seeking an adequate interpretation of non-health within the 'lay referral system' – see E. Freidson's concepts [29, 33]), and also with medical professionals (e.g. by participating in arriving at a medical diagnosis; this question is illustrated, for example, by the investigations of Stewart and Sullivan concerning the participation of lay people in formulating an SM diagnosis [38]). They (the ill people) then legitimize the acquired status of the sick person by taking (or not) definite actions in the context of daily life. This issue is indicated by U. Gerhardt, who writes that '*as soon as the patient has left the doctor's office […] the patient resumes control of the illness reality*' [31]. In this interpretation, the sick person has agency, his position being far stronger than in the analyses that apply the labeling theory to mental disorders. The concept of the sick person promoted in the interactionist model of illness is summarized in Kathy Charmaz's formulation, who assigns the chronically ill person the role of an '*innovator*', who actively creates new ways of living in illness, as well as his own, personal identity [36]. A look at this activist model of being chronically ill from the clinical perspective (we might add that the model is anchored in extensive empirical studies carried out using the qualitative methodology) suggests some doubts, however: this model may disregard the attitude of quite a large group of ill persons who are characterized by passive and helpless attitudes, preferring the paternalist model of medical care in which the 'power of decision' lies entirely in the doctor's hands.

In the context of the theoretical tradition of symbolic interactionism, a different model of being ill has also been proposed, the characteristic feature of which is the concept of the sick person as a passive 'victim' of '*environmental processes of normative evaluation*' (the term used by Uta Gerhardt) [31]. A detailed description of the 'anatomy' of this process in the case when the evaluating instance is society is presented in the book by Erving Goffman *Stigma* [39, 40].

Before we examine this issue in greater detail, we should first remember Eliot Freidson's position concerning the sociological dimension of illness: in his view already presented above, '*medicine creates the social possibilities for acting sick*' [29]. In this approach, which is an application of

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the labeling theory to somatic illnesses, the illness in its social dimension is treated as a 'professional construct' created by the medical profession. We shall now focus, however, on another situation, described by E. Goffman, in which the phenomenon of 'illness' is jointly created by the 'social audience', i.e. by other lay people who recognize a state (behaviour, feature, etc.) as deviation, which is tantamount to stigmatizing a person who is a 'carrier'/'holder' of an atypical attribute. The essence of the problem is rendered by Uta Gerhardt as: '*the etiology of illness is the occurrence of the <societal reaction>*' [31]. The ill or disabled person having a mutilated or deformed body is recognized as deviant without his active participation and against his will; consequently, it seems entirely legitimate to use the term 'victim'. The person suffers negative, social consequences of 'possessing' a disease or impairment in the sphere of his personal and social identity, which consist in that the two dimensions of self-identity are, we may say, 'damaged'. In this case, sociocultural influences (i.e. the opinion of social audience) evidently impact the ways of experiencing illness/disability. Depending on the 'power' of the labeling instance deciding that a deviation has occurred [41], serious consequences may arise, such as 'secondary deviation' or 'a deviation career', the exponent of which is the self-acceptance of the societal-imposed role of a deviant. In such a case, the 'victim' begins to behave in accordance with the intention of the social stigmatizing environment, and then we are dealing with a mechanism of exclusion and (simultaneous) self-exclusion of the stigmatized persons from the mainstream of social life.

While discussing the issue of stigmatization and consequences of this process in experiencing illness, we touch upon the symbolic meanings of illnesses ('*meaning as significance*' – the terminology proposed by M. Bury in the field of the phenomenological- orientated British sociology of illness), dependent on the cultural context [42, 43] that determine the ways of perceiving the ill persons by the social audience and of managing them. This question was also strongly articulated in medical anthropology, in which Arthur Kleinman emphasized that '*cultural meanings mark the sick person, stamping his or her with significance often unwanted and neither easily warded-off nor coped with. The mark may be either stigma or social death*' [44]. A good example of this problem is the concept of 'HIV stigma trajectory' proposed by A. Alonzo and N. Reynolds, which points out the processual specificity (related to the biomedical trajectory of the infection) of the stigmatization of HIV virus-infected persons [40]. This problem also applies to 'disability', which is now seen as a social construct in the aspect concerning social actions taken towards people with physical impairments. The issue is covered by the so-called 'social model of disability', also contributed to by the achievements of Polish medical sociologists. Within it, a significant shift of accentuation occurs from the individual/victim to the oppressive-working society and social mechanisms that create and sustain the experience of disability [45]. The impact of '*cultural meanings of illness*' goes beyond modelling the ways of experiencing illness, and also pertains to practical issues concerning the use of medical care. P. Conrad and K. K. Barker give the example of obese women who, because of the stigma related to obesity, avoid routine preventive gynecological check-ups, which results in higher cancer rates in this group [4].

We can thus see that the illness experience only seemingly has an exclusively individual dimension. Actually, this is a socially and culturally constructed phenomenon, to the effect that social interactions shape the subjective activity implied by being ill (illness experience as 'work'), while cultural meanings of illness may result in stigmatization of the sick person and in 'damage' to his personal and social identity. The illness experience is therefore an intersubjective phenomenon, which means that, as A. Kleinman and D. Seeman state, '*it is constituted in social space*' [5]. These authors emphasize that: '*The experience of illness is not bounded by the bodies or consciousness of those who are ill. It reaches out to encompass a household, a family, or a social network. It reaches deep into the inner world of patients, yet is decidedly transpersonal*' [5].

To sum up, two versions of the interactionist model of illness can be distinguished that differ in the way of perceiving the sick person's agency. The first version – an activist one, developed in the works of Anselm Strauss and the representatives of his 'school of medical sociology' – perceives the sick person as the agent and places emphasis on his/her agency, while the other, based on the labeling theory, focuses on situations in which the sick person is a passive victim of social assessment (such suggestions were formulated in the anti-psychiatric trend and in the works of E. Goffman).

Uta Gerhardt points out that the interactionist approach to illness promotes a novel interpretation of illness as a 'social construct' created by external (environmental/social) factors [31]. Medical sociology offers a number of specific elaborations to this question. It assigns the role of the social actor/creator of illness to medicine (the views of anti-psychiatry and those of E. Freidson), or to the 'lay system' (Freidson's concept), or – in the negotiation model of illness – to both sides (cf. e.g. J. Roth's concept [46]). The negotiation model, as interpreted by U. Gerhardt, shows that the '*social construction merely means mutual involvement of various actors in medical setting*' [31].

It should be added that the interactionist model of illness accentuating the role of lay persons in the processes of social construction of illness and being ill, as well as of exercising medical care, has also played an important role in shaping the cognitive identity of medical sociology, consisting in dynamizing the non-medicocentric research orientation in the subdiscipline, in which a significant position is accorded to the sick person's perspective [47].

The social origin of meanings of illness in the approach of phenomenological sociology and in the realities of information society. Theses on the social construction of illness experience were also advanced with reference to the phenomenological dimension of this phenomenon which concerns subjective interpretations and meanings given to illness and being ill by the ill people themselves. Interesting evidence for the social construction of the meanings of illness was provided by empirical studies inspired by M. Bury's concept of illness as '*biographical disruption*', which is accorded the high status of one of the most important sociological conceptualizations of the 'chronic illness' phenomenon. In his concept, M. Bury suggests that in connection with illness it is necessary to reconstruct the personal biography and individual concept of self, which justifies the treatment of illness as a '*critical situation*' or '*biographical disruption*' [48]. The purpose of this concept is to draw attention not only to the lay meanings of illness

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(one of them being '*biographical disruption*'), but also to the social context in which they are constructed because, as M. Bury writes: '*The notion of biography suggests that meaning and context in chronic illness cannot easily be separated*' [48]. Apparently, by stating this, the British medical sociologist anticipates the possibility of not confirming the concept of illness as '*biographical disruption*' in other social contexts. Its later verifications provided ample evidence that contracting a chronic illness in a different social or biographical context (e.g. in old age) is treated by the ill persons in a different way, one that does not place emphasis on 'disruption' of the personal biography (it should be added that non-chronic illnesses, including mild and severe, are not the object of interest of the sociology of illness experience, because they do not imply consequences of interest to the sociologist, defined by the term 'illness experience' in its sociological meaning concerning work on the illness, daily living and on personal biography). For example, Christopher A. Faircloth et al. analyzed experiences of elderly ill persons suffering from cerebral stroke (mean age 66.18) and demonstrated that the biographical context of old age, associated with the incidence of illnesses predisposing to cerebral stroke, causes the fact of contracting this illness to be perceived as an expected/probable element of the personal biography rather than '*biographical disruption*' [49]. The social standing of the ill persons is also a factor that models the illness experience. In the context of life full of adversities, the ill persons of low socioeconomic status use a normalizing strategy in the case of illness and treat it as an expected situation ('*normal*' illness) [50]. On these grounds, S. J. Williams concludes that the concept of illness as '*biographical disruption*' accentuates the meanings of illness and being ill characteristic of the period of youth/adulthood, and of the high socioeconomic status [50]. Therefore, the phenomenological dimension of illness and being ill remains under the influence of the specific social situation of the ill persons; the stage of life cycle, and the social standing of the ill people being of significant importance.

To conclude this synthetic reflection focusing on selected problems of the social construction of illness phenomenon, it is in order to place this issue in the reality of the information society associated with the spread of the Internet. P. Conrad and K. K. Barker give priority importance to this question in the array of directions for future sociomedical research. They emphasize that a significant reconstruction of illness experience is taking place on the Internet: the experience is losing the character of 'privatizing experience', and becoming an 'increasingly public experience'. An indication that illness experience has become public or collective is the emergence of '*illness subcultures*', and '*illness-based social movements*' [4], which are becoming a significant driving force behind the self-empowerment of lay people in matters of illness and being ill, thereby challenging the domination and authority of institutional medicine in this area of problems [cf. 4]. This issue is investigated in the sociology of diagnosis, showing that medical diagnosis makes it possible to socialize (collectivize) the illness experience. That precisely can be observed on the Internet where '*diagnosis-focused internet communities*' (A. Jutel's terminology) are functioning. They perform a supporting function and are interpreted in terms of alternative 'medical culture', in which the leading significance is given to subjective experience [24]. In this context, the social reconstruction of ways of experiencing

illness is also taking place, manifested in constructing '*new illness identities*' [4]. This process is also observable in a larger, non-virtual context. It can be seen nowadays in the promotion of a new, positive idea of being chronically ill ('*being successfully ill*'), consisting in living an active and meaningful life despite illness and its constraints [51].

CONCLUSIONS

The cognitive identity of contemporary medical sociology is formed, first of all, through connections with general sociology [7, 47]. According to Marek Latoszek, they consist in that '*a particular sociology (*here, medical sociology) *provides empirical material, while general sociology provides theory, the conceptual apparatus and methods*' [52]. In his view, there is a specific 'feedback' between the two disciplines, consisting in that '*the starting point for any new investigations* (in the field of particular sociologies – author's note, M.S.) *should be the knowledge accumulated by general sociology, while the results of particular sociology may confirm, or not, hypotheses taken from sociological theory*.' As the doyen of Polish medical sociology points out: '*in the latter case it will be necessary to make modifications and changes: in this consists the development of sociological theory*' [52]. The achievements of the sociology of illness from the aspect of documenting the social construction of the phenomenon of 'illness experience', provide significant data enabling verification of the theses of social constructionism. Sociomedical knowledge showing the parallelism of the biological ('disease') and sociocultural dimensions of non-health ('illness'), the relationship between these dimensions and their social grounding, provide support for a moderate version of this trend which distinguishes '*the real world*' and socioculturally determined '*descriptions of it*' [2].

In conclusion, we must also ask the question about the cognitive values of the achievements of the sociomedical analytical trend in question. The perspective of social constructionism, applied in sociomedical studies on illness and being ill, points out that the illness experience develops not only in connection with experiencing somatic discomfort, but also in relation to culture, society and its accepted values. Extending the suggestion by S. Petersen et al., we can say that the '*constructivistic model of health care*' makes it possible not only '*to access the private, experiential meaning that illness has for patients*' [53], but it also reveals the sociocultural grounding of the individual experience of illness and social actions that also create it. In the practical dimension, sociomedical studies with such characteristics support the legitimacy of the sick person's perspective in the processes of medical treatment.

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