İçtimaiyat
Sosyal Bilimler Dergisi | Journal of Social Sciences

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Makale Bilgileri/Article İnformation
Tür-Type: Araştırma makalesi-Research article
Geliş tarihi-Date of submission: 07.09.2024
Kabul tarihi-Date of acceptance: 27.11.2024
Yayım tarihi-Date of publication: 31.05.2025

Hakemlik-Review
Çift Taraflı Kör Dış Hakemlik
Double-Blind External Peer Review

Etik beyan/Ethics statement
Yazar(lar), çalışmanın hazırlanma sürecinde etik ilkelere uyduklarını beyan etmiştir.
The author(s) declared that they complied with ethical principles during the preparation of the study.

Benzerlik taraması- Plagiarism checks
intihal.net iThenticate

Çıkar çatışması-Conflict of interest
Çıkar çatışması beyan edilmemiştir
No conflict of interest declared

Finansman-Grant Support
Fon, hibe veya destek alınmamıştır
No funding or support was received

The Social Construction of Illness and Health: Health and Body

Abstract

Social constructionism is an approach that emphasizes human consciousness and argues that human beings reach their own consciousness through social interaction with the external environment. This approach developed by Berger and Luckmann tried to overcome the dichotomy of structure and agent and focused on human actions. The concepts of illness and health are social constructions as well as medical phenomena. Illness and the experience of illness, pain and the experience of pain are different from each other. It would be a one-dimensional approach to analyze the disease by detaching it from its social context. Since the 1970s, the number of studies drawing attention to the social context of health and illness has increased. Thinkers such as Foucault, who was critical of the institution of health, argued that health is increasingly part of the aim of controlling society. With the medicalization of life, medicine has encircled human life and has become a part of strategies to control the human body. The aim of this article is to focus on the concepts of illness, health, medicine and body in the context of social constructionism, a sociological approach that focuses on the world of meaning of human beings, and to deconstruct medical knowledge.

Keywords: Medicine, Social Construction, Illness, Health, Body.

Hastalık ve Sağlığın Sosyal İnşası: Sağlık ve Beden

Öz

Sosyal inşacılık, insan bilincine vurgu yapan ve insanın dış çevre ile kurduğu sosyal etkileşim yoluyla kendi bilincine ulaştığını savunan bir yaklaşımdır. Berger ve Luckmann tarafından geliştirilen bu sosyal yaklaşım yapı ve fail ikiliğini aşmaya çalışmış, insan eylemlerine ve onun sonuçlarına odaklanmıştır. Hastalık ve sağlık kavramları tıbbi bir olgu olduğu kadar sosyal bir inşadır. Hastalıkla hastalık deneyimi, ağrı ile ağrı deneyimi birbirinden farklıdır. Hastalığı sosyal bağlamından koparıp incelemek tek boyutlu bir yaklaşım olur. 1970'lerden itibaren sağlık ve hastalık konularının sosyal bağlamına dikkat çeken çalışmaların sayısı artmıştır. Sağlık kurumuna eleştirel yaklaşan Foucault gibi düşünürler, günümüzde gideren artan oranda, sağlığın toplumu kontrol etme amacının bir parçası olduğunu savunmuştur. Hayatın tıbbileştirilmesi ile beraber tıp, insan yaşamını çepeçevre kuşatmış, insan bedenini kontrol etme stratejilerinin bir parçası haline gelmiştir. Bu makalenin amacı sosyolojik bir yaklaşım olan ve insanın anlam dünyasına odaklanan sosyal inşacılık bağlamında hastalık, sağlık, tıp ve beden kavramlarına odaklanmak, tıbbi bilgiyi yapı söküme uğratmaktır.

Anahtar Kelimeler: Tıp, Sosyal İnşacılık, Hastalık, Sağlık, Beden.

Yazar Katkı Oranları/ Author Contributions

Çalışmanın Tasarımı/Conceiving the Study	Yazar-1 (%100)
Veri Toplama/Data Collection	Yazar-1 (%100)
Veri Analizi/Data Analysis	Yazar-1 (%100)
Makale Yazımı/ Article Writing	Yazar-1 (%100)
Gönderim ve Revizyon/Submission and Revision	Yazar-1 (%100)

Atıf- Citation (APA)
Erkan, Ü. (2025). The social construction of ıllness and health: Health and body. *İçtimaiyat*, 9(1), pp. 483-499. DOI: https://doi.org/10.33709/ictimaiyat.1545158.

1. Introduction

Beyond being a branch of science that deals with human health, medicine has increasingly become a science that intervenes in, monitors human life. In this process, characterized by the medicalization of life, has facilitated the infiltration of medical practices into various aspects of human experience, often revolving around the ideal of the healthy body. Consequently, numerous subjects that were previously outside the purview of medicine have undergone medicalization. Medicine has thus assumed a role within the health industry that emphasizes the regulation and reconstruction of the body. The body has become intertwined with the constructs of healthy living and the archetype of the desired body image, influenced significantly by prevailing capitalist ideologies.

Since the 1970s, topics previously regarded predominantly as biological and physiological, such as the concepts of illness-health and the human body, have begun to be explored within sociocultural frameworks. This shift has been influenced by sub-disciplines such as medical etiology, which seeks to identify the underlying causes of diseases. It is recognized that diseases arise not solely from physiological agents such as microbes, viruses, and bacteria, but also from lifestyle choices, as well as cultural norms and values. Consequently, this acknowledgment has prompted a greater focus within medicine on sociocultural considerations (Friedson, 1970). Medicine delineates the distinctions between health and illness, providing guidelines for individuals to pursue a healthy lifestyle, while striving towards the overarching objective of a "healthy" existence through preventive health services. The fundamental aim of medicine is to enhance social well-being by perpetually advancing health, healthcare delivery, and the overall quality of life for both individuals and communities, achieved through the promotion of health, the prevention of diseases, and the efficacious utilization of resources.

The focus of medicine on sociocultural fields has also strengthened its interaction with sciences such as sociology, psychology and anthropology. Social constructionism, which emphasizes human consciousness and the social world constructed by it in the sociological tradition, emphasized that objects are not independent of consciousness, and expressed the thesis that humans live in a social environment as well as a physical environment and socially construct this physical environment. Social constructionism, rooted in the Weberian tradition, advocates for the significance of agency in the interplay between social structures and individual actions, illustrating how individuals create their own social realities and subsequently generalize these constructs. The contributions of Berger and Luckmann clarify that individuals are not mere bystanders within social structures; rather, they exist within a sociocultural environment from birth, actively participating in and shaping this environment. The social view, once formed and normalized, is perpetuated through socialization and is continually reconstructed. These perspectives have also been substantiated through sociological frameworks such as social interactionism and symbolic interactionism.

The application of social constructionism to the field of medicine has reinforced the notion that the human body cannot be solely regarded as a biological and physical entity, and that illness and health should be understood in conjunction with human experiences. It is important to differentiate between illness and its experience; even physiological sensations, such as pain, are influenced by cultural factors. The thresholds, interpretations, and valuations of pain are inherently social constructs (Srnivasalu, Selladurai et. al. 2022: 56-57). Furthermore, societal

distinctions are ascribed to specific diseases, leading to the stigmatization of certain conditions. For instance, illnesses such as HIV, certain gynecological conditions, and epilepsy, which hinder individuals from fulfilling their societal roles, are particularly susceptible to social exclusion (Epstein, 1996). This indicates that illness has both social and cultural dimensions in addition to its physical aspects.

The image of the healthy body targeted by medicine has influenced the efforts of the concept of health to manufacture and construct the body. The main purpose of the healthy body is to reveal the full potential of the human being and to make it as productive as possible. As Foucault (1992) emphasizes, modern power is centered on the human body and focuses on developing it, making it productive and disciplining it. This paradigm represents a significant evolution within modern capitalism, wherein power governs all facets of human existence, from reproductive choices and sexual practices to the boundaries of human cognition, rendering the body an integral element of production. In this context, medicine has gradually replaced morality and law and has taken on the responsibility of caring for the body. It has become a normative discipline that categorizes the human body as normal and abnormal, classifies individuals, and constantly maintains control over it (Foucault, 2002).

The objective of this article is to demonstrate that the area of medicine, disease, health, and the body represent social phenomena as much as they are medical in nature. Additionally, it seeks to illustrate that the physical domain is interwoven with the social area, as individuals respond to issues of illness, health, and embodiment through social constructions, mirroring their engagement with other societal phenomena. It also aims to explain the role of medicine in the contemporary period as an instrument of social control, going beyond its traditional function of treating medical health problems. The first section of the article explores the social constructivist framework, incorporating the seminal contributions of Berger and Luckmann. The subsequent section examines the interrelation of medicine, illness, and health through the lens of social constructivism. Finally, the third section delves into the themes of body control, regulation, and surveillance.

This study aims to make a contribution to the field of health sociology, which has started to develop in our country especially after the 2000s. It aims to draw attention to the increasing control power of medicine in society, as medicine, which is a public service, pays more attention to the sociocultural aspects of society in health services. It is to approach medicine in the concept of social constructionism and to focus on the power of influence of medicine through body image. For this, a literature review was conducted and various studies on the subject were utilized.

2. Illness And Health in The Context of Social Constructionism

Social constructionism constitutes an approach that arose in response to the positivist and empiricist paradigms that predominated the early 20th century. Newman and Holzman (1999) assert that the positivist approach relied on criteria such as objectivity and certainty. In contrast, alternative perspectives, including phenomenology, existentialism, and hermeneutics, emerged as critiques of positivism, which has been characterized as a one-sided approach. The basis of social constructionism, which is informed by phenomenological traditions, can be traced back to influential scholars such as Emile Durkheim, Karl Mannheim, and W. I. Thomas. Galbin (2014: 82-83) notes that social constructionism emphasizes the social nature of human existence and

the significance of interactions with others. While not dismissing biological and genetic influences, this approach contends that a substantial portion of human life is constituted through social and interpersonal exchanges. Social constructionists fundamentally reject conventional positivist knowledge, which is inherently non-reflective. Furthermore, they adopt a critical perspective toward prevailing assumptions regarding society and social life. Lastly, social constructionists maintain that our comprehension of the world emerges from historical processes of interaction and negotiation.

Social constructionists have tried to show that objective reality is in fact a social construction, and that it is impossible to separate knowledge from society and culture. Constructivist inquiry has shown how knowledge and values emerge from historical traditions, are reinforced through social networks, assembled through literary tropes, legitimized through rhetorical devices, and operate in the service of particular ideologies to shape structures of power and privilege.

According to Conrad and Barker (2010: 68), after the 1960s, researchers such as Becker and Gusfield, with an anti-positivist orientation, argued that what was identified as “deviant” or “social problem” was not “given” but rather emerged within a social context and in response to the demands and moral values of social groups. These scholars have also argued that all these categories were developed for the purpose of social control. They have applied similar situations to illness and medicine, arguing that illness and medicine are also used as instruments of social control.

According to Newman and Holzman (1999), social constructionism deconstructed both professional and everyday knowledge after the 1970s. It has challenged claims to authority, truth, rationality and moral superiority by pointing to the social, linguistic, rhetorical, ideological, cultural and historical forces responsible for the production of this knowledge.

Social constructionism has questioned many categories and knowledge presented as objective realities. Social constructionism, which is essentially a theory of knowledge, has taken on a specific form especially with the works of Berger and Luckmann. According to Balkız and Öğütle (2012: 34-36), there is a realist Durkheimian tradition in sociological theories that emphasizes objective reality on the one hand, and a Weberian tradition that emphasizes the subject in the structure/agent relationship on the other. The social constructionist approach is closer to Weber than Durkheim. The social constructionism developed by Berger and Luckmann is more eclectic than systematic and closer to social philosophy than social theory. Berger and Luckmann have tried to show how elements such as social structure and culture, which we find ready when we are born and to which we cannot escape, are constructed through social interaction. According to them, the human being is an incomplete being and exists only through mutual interaction within society.

Berger and Luckmann's subject, like the pioneer of the discipline Karl Mannheim (Mannheim, 2002: 12), is the problem of knowledge. In their book “The Social Construction of Reality”, they discussed human knowledge. The importance given to consciousness by the German phenomenological tradition and the idea of German historicism that all our knowledge is constructed in history led them to deal with the social origin of knowledge. They tried to show the impossibility of a knowledge that is independent of human consciousness, that is free from social interaction. The main thesis of the book is stated as follows. “Reality is socially constructed, and the sociology of knowledge must analyze the process by which this

construction takes place" (Berger and Luckmann, 1991: 13). According to them, the sociology of knowledge was founded in 1920s Germany by the German philosopher M. Scheler with a context of the intellectual agenda of the period. It was not found very interesting by other countries. Sociology of knowledge is concerned with the relationship between human thought and the social context in which it emerges.

Berger and Luckmann's approach are systematic and analytical. Just as Descartes systematized his ontological views, they went to the foundation of knowledge and made an ontological and epistemological analysis of human knowledge from ground zero. While doing this, they sometimes resorted to philosophy, but generally preferred to remain on the ground of sociology. Berger and Luckmann (1991: 33-35) primarily deal with the reality of the external world or, as they call it, the reality of everyday life. For this, they make use of phenomenological analysis.

According to Berger and Luckmann, who draw heavily on phenomenology, everyday life is a coherent world interpreted by people. According to them, consciousness is always intentional. It is always directed towards objects. According to them, the supreme reality among multiple realities is the reality of everyday life. "The tension of consciousness is at its highest in everyday life, which means that everyday life imposes itself on consciousness in the most compelling, most insistent and most violent way." (Berger and Luckmann, 1991:35). According to Andrews (2012), Berger and Luckmann see society as both an objective and subjective reality. Society is both objectively independent of the individual and constructed through human actions and interactions. According to Berger and Luckmann, everyday life is experienced fully awake and manifests itself for me as the strongest reality. According to them, everyday life is organized before we are born. Therefore, I can only know it as it is organized, not as it is. It is language that reflects the order in everyday life. "... language shows the coordinates of life in society and fills this life with meaningful objects." (Berger and Luckmann, 1991:36). Everyday life presents itself to me as here "here" and now "now". What presents this to me is the reality of my consciousness. But it also includes phenomena that are not here and now. Among this world of different phenomena, the one closest to my consciousness is the one I experience bodily. My interest in this world is determined by what I am doing, have done and plan to do in it. This world is my world as such.

Referring to Alfred Schutz's concepts of common sense, typification and reciprocity (Slattery, 2008: 233) for the reality of everyday life, Berger and Luckmann emphasize the intersubjectivity of everyday life. The fact that knowledge is based on mutual construction shows that it is also intersubjective. Subjects, like me, experience this everyday life. I know that they, like me, grasp this world as it is organized. Like me, they perceive this world as immediate and present. I also know that they, like me and unlike me, perceive the everyday world similarly or differently. My conceptions and theirs may conflict. I know that I live in a world in common with them. "Most importantly, I know that there is a constant reciprocity between my meanings of this world and theirs, that is, that we share a common sense of the reality of this world" (Berger and Luckmann, 1991: 37).

Everyday life carries a certain spatiality and temporality. Each individual is aware of a flow of time in his/her own consciousness that depends on the physiological rhythms of the organism. Intersubjective interaction also takes place within a temporality (Berger and Luckmann, 1991:

41). Temporality also imposes my conception of history. I was born, educated and practiced a profession at a point in cosmic time.

Berger and Luckmann then focus on the social interaction that occurs in everyday life. According to them, this interaction is face to face. The here and now of the self and the other affect each other. My expressions and his/her expressions constantly influence each other. Gestures and mimics also play a role here. The person maintains the communication according to the reaction he/she receives. This interaction is simultaneous. According to them, face-to-face interaction takes place based on certain patterns. These are typificatory schemes. With this typification such as “cheerful”, “business person”, “European”, I understand and interact with the other. In some cases, this typification may not be sufficient and may be crippled for some other reasons. In this case, the schemas will change. These schemas are also reciprocal. These are the schemas that the other, as well as I, uses when perceiving me. The two typifying schemas are in constant negotiation at every moment. In everyday life such a negotiation is in every respect pre-arranged. I use anonymous typification of people I know little or not well enough. For example, when I meet “English Henry”, I typify him as a typical Englishman and interpret his taste in food, emotions and behavior accordingly. Others may remain relatively anonymous to me, even though I am in constant interaction with them. For example, although I see the newspaper kiosk worker on the street as often as my wife, my experience of her is insufficient because she is less important to me. The reality of everyday life becomes more anonymous as we move away from face-to-face interaction. “Social structure is the sum of these typification and the repeated patterns of interaction established through them. As such, social structure is an essential element of the reality of everyday life” (Berger and Luckmann, 1991: 48).

The intersubjectivity of everyday life and the systematization and typification that systematize it enable the social structure to function in a certain order. This is supported by symbols and icons. According to Berger and Luckmann, people use various symbols and icons in everyday life. Symbols are intersubjective. “Signs are clustered in certain systems. Thus, there are systems of signs based on gestures, systems of stereotyped body movements, systems of various material objects, etc.” (Berger and Luckmann, 1991: 50). Even if language is not here and now, it can be detached from face-to-face communication as a means of intersubjective communication.

> “I can talk about countless things that are simply not available in a face-to-face situation, including things I have never experienced and never will” (Berger and Luckmann, 1991: 52).

Thus, within the framework of the language system, we communicate with others at the same time and share their worlds. Language arises from everyday life and its primary reference is to it.

> “Language, as a system of signs, has the quality of objectivity. I encounter language as a phenomenality that is external to me and it effect on me is coercive. Language forces me to use its own patterns... Language provides me with a ready-to-use facility for the ongoing objectification of my flowering experiences... Language is a sign system that can convey the experiences I will have throughout my life... Language also allows me to typify my experiences... Language anonymizes experiences as it typifies them...” (Berger and Luckmann, 1991: 53).

Berger and Luckmann then focus on the interaction of humans with their environment and how institutionalization occurs. According to them, all beings except for humans adapt to the natural environment and act according to instincts. For them, the social environment is largely biologically structured. On the other hand, the relationship between human beings and their environment is based on the principle of world-openness. The fact that in the same period of time, human beings make a living as nomadic shepherds in some regions and as agriculturalists in others shows that their environment is based on social interaction rather than biological possibilities. “The human organism is capable of applying its given endowment in the state of formation to a wider, as well as constantly changing and diversifying field of activity. This particularity of the human organism is grounded in its ontogenetic development.” (Berger and Luckmann, 1991: 66).

Berger and Luckmann then focus on the relationship between human beings and social structure. According to them, the social structure exists before the human being. The human being is always limited by a social order in this world. Accepting that the social order exists before we are born and limits us, like Durkheim, Berger and Luckmann state that this social structure is a product of human interaction. “Social order is not part of the 'nature of things' and cannot be derived from 'laws of nature'. Social order exists only as a product of human activity” (Berger and Luckmann, 1991: 70). But how does this happen? According to them, all human activity is based on habitualization. Each human action is molded by its agents as a pattern that can then be repeated. This emphasizes the repeatability of the same action the next time. This habitualization applies to both biological and social actions. These actions are meaningful for them and make their lives easier, establishing certain routines. In this way, it limits options and other possible contingencies. This situation provides psychological gain to the individual. The individual is relieved from tension and begins to specialize. In this way, it provides a new time period for making innovations. What follows is institutionalization. “Whenever there is a mutual typification of habitual actions by types of agents, then institutionalization occurs” (Berger and Luckmann, 1991: 72). According to them, this institutionalization is mutual and pushes other individuals to behave in a certain way. Institutions limit human actions by pushing them to behave in a certain way. What enables this is typification. Typification allows individuals to predict each other's behavior. Thus, it saves them from the tensions that may arise. It routinizes the actions. It routinizes actions. This is followed by division of labor. The habitual actions of two people can be changed and recycled by them. But when new generations encounter them, they take on an external and coercive character. 'Here we go again' has now become 'This is how these things are done' (Berger and Luckmann, 1991: 77). It gains a more objective reality and becomes unchangeable. The world becomes the world for individuals through socialization. Institutions are now externalized and have a power of control over the individual. These institutions emerged as a result of the externalization and typification of individual interaction and then became institutionalized with subsequent generations. Externalization is based on a dialectical process and is reconstructed every moment. In other words, society is not static but produces new externalizations with new interactions.

The objective reality of everyday life transforms over time into a social reality. This is enabled by human externalization. This externalization allows individuals to acquire certain habits and to anticipate the behavior of others. This is called habitualization. As these typification and rules are passed down from generation to generation, institutionalization begins. The next

generation, even though it did not create them, accepts and turns them into norms of behavior. Institutionalized reality becomes an external, objective and coercive force. They are already there and are internalized through the process of socialization (Balkız and Saygın; 2012: 37-38).

One of the concepts used by Berger and Luckmann is sedimentation. According to them, some knowledge is sedimented and fixed in human consciousness. For the formation of a common stock of knowledge between individuals, a process of intersubjective sedimentation is needed. It only acquires a social form when it is objectified within a sign system. These experiences become increasingly anonymized and transferable. It gains a social form through the repetition of common experience (Berger and Luckmann; 1991: 86). Once these anonymized experiences are conveyed through language, they can be used as a basis for different legitimations by new generations. Religious aphorisms, mythologies and some moral rules are formulated in this way. For them, a high level of institutionalization depends on specialization and division of labor. Once institutionalization is established, it becomes permanent. Institutionalization is not a one-way and irreversible process.

In summary, Berger and Luckmann, based on phenomenology and the anti-positivist approaches, argued that instead of a world of phenomena based on an objective reality, unchanging and repetitive in the same way, reality is based on the process of social interaction and mutual construction. According to them, the process of construction based on social interaction acquires an objective character through routinization of activities, certain typification and institutionalization, and individuals are involved in this process through socialization. What all this tells us is that concepts such as medicine, health and the body, which are considered to be objective and scientific, are in fact based on social construction and interaction.

3. The Social Construction of Illness and Health

Social constructionism states that the material world and mechanical phenomena are also social and that they are transmitted through a social construction. From this point of view, the phenomenon of health and illness, which we will discuss, is as much a part of the sociocultural world as it is a part of the mechanical and positive system. This shows that phenomena such as medicine, illness, health and the body are also products of social construction. Since the 18th century, medical science, which has made great progress, has long defined the human being as a mechanical system and treated him as a machine.

According to Nazlı (2007: 150-155), for a long-time illness was dealt with only biomedical methods and the sociocultural aspect of health was neglected. Behind the biomedical approach is the understanding that sees the body as a machine. Disease and physical inadequacy are attributed to a bodily malfunction. The human body, which is seen as an advanced machine, is considered based on medical and physical causes. Disease is defined as a pathological condition based on certain symptoms. The so-called “disease” ignored the patient and his/her subjective experiences. Over time, this attitude has been replaced by the concept of “illness”, which includes the patient's experiences and social roles.

According to Aytaç and Kurtdaş (2015: 231-232), health and illness is a social issue as well as a medical one. Social sciences as well as medicine are needed to achieve, protect and maintain a healthy life. The fact that human beings live in a society and have a certain culture makes the intervention of social sciences in areas related to medicine such as illness and health inevitable.

The study of medicine and health outside of medical processes has increased since the 1970s. Eliot Freidson made an important contribution to the social construction of illness with his book "Profession of Medicine" written in 1970. According to Freidson (1970), with the professionalization of health, medicine started to intervene more and more in our lives, and health professionals started to dictate to us what is acceptable and what is not. The professionalization of health has shown us how the boundary between health and illness has become blurred and how health/illness has become an instrument of social control.

The idea that illness can produce a social control instrument or a mechanism of social exclusion beyond a medical condition was articulated by Goffman's theory of “stigma”. Goffman emphasized that stigma is essentially a boundary or mark drawn by society, that is, an ascribed social reality (Goffman, 1986). Society stigmatizes and excludes some people in terms of their physical “defect” and others within the framework of moral, religious or social norms it has determined. Stigmatization is first dictated to the individual by society and becomes secondary when the individual accepts it. Stigmatization essentially functions as a means of social control.

T. Parsons, a functionalist sociologist, also established a relationship between illness and the social roles of the individual and used a concept called “sick role”. According to Parsons (1951: 285-292), illness is a situation in which an individual's social roles and position in society are suspended. Parsons saw this situation as a kind of “sanctioned deviance”. Illness is not only an individual condition but also a social phenomenon. Illness is also related to social norms, social roles and obligations. During the illness process the patient is exempted from social roles. The sick person must make an effort to recover, seek medical help, and cooperate.

Strauss and Glaser (1975), like Parsons, were also interested in the social aspect of illness. According to them, there is a difference between illness and illness experience. Illness experience is a process that includes how patients experience the illness process and how they perceive their social interaction and social world. Illness also affects the social roles, interactions and tasks of most people. They cannot go to work, spend time with their families, socialize with friends or move freely. Chronic illnesses cause individuals to re-evaluate their lives and, in some cases, rebuild their identity (such as surviving cancer). In addition, patients sometimes organize themselves on the internet and social media to produce alternative information about the disease and construct a new reality based on their own and others' experiences. A social constructionist approach takes the experience of illness seriously, examining the social and personal meaning of illness and exploring how illness is managed in the social context in which patients live.

The idea that illness is not only a medical condition but should also be considered within the social environment of the individual and the various meanings and roles attributed to it is an approach that has gained strength in recent years (Kaplan, 2016: 12). This approach is called the biocultural model. It is an approach that deals with illness in the context of the patient's subjective experiences and his/her social environment. The disease, which is considered in a broader context, is affected by various factors such as the patient's age, education level, social status, gender, class and ethnicity, and reveals different experiences in individuals. Not only the diagnosis of the disease, but also the doctor-patient relationship, the disease process and treatment methods are affected. During the illness process, the individual tries to adapt to the illness and the sick body with the help of various social construction processes.

According to Srnivasalu, Selladurai et al. (2022: 54), there are three main approaches to defining the concepts of health and illness. These are naturalists, normativists and hybrid theorists. Naturalists explain illness by emphasizing biological and physiological values that are considered normal for humans. In other words, they deal with illness in a medical and medical context. Normativists, on the other hand, argue that the concepts of health and illness involve value judgments. Health reflects the state we desire to be in and illness reflects the state we avoid. Hybrid theorists try to synthesize these two approaches. Naturalists are more concerned with the medical aspect of illness. Normativists, on the other hand, examine the impact of illness on the individual and psycho-cultural processes. Hybrid theorists examine both the biological symptoms of the disease and the effects of the disease on the individual. Studies have shown that it is possible to reduce the impact of cultural studies on disease prevalence.

According to the authors, the individual experiences certain experiences at birth and expresses these experiences within cultural patterns. The individual's behavior is maintained in harmony with the cultural structure. Culture is related to many factors such as illness and health. Studies conducted in countries such as the UK and the USA show that factors such as ethnicity, race, social welfare level, immigration affect individuals' access to health services, and that members of minority groups are more likely to suffer from cancer, heart disease, diabetes, asthma and some other diseases (Srnivasalu, Selladurai et al.; 2022: 55). According to Aytaç and Kurtdaş (2015: 238), race and ethnicity increase the risk of developing some diseases. Cancer, HIV or heart diseases are more common in blacks. Blacks are also more at risk of kidney disease than whites. They also have less chance of kidney transplantation. Sociocultural patterns such as racism and xenophobia in the society cause groups such as foreigners, migrants and asylum-seekers to be exposed to more discrimination and to benefit less from health services. Due to low income, malnutrition and lack of access to medical facilities, these people cannot benefit equally from the health system (Cirhinlioğlu, 2012).

Conrad and Barker (2010: 69) have shown how different social meanings are constructed for certain diseases. For example, Sontag (1978) showed that cancer and cancer patients have negative connotations of evil and oppressive, while Barry, Bresscall et al. (2009) focused on the metaphor of “obesity as sin”. Some diseases are stigmatized, some are discussed while others are accepted without discussion. Diseases such as leprosy and HIV are also shown among stigmatized diseases. These stigmas also affect the roles of the individual in society, his/her social status and various behavioral patterns to which he/she belongs, and society may exclude these individuals. According to Srnivasalu, Selladurai et al. (2022: 60), cultural taboos in India prohibit people from speaking openly about certain diseases. The concept of karma is identified with illness and the subject is often treated in a mystical way. Talking about breast, cervix and prostate as a body part or being impressed by the accuracy of cancer is considered taboo language. Talking about the diseased parts of the body is also discouraged because they are sexual parts of the body. In many cases, patients are reluctant to talk about symptoms associated with family members because of the stigma associated with the disease. Treatment or services for stigmatized diseases are often problematic. In diseases such as epilepsy, HIV or obesity, service users are mistreated and ostracized. To avoid this stigma and mistreatment, patients consult doctors less often and are at greater risk of developing the disease (Conrad and Barker, 2010: 70).

It can be seen that illness cannot be addressed solely through a medical process or diagnoses based on certain symptoms. The social acceptance of illness, the roles of illness, the meaning of illness in society, the various forms of behavior expected by society during illness reveal the sociocultural aspects of illness. Like other phenomena, illness is constructed by society through social construction. While some illnesses are considered natural in society, others are stigmatized and excluded. At the same time, society expects sickness roles from the patient and frees him/her from social roles for a certain period of time. He is expected to recover quickly and return to his old social roles.

Conrad and Barker (2010: 70-71) also describe how medicine ignores some diseases. Unless a doctor makes a diagnosis, a disease is just a condition with certain symptoms. Symptoms are elevated to disease status by a doctor's diagnosis. But doctors are silent about chronic fatigue, fibromyalgia syndrome, irritable bowel syndrome, multiple chemical sensitivity, etc. These illnesses are medically suspect because they are not associated with any known physical abnormality. You have to fight to prove that you are sick. Doctors, the public and even the patient himself question the authenticity of the symptoms. In the case of controversial illnesses, doctors may believe that the illness is in the individual's head, and some health care providers are reluctant to cover such conditions. Hospitals tend to ignore such illnesses because they are considered expensive to diagnose and treat. People with such illnesses are rarely recognized as disabled and retired. Research institutions also allocate fewer resources to the treatment of these diseases, leaving them untreatable.

Srnivasalu, Selladurai et al. (2022: 56-57) show how the sensation of pain is influenced by culture. According to them, pain is not only a physiological response to tissue damage, but also involves emotional and behavioral responses based on an individual's previous experiences and pain accumulations. Chronic pain leads to serious physical consequences and psychological strain, affecting further disease progression. Pain, like the experience of illness, has consequences for the individual, such as the inability to fulfill certain social roles, withdrawal from social activities, and inability to care for family members. A person's pain sensation is a multidimensional process related to culture, emotion, mind and body. Pain sensation is also influenced by social conditions and cultural framework. The meaning of pain is also related to culture. Strategies for coping with pain also differ across cultural groups. The biocultural approach suggests that the experience of pain is fundamentally understood and controlled by social learning and social correlation processes that shape the impressions of people within a given culture. These processes influence people's impressions of and responses to physical signs and symptoms. Culture influences how people express pain, how they cope with pain and how they experience pain relief. The biocultural model hypothesizes that genealogical supports from family and community involvement can influence physiological and mental responses. According to the biocultural model, culture conveys powerful and diverse lessons about pain, and the meaning and resources attributed to pain vary from culture to culture. Tolerance to suffering varies greatly not only between individuals but also between groups. The meaning given to pain by hunters, warriors, Eskimos, romantic poets is different from that given to victims of sexual abuse. Pain lies at the intersection between biology and culture.

Another issue related to health is the increasing commercialization and medicalization of health. This leads to medical knowledge being detached from its context and falling under the influence of commodity capitalism, symbolic life practices and popular culture icons. Medical

knowledge is not only a knowledge that controls human life and directs it under the motto of "healthy life", but it has also become the center of a political technology that targets the human body. This new model built on healthy living, targeting the body, mediated by cosmetics, sports and medicine, tries to build a new healthy living context that is far from medicine. This new context is based on the ideals of the beauty industry rather than medicine. The fact that medicine has become an instrument of control, the control power of doctors over the human body, what is to be medicalized, where medicine begins and where interpretation and construction come into play have led to the attribution of a different meaning to medicine than before. Illich (2011: 37-38) calls this "iatrogenic medicine". Population is tried to be controlled by medicine. Medicine labels some people as "unfit" and produces new categories of disease. Medicine medicalizes life, making individuals constantly dependent on it. Saying that "Medicine always creates a patient" (İllich, 2011: 38), İllich states that medicine is gradually replacing the clergy, and that doctors have the privilege of determining who is sick and who is acting, just like the priest who determines who is a sinner and the judge who determines who is guilty.

With the commercialization of medicine and the concept of healthy living gaining a brand value, doctors have felt responsible not only for diseases but also for various areas such as daily life, nutrition, sports, dressing, coping with stress, and rest, and have started to dominate the whole of human life. From diet, to sports and breathing exercises, to yoga, to stress relief techniques, medicine has become controlling in many areas. Medicine tries to do this by rebuilding health. What is at stake here is not even medicine, but companies intertwined with medicine, the culture industry, and commercial capitalism that turns the body into a subject of service. The focus of all these is the human body. This new industry, which aims to perfect the human body and make it permanently young and attractive, has also taken medicine under its control, or medicine has gone beyond its field and started to medicalize life.

4. Body Construction and Social Control

Rene Descartes' Cartesian philosophy, which is based on the separation of body and soul, has led to the neglect of the body for a long time and to the centering of the soul, which is the basis of human existence. The control of the soul over the body has led to the body being pushed into the background. According to Howson and Inglis (2001: 299), a second reason for the neglect of the body in sociological studies was the focus of sociology on the rational actions of the subject who acted rationally. The debate about the over-rationalized subject and rational society caused the body to be relegated to the background.

One of those who showed an early interest in the subject of the body was Marcel Mouss. Mouss (1937-71-72), who focused on the subject in the context of "descriptive ethnography", stated how body techniques such as walking, running, and sitting varied according to different nations. N. Elias also focused on table and dining manners, the use of the body and its formalization, which began with the Middle Ages in his book" The History of Manners". The procedures that have been changed with the Renaissance have started to reach a certain standard with modern times (Elias, 2004).

Ideas such as poststructuralism, feminism and postmodernity have been effective in increasing sociological interest in the body. Feminism, which argues that gender is not a natural or biological phenomenon but a cultural construction, the concept of the "genderless body" (Deleuze, 1990) of poststructuralism, which tries to overcome the dualism between men and

women, and the criticisms of postmodernity's forms of control over the body have led to the body being placed at the center of the sociological perspective. According to Howson and Inglis (2001: 298), the British Sociological Association determined the theme of 1998 as "Making Sense of the Body". Thus, there has been a significant increase in the number of researches and articles on the body. The number of articles and studies on consumer culture, body and gender roles, boundaries related to the natural and social, illness, ethical problems, body and health has increased.

One of the sociological studies that deals with the subject of the body belongs to B. Turner. In his book "The Body and Society", Turner stated that in late modern societies, the body has become the center of political and cultural activity. According to him, somatic society is more concerned with the regulation of the body. It aims to regulate bodies through means such as population control, hygiene, and gender education (Turner, 1992: 12-13). According to him, in the past, the body was controlled by religion and law, but today it has begun to be replaced by medicine. As society became more secular, medicine became a moral arrangement, not a clinical one (Turner, 1992: 12-13). According to Turner, there are four basic controls that are central to the social order. These are the control of the population, that is, of reproduction. The second is medical surveillance and control of crime, which occurs with the regulation of the body. The third is restraint, which refers to incentives to control desire and passion in the interests of the inner self and social organization. The fourth is the representation of the body.

Another sociologist, Giddens (1991: 218), pointed out that modernity carries certain advantages and risks. According to Giddens, who focuses on the uncertainties and risks created by the modern era, the body used to depend on nature and was governed by natural processes dependent on human intervention. The body is becoming more and more invaded by abstract systems today. With the desire to control the body, health, diet, aesthetics, exercise, sports and even sexual life have started to be more controlled.

The interest shown by social sciences in the body has also led to an increase in research and studies on the relationship between the body and medicine. According to Nettleton (2021), different approaches to studying the body have emerged. The naturalistic approach has treated the body as a medical and biological phenomenon. Another approach that examines the body is the sociological approach. The sociological approach focuses on social institutions and the body and strategies aimed at controlling it. Our bodies are highly politicized. This has most often occurred when medicine has turned to strategies for controlling the body, especially the female body. For most sociologists, the body is socially structured beyond a physical or biological reality. Bodies are affected by social and cultural activities. Social constructivism, especially the phenomenological approach, also recognizes that the body is structured.

The fact that the body is a social and cultural construction means accepting that it is shaped by society and operates through processes such as social interaction and social control. Foucault is one of the thinkers who is interested in the subject of the body Foucault, who addressed the form of power he called biopolitical power, emphasized that modern power is not transcendent but immanent. According to him, power travels in the capillaries of humans and normalizes them. Modern power is a dynamic power that emerges in the context of social relations. Power controls information, separates and classifies people and disciplines them through hospitals, prisons, barracks and churches. Modern power is not oppressive, on the contrary, it is libertarian. It encourages speech, not silence. It controls the order of discourse,

determines relationships and pushes people to behave in a certain way. The aim of biopolitical power is to create docile bodies and control the population. It is to transform people into a modern working class and to monitor them without being seen. The tool that will provide this is a modern panopticon (Foucault, 1992-251).

In his book on sexuality, Foucault (2007:12) expressed how modern power has made sexual life, which is forbidden to be discussed, as part of power. The purpose of sexuality was reproduction with the Victorian Age. According to him, sexuality was only allowed in brothels and psychiatrist's chairs. One was a commercial institution and the other was a medical technique. The purpose of this was to minimize pleasures. Those other than acceptable pleasures were prohibited. Sexuality gradually became useful, that is, aimed at increasing the population. Sexuality or the human body now became a subject that also concerned the state. Sexuality was no longer something that was repressed, but something that needed to be said, expressed and classified. With the 19th century, prohibitions began to loosen, and law gave way to medicine. Sexuality was now the subject of medicine. Classifying perversions and excesses and determining the pathological reasons behind them was left to medicine. Psychiatrists began to take the place of priests.

The way modern medicine controls the human body by replacing the church and legal system has transformed medicine into a modern instrument of control. According to Foucault (2002), with the establishment of modern hospitals, medicine has gained a normative form that classifies human life, determines deviance, and separates the appropriate from the inappropriate. It has gained various normative privileges such as who is sick and who is locked up, who is punished and who is exempt from punishment, and even tracking and recording people, quarantining, and putting in mental hospitals. Medicine has become a part of normalization rather than health. Medicine and political technique have become intertwined. The purpose of hospitals is to keep healthy people away from patients and to protect patients. So much so that modern medicine aims to protect people more than themselves. According to Metin and Erdem (2019), medicine has become an institution that controls the social life of individuals rather than their health, in the backup of the healthy life industry. It has secured itself with the monopoly of specialization and the health economy, and has gained a power of control over people.

It is seen that the body, which has become one of the main subjects of sociological study with the modern era, is a medical subject. As mentioned in the section above, medicine's relations with the health industry, aesthetics, plastic surgery and cosmetics industry have caused it to emphasize a controllable human body that carries the motto of the ideal body rather than health. Modern medicine, which fetishizes healthy living, has become a means of social control in its own context by basing it on techniques such as sports, diet and yoga. In this way, doctors have come to intervene in every moment of human life. Weight control, looking fit, cosmetic and surgical interventions have made this process more complex. Body technologies have become increasingly sophisticated and more complicated. There are now a wide variety of medical technologies to shape, change and recreate our bodies. Such as gene therapy, cosmetic and plastic surgery.

This new form of modern medicine, which constantly monitors and intervenes, has become more possible with the development of communication technologies. According to Frank (1992: 82), with the postmodern period, the real body has disappeared and has been replaced by

screens. Now the real body is imperfect. At the heart of medical care is the image of the body. The image of the body is more accurate than the body itself. Doctors trust MRI, test results, X-rays and other signs of disease more than the patient and his body.

According to Okmeydan (2017: 47), the concept of panopticon mentioned by Foucault was inadequate, and the concept of “omnipticon” was produced instead. With the globalization of modern power, people began to enjoy being visible with the omnipticon, which replaced the unseen surveillance in the panopticon. In fact, with the help of cyber channels, people are now being pulled into cyberspace from where they sit and the lives of others are being monitored. This is called “synopticon”. With social media networks, people have become a part of voluntary surveillance and being followed. People watch and follow others from where they sit, and make their own social lives and bodies a part of this system. Here again, the focus is on the body. Thanks to social media networks where the perfect body image is put into circulation, people, especially young people, are be exposed to body pressure. Body pressure is the pressure caused by a person having a negative body image, dissatisfaction with their body, or feeling ashamed (Sæle, Sæther et al.; 2021: 3). The person's dissatisfaction with their own body, which affects their own body image, has emerged with the concept of the social body constructed by the media and medicine. Due to the media, social media and the accompanying medical control that tries to put everyone in a young, fit and perfect body, many people are dissatisfied with their own bodies and have to resort to the beauty industry, surgical techniques, sports and other cosmetic measures to overcome this. Behind all of this is the body image constructed and circulated by popular culture. It should be emphasized more that this is not medical, human bodies are not perfect, beauty is not based solely on body measurements, but is created through various programs such as filtering and rearranging.

5. Conclusion

Human lives in a world that is made meaningful by himself and his/her environment. Beyond physical and mechanical processes, the human being is a being that builds, interprets and develops. The same is true for positive cases. Illness is as much a social condition as it is a medical phenomenon. Illness is a social construct both in terms of the isolation of the individual from various social roles and in terms of the meaning given to the disease. For this reason, disease is the subject of not only medicine but also social sciences. Approaches such as symbolic interactionism, phenomenology, hermeneutics, and social constructionism focus on human consciousness and its world of meaning. These approaches are against the examination of phenomena such as disease, health, and the body with one-dimensional and purely mechanical processes. They examine the human being from a broader perspective.

The adaptation of social constructionism to phenomena such as illness, health and the body shows us that medicine must increasingly cooperate with social sciences today. In particular, in the context of investigating the causes of illnesses, etiology and preventive health services cannot be successful without understanding the sociocultural structure of society. At the same time, a sociological perspective on medicine will also allow us, as Feyeraband (1991) puts it, to socially control phenomena that are free from society and presented as an indisputable reality by an army of experts. Science, like all knowledge, must be open to social control and criticism.

As a result, medicine needs the support of the social sciences. Medicine is not only the absolute science of the mechanical workings of the universe offered by an army of experts, but also

deals with a socially constructed human body. For this reason, medical knowledge must also be open to criticism, it is necessary to distinguish where medicine begins and interpretation comes into play, and medical professionals must give up the desire to control life. Interdisciplinary and multidimensional approaches are needed.

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