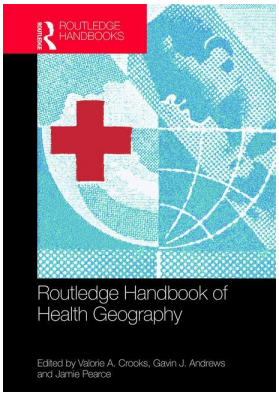

Routledge Handbook of Health Geography

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Publication details
https://www.routledgehandbooks.com/doi/10.4324/9781315104584-15
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Published online on: 11 Jun 2018

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SOCIAL CONSTRUCTIVISM (IN A SOCIALLY CONSTRUCTED HEALTH GEOGRAPHY?)

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> All knowledge is derived from looking at the world from some perspective or other, and is in the service of some interests rather than others.
>
> *(Burr, 2003, p. 6)*

According to the principles of constructivism, the world is structured on the basis of systems of representation or action. Human beings interact with both their surroundings (environment) and others (society). These systems constitute perspectives for understanding this interaction in human and social sciences. Constructivism, developed in the 1920s, refers to classical philosophical principles that question the everyday concepts of truth, knowledge and objectivity (Kant is frequently cited; see Krasnoff, 1999). Born at the emergence of critical thinking in human and social sciences, constructivism contributed to a broadening and enrichment of reflection in this field and, more recently, in health geography. At the same time, however, constructivism has met with much criticism and controversy.

This chapter is structured into three parts. The first part retraces the history of constructivist thought, whereby contributions made by those from diverse disciplines (mainly sociology, philosophy and psychology) are discussed in relation to the global evolution of research in health and medical sciences in general, and more specifically in the field of health geography. The limits and criticisms of constructivism are also presented. The second part examines the various mobilizations of constructivism in health-geography research – for example, studies on diseases, behaviors, individual and collective issues, health-care systems and their organization. Consideration is given to certain disciplinary and sub-disciplinary fields and to specific research approaches (e.g., mental health, gender studies). The third part comprises a discussion on the repercussions of this research on public action in the health sector.

The development of constructivist thought

Constructivist thought developed as a rejection of naturalism, which adheres to an immutable state of things that are governed by natural order or determinism (natural or divine). Constructivist thought represents a break from epistemologies common in human and social sciences, such as functionalism (actions are driven by a social function in response to a need) or structuralism (social reality is derived from fundamental structures that are often unconscious). Inspired in part by phenomenology (what we observe is inseparable from

the subject who becomes aware of it, this awareness having no value without the subject), constructivism refers to a philosophical posture for which all reality is conceivable only through categories of filters, the interpretation of perspectives and approaches, and systems of representation (Orain, 2014). In constructivist theory, reality is not what we observe; rather, it is an object constructed by science, norms and rules. In this sense, all reality is subjective in nature. In order to understand this reality, a social and normative construct, it is necessary to develop a scientific system of construction to study the structure of things hidden behind appearances, according to what Derrida (1992) called a deconstruction process. This process is subject to different understandings, which are presented hereafter.

Pierre Bourdieu (1987) wanted to go beyond structuralist theory by means of a constructivist structuralism, which stipulates that in the social world itself, objective structures are independent of the consciousness and will of the agents, capable of directing or constraining their practices or their representations. Thus, Bourdieu believes that individuals construct and reconstruct social reality from existing structures – in other words, that there are objective structures that individuals find in society and adopt depending on the leeway they allow themselves to deconstruct and appropriate them.

Two authors, Peter Berger and Thomas Luckmann (1967), apply a phenomenological constructivism perspective. In contrast to Bourdieu's approach, which uses social structures to specify the constructivist dimension of social reality, Berger and Luckmann favor an approach based on individuals and their interactions. This *phenomenological* approach seeks to understand the reality of everyday life based on the fact that the latter contains typification principles that determine the way in which social actors behave and interact. Thus, individuals exist in relation to their social position and to the representations they give rise to, on one hand, and those they make on the other. And this varies from place to place.

Constructivist theory leads us to think of space as a sum of realities constructed in relation to each other. Its tendency to question any universal truth (something can be true in one place, in one society, but false elsewhere) has resulted in much criticism being leveled at constructivism, including:

(1) Criticism with respect to relativism. Can everything be relativized? If all reality can vary depending on representations, perceptions and social and/or cultural constructions, then there is no truth, only representations. And in this case, relativism would take precedence over everything else

(2) Criticism with respect to solid scientific foundations. Constructivism is incompatible with evidence-based medicine, for example. "Whether or not a particular behavior or experience is viewed by members of a society as a sign or symptom of illness depends on cultural values, social norms and culturally shared rules of interpretation" (Mishler, 1982, p. 141). This assertion is in direct contradiction with the biomedical model, which is defined in reference to universalist criteria, rules and data. Making a diagnosis consequently becomes an interpretive act rather than a technical procedure. This leads to the fact that the diagnosis is no longer seen as a measure of deviation with respect to a biological norm, but more broadly as the action of attempting to understand the illness. This position supports criticism of the traditional biomedical model. It is also very present in certain medical fields (e.g., mental health). But this is not without a pitfall, namely the tendency to doubt everything and therefore the risk of challenging acquired knowledge (e.g., the current questioning of the need for vaccination by a significant percentage of the population).

In spite of these criticisms (or taking them into account), social constructivism has resulted in many developments in the area of (a critical) health geography.

Contributions and mobilizations in health geography

Hester Parr (2004), referring to Kearns and Moon (2002), noticed the growing place of cultural geographies in geographies of illness and impairment. This is accompanied by the questioning of outdated stereotypes of medicine and a claim for robust basic and applied research. This encourages geographers to further utilize existing theoretical resources on health and subjectivity (Parr evocates Foucault) to interpret new

public-health initiatives, with a particular focus on how aspects of social life are increasingly subject to the medical gaze. Moreover, Parr's point could be reversed, since an increasing number of medical issues are now analyzed with regard to their social determinants. Globally, constructivism plays an important role in the development of critical health geography through several notions, which are discussed hereafter.

Social and situational construction of illness

One of the contributions of constructivism is to consider the cultural meaning of illness, arguing that illnesses have both biomedical and experiential dimensions (Conrad and Barker, 2010). Negative representations associated with diseases such as HIV/AIDS, cancer or mental illness impact those afflicted and can limit their access to treatment or affect the way in which they live with the illness (e.g., impairing social relationships). Another issue is the contestation of certain illnesses, which can vary from one place to another. Attention-deficit/hyperactivity disorder (ADHD) is, for instance, a subject of controversy. The rate of people diagnosed with ADHD is higher in North America than in Europe (Conrad and Bergey, 2014), particularly in southern countries, although it is not clear whether this difference is related to the populations themselves or to the way in which the disorder is diagnosed. Cultural differences, such as perceptions of what constitutes normality, might explain why a hyperactive child is more generally considered normal in southern Europe than in the United States. Europe is also more reticent with respect to medicalization than the United States, and the place of medication in society is another form of social construction in the health sector.

Moreover, illness, disability or any incident affecting health can be seen as being socially and geographically constructed. Behaviors, everyday mobility and relationships can be modified by an illness or a change affecting the body. Fournand (2009), for example, has shown a change in how pregnant women relate to their environment and their different uses of urban amenities. Such a change varies depending on the cultural, social, political and economic context. The place of pregnant women in public spaces is subject to variations. For instance, Fournand points out that as soon as the pregnancy is announced, sport, nocturnal parties, and evening dinners at the restaurant are abandoned, for various reasons (not only medical). The public sphere of pregnant women gradually diminishes, becoming almost non-existent just before birth. On the other hand, when breastfeeding in a public space, a young mother creates around her body, and that of her child, a bubble of intimacy that blurs the boundaries between body and space (Mahon Daly and Andrews, 2002). The body can thus be considered as having a geographical dimension.

Approaches through the interactions of actors, organizations and authorities

Foucault is one of the authors in constructivism theory whose works have had considerable impact, notably through the concepts of biopower and biopolitics that he developed (1974). In the construction of his field of knowledge, Foucault, consciously or unconsciously, resorts to a constructivist hypothesis when attempting to read between the lines of the prevailing discourse of 17th- and 18th-century Western society on the subject of insanity and whether it was considered a disease and/or a social reality. Moreover, Foucault considers that the biological processes affecting populations need to be ruled by a regulatory or assurance authority that he calls *biopolitical*. This authority, depending on the representations, norms, meanings and values given to the illness, would be responsible for taking measures diversely oriented by these influences (such as the choice to lock the mentally ill away). Schematically, Foucault considers that the disease can be relegated within institutions (internment) or confined within the bodies that must be *monitored and punished* (to paraphrase the title of one of his works) when they deviate too much from the norm. From then on, society's control over individuals is accomplished not only through consciousness or ideology, but also in the body and with the body. For capitalist society, it is the biopolitical that matters more than everything else – the biological, the somatic, the corporeal. The body is a biopolitical reality; medicine is a biopolitical strategy.

Geographers have examined in different ways types of connection, variously captured by the terms "biopower," "biopolitics" and "biosociality." At-risk behaviors, for example, are possibly reinforced by one being ousted or living in spaces of relegation. Craddock (1999), cited in Atkinson et al. (2015), explores the co-production of race, place and pathology in relation to smallpox epidemics in 19th-century San Francisco, illustrating how a political anatomy of the Chinese body read disease and depravity into its fundamental structure and simultaneously stigmatized both Chinatown and Chinese bodies. Thompson, Pierce and Barnett (2007), on the basis of a study on smoking in New Zealand, have pointed out that the tendency (in the prevention campaign conducted by authorities) to stigmatize smokers results in already stigmatized environments and on deprived or stigmatized groups to produce either resistance (toward a change of behavior) or a sense of helplessness on the part of disadvantaged smokers. This illustrates the complex interactions involved in biopolitics as it relates to health in particular contexts. A general prevention message may then have counterproductive effects in particular places where it could appear as a constraint or a moral injunction emanating from a distant (bio)power. Fleuret and Tusseau (2010) provide another example in their study on HIV prevention in Mali. Prevention discourses, when seen as a direct translation of a white-occidental model, contribute to reinforcing the belief in a significant part of the population that HIV/AIDS is a disease invented by the *whites* to sell their drugs. This appears to be particularly true in the most deprived townships of Bamako.

The notion of gender is also an illustration of a socially constructed reality, and Simone de Beauvoir's famous words, "[o]ne is not born, but rather becomes, a woman" (1949, p. 13), are very frequently quoted in support of the idea that inequality between men and women is culturally constructed, not biological. As it is men who produce ideology and who are dominant, women are considered as their otherness. This anti-essentialist posture has resulted in the binary categorization of humanity (we are born male or female) and of social divisions based on behavior, social roles, norms and representations, which as a whole are encapsulated by the word *gender*. Gender, homosexuality and transgender themes are relatively recent in health geography and can be linked to the contributions of constructivist thought.

It is interesting to discuss the case of homosexuality here. Homosexuality was long regarded as a mental illness or degeneration, degeneracy and perverse behavior. Naturalist arguments are still mobilized today by reactionary movements (which speak of unnatural sexuality). The definitive withdrawal of homosexuality from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* dates from 1987, while its withdrawal from the World Health Organization's international classification of diseases is as recent as 1992. Examples of evolution in the social construction of diseases are numerous (i.e., mental illness was formerly seen as a sign of satanic possession or witchcraft; pregnant women were discouraged from driving for fear of harming the unborn child, etc.), but for the sake of conciseness, it is not possible to mention them all here.

A few words about the fuzzy repercussions of constructivist research on public action in the health sector

According to Loriol (2012), the social sciences often refer to the concept of *social constructions* without any real clarification or explanation of the notions that these constructions cover. This poses the problem of their operationalization in public action. For example, in the field of mental health in the workplace, excessive fatigue, stress and burnout are all issues whereby their definitions are not sufficiently precise or stable. Consequently, according to Loriol, much confrontation exists between the various actors in the field of psychosocial risks, each imposing their own understanding of a category, such as stress or fatigue, and each approach proposing a different definition, targets and methods. "The result of the actions and positions of actors who agree or disagree with each other is therefore variable: the putting on the agenda or scrapping of

a public issue, the emergence of a notion, the media coverage or lack of recognition of an illness" (Vézinat, 2013). This raises the question of methods and of certain difficulties in clarifying matters. Methods and concepts, such as grounded theory and interpretive models, have started to provide some answers. Qualitative methods have gradually begun to receive acceptance alongside quantitative methods; the latter nevertheless is still considered more objective.

Ultimately, does adopting a constructivist posture really result in calling the dominant biomedical model into question? Do we really arrive at oriented public action? The key issue raised by medical/health geographers, then, is the field's orientation to what might be meant by *the medical* (Atkinson et al., 2015). Despite claiming to challenge the dominance of *the medical* in medical humanities, does constructivism really contest the authority associated with *the medical*? For Atkinson et al., those claiming to speak from a *medical* position continue to claim an authority that remains unchallenged.

An example of this is the domination of the curative over the preventive in the health field; the former stemming from biomedical intervention on the human body, the latter from a set of actions that are every bit as concerned with the social body and environmental social determinants as with the biology of the body itself. The second is therefore much more complex to elaborate, to operationalize and to assess. For these reasons, in a context of tightened agendas, policy-makers (as well as researchers pushed by the need to publish) will tend to move toward the first.

Conclusion

Introducing relativism in social-sciences approaches of health and medical issues, constructivism can be seen as one of the pillars of critical health geography. To paraphrase Straus (1957), constructivism can be seen as a highlighting of differences and a form of competition between *in* and *of*. There is a geography in medicine, involved in medical questions in search of solutions (e.g., epidemiological), and a geography (and sociology) of medicine dealing with health, medical, healing and care issues as shedding light on the functioning of societies or on the organization of regions. A challenge for the future is to operate the junction between a geography seen as objective (evidence-based) and a complementary one seen as subjective, mixing their methodologies to enrich each other.

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