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The Body, Illness and Partial Disability

1. Introduction

The issues of this chapter, located on the border between sociology of the body and the sociology of illness, enable it to be called the sociosomatic study of illness. The subject of the analysis will be the impact of the changes occurring in the human body in the process of illness on the personal and social identity of the sick individual, and in presenting this subject the authors adopt an individual perspective, which means that the body-illness relationship is presented from the perspective of the subject experiencing the illness. The basic point of reference of the analysis will, therefore, be the body individually experienced, interpreted, and experienced by the sick or disabled individual. Phenomenology, which is the theoretical bond of the presented sociological theoretical positions and empirical research, treats the body as the basis of “living” experience and human agency. The issue of the living experience of the body, or the phenomenology of embodiment, will be presented and the body itself will be understood here as a physical object. The authors of the chapter wish to highlight the importance of the body as a phenomenon that deserves the attention of sociologists, while emphasizing that, according to the ontological vision of the body that is the basis of this study, the human body cannot be reduced to discourse.

2. The most important theoretical concepts

Selected theoretical concepts regarding the body in illness

The subject of this part of the chapter will be conceptualizations of the body that are used in the analyses and research on the body in illness and disability. Selected theoretical perspectives and views on the sick and disabled body developed in sociology, considered important by the authors, will be presented. The presented theoretical concepts combine two ways of analyzing the body in illness: an approach to the body treated as a biological phenomenon and, at the same time, an approach to the body as a “plastic” phenomenon, a product of society, created through the meanings assigned to it (the position of social constructivism).

2.1. Naturalistic visions of the body

Naturalistic concepts of the body define a strongly embodied way of analysis focusing on the biological, physical, and material body, which the sick individual experiences in illness and on which the experience of illness or disability is based. The subject's entire attention is directed to the body. Ill individuals attach importance to their bodies, but in purely physical categories related to the repair possibilities of medicine.

Maurice Merleau-Ponty's phenomenology of the limbless body

It is impossible to imagine the analysis of the body in illness without referring to the phenomenology of **Maurice Merleau-Ponty**, whose influence on the emergence of the sociology of the body is difficult to overestimate.

Phenomenology (Greek *phainómenon* – phenomenon, *lógos* – word, science) – one of the most important philosophical trends of the 20th century, the founders of which are considered to be Edmund Husserl and Max Scheller. The subject of phenomenology are phenomena understood as those which are revealed to the consciousness in direct cognition. The task of phenomenologists is to reach the pure essence of phenomena by viewing and describing human experience without previously accepted assumptions or beliefs. One of the leading representatives of phenomenology was Merleau-Ponty, who devoted significant parts in his works to describing the existence of the body. While criticizing the eternal dualism concerning the mind and body, he presented the body as a subject, emphasizing the importance of embodied cognition. According to Merleau-Ponty, the human body is a source of knowledge and experience.

The presence of Merleau-Ponty's concept in the theoretical part of this chapter is justified by the fact that the author devoted considerable space and attention to the imaginary limb syndrome, which became a background for him to explain to the reader of *Phenomenology of Perception* what the body was in general (Merleau-Ponty 2002). The phenomenon of feeling a non-existent limb was more than just an example for Merleau-Ponty. It was a kind of canvas on which the author dealt with a body crippled by a limb deficit, its habitual actions, expression of movement, motor behaviors, its use of objects and movement in space. Merleau-Ponty thus appears here as a theoretician of the sick, incomplete body, a body defined by incomplete efficiency. According to Merleau-Ponty, the imaginary limb syndrome could be fully explained using either physiological or psychological categories. Neither of these two types of explanations taken together could be considered sufficient. This was because the indicated ways of interpretation referred exclusively to the category of objective thinking, which caused one to "lose contact with perceptual experience, of which it is nevertheless the outcome and the natural sequel," (Merleau-Ponty 2002: 82). Objective thinking constitutes the body as an object, without being able to know it or discover what it is for the subject that is in it. Objective cognition does not take into account the relationship between the body and the world. However, the

body does not submit to objective treatment, it escapes it, which prompted Merleau-Ponty to reach for other ways of explaining the sensation of a non-existent limb in the body. What goes beyond objective categories is phenomenological thinking.

Let us first briefly present the problem of a body crippled by a limb deficit described by Merleau-Ponty as the phantom limb syndrome. Phantom experiences of sick individuals with limb deficits go far beyond phantom pain. The phantom arm or leg of a sick individual who has suffered an accidental or clinical amputation retains the features of its actual lost limb. The feeling of the presence of a non-existent limb means that the sick individual, despite being aware of the lack of the limb in their body, does not experience its loss. The most typical symptom occurring in phantom limb syndrome is the retention of the ability to move the phantom limbs (Kowal 2014: 91).

The phenomenological interpretation of the phantom limb phenomenon defines this experience as a silent negation of disability (Kowal 2014: 97). Based on the phenomenological perspective of “being in the world,” “what it is in us which refuses mutilation and disablement is an I committed to a certain physical and inter-human world, who continues to tend towards his world despite handicaps and amputations and who, to this extent, does not recognize them *de jure*,” (Merleau-Ponty 2002: 94). The sick individual, being rooted in a certain environment, is bodily intertwined with the world. One might say that their body is entangled in the world, immersed in it.

The body – according to Merleau-Ponty – “is the vehicle of being in the world, and having a body is, for a living creature, to be intervolved in a definite environment, to identify oneself with certain projects and be continually committed to them,” (Merleau-Ponty 2002: 94).

Having an imaginary limb means being open to action, to the complete world that surrounds the sick individual and that puts them in the same situation as before the loss of their limb. In this world, well known to the sick individual, there are objects that one with a limb deficit still perceives as useful, even though they can no longer manipulate it. According to phenomenological interpretations, it is precisely the bodily being in the world, or more precisely the openness of the incomplete body to the world and action in this world, that constitutes the essence of the mechanism of experiencing phantom sensations. The most important benefit of these is the “the guarantee of wholeness” (Merleau-Ponty 2002: 94), that is, experiencing one’s body as complete. The very awareness of the imaginary limb is defined by a certain ambiguity.

The phantom arm – as Merleau-Ponty claimed – is not a representation of the arm, but the ambivalent presence of an arm (Merleau-Ponty 2002: 94). The sick individual forgets that they do not have a hand, because they constantly rely on it. The author notes, however, that the imaginary hand “is not a recollection, it is a quasi-present,” (Merleau-Ponty 2002: 98). The individual uses a non-existent hand, rejecting the need to perceive their body, because “it is enough for him to have it

‘at his disposal’ as an undivided power, and to sense the phantom limb as vaguely involved in it,” (Merleau-Ponty 2002: 93).

The sick individual has stated that their arm is missing, which does not mean that they have lost it. They still keep it “on the horizon of his life,” which does not allow them to experience its loss. “The awareness of the amputated arm as present or of the disabled arm as absent is not of the kind: «I think that...»” (Merleau-Ponty 2002: 94). The sick individual feels the non-existent limb because they are unable to come to terms with its loss, which brings the experience of the phantom limb closer to the phenomenon of repression in their psychoanalytic understanding. “Time in its passage does not carry away with it these impossible projects; it does not close up on traumatic experience; the subject remains open to the same impossible future, if not in his explicit thoughts, at any rate in his actual being,” (Merleau-Ponty 2002: 95). Blocking at the level of action, in which the sick individual encounters a real obstacle in the form of the missing limb, implies a phantom hand, which is a “repressed experience, a former present which cannot decide to recede into the past,” (Merleau-Ponty 2002: 99). The ill individual’s situation is defined by a loop, being locked in one world, a state of impasse, in which it becomes impossible to undertake new projects.

The body, defined by incomplete ability undoubtedly requires a phenomenological explanation. It requires going beyond objective categories, because “the consciousness of the body invades the body, the soul spreads over all its parts, and behaviour overflows its central sector,” (Merleau-Ponty 2002: 87). According to the author of *Phenomenology of Perception*, the human body is an integral part of the subject, or the self. “But I am not in front of my body, I am in it, or rather I am it,” (Merleau-Ponty 2002: 173). The body, changed, because it is incomplete and not fully functional, is experienced as one that does not accept limitations and still wants to engage in previously performed activities. It still maintains the same type of focus on the world. It is not hindered in this by the lack of the limb, which it experiences as constantly present. It still wants to connect with objects in the space of its life. It is intertwined with the world, which is why, when it finds itself in a situation that requires the use of the limb, it adapts to it in a pre-reflective way. It does not cease in its efforts to use objects in the habitual way, despite their ineffectiveness.

“To be a body, is to be tied to a certain world [...]; our body is not primarily in space: it is of it” – Merleau-Ponty wrote (2002: 171).

In Merleau-Ponty’s analyses, the body appears as one that wants to maintain its integrity at all cost. It wants to continue to fit into a complete world, which is why it retreats into delusions and autistic experiences, on which it counts as much as on a real limb. This is a body that escapes from true reality because it exposes its deficits and weaknesses. The illusion of having a non-existent limb is created in the layer of “the habit-body,” which contains the possibility of performing specific functions, e.g., moving and gesturing. The second bodily layer is “the body at this

moment,” which, as a biological body, is subject to injuries, diseases, and limitations (Merleau-Ponty 2002: 95). Experiencing a non-existent limb means that the habitual gestures of using the hand or leg, although they are no longer anchored in the layer of the actual body, are still guaranteed in the habitual body. Habits are not located in the biological body, which is why the sick individual did not lose them with the amputated limb. The ill individual’s body, according to Merleau-Ponty, retains habits, which gives it “our power of dilating our being-in-the-world,” (Merleau-Ponty 2002: 166), but in many situations it loses the ability to connect with objects, which in the phenomenological interpretation are defined as “a bodily auxiliary, an extension of the bodily synthesis,” (Merleau-Ponty 2002: 176). In order for the imaginary limb syndrome to be extinguished, reflection is needed to use one’s own body in a different way and to adapt to the surrounding objects as those which will cease to be for the sick individual “thing manipulatable for me” and will become “thing manipulatable in itself,” (Merleau-Ponty 2002: 95).

Drew Leder’s dys-appearing body concept

Drew Leder, the author of the concept of the “dys-appearing body” (Leder 1990), can be successfully considered the heir to Merleau-Ponty’s “bodily being in the world.”

Dys-appearance is a term Leder used to describe the way in which “the body appears in explicit consciousness,” which accompanies its dysfunctions and pathological states (Leder 1990: 86). The prefix dys- in Greek means “bad,” “severe” or “sick.” The author used it to refer to the situation of the body’s “appearance” as a “thematic focus of attention,” which was a manifestation of the body’s emergence from a certain background (Leder 1990: 84).

“The corporeal field” is the place where the body remains as long as its state is considered correct, normal, and problem-free (Leder 1990: 24–25). Nevertheless, when the state of our body is defined by some dysfunction, and, therefore, ceases to be considered normal, we disappear from the social world and enter the world of our biological body.

Leder included the theory of the “dys-appearing body” in his most important work entitled *The Absent Body* (1990), which can be described as a phenomenological study of the lived experience of the body. The author’s fundamental question recurs many times throughout the pages of this publication: “why, if human experience is rooted in the bodily, is the body so often absent from experience?” (Leder 1990: 69).

The body in Leder’s conception is a self-withdrawing body. In everyday life, the body recedes into the background, which is the condition that enables us to act purposefully and rationally. In the context of withdrawal from experience, Leder writes about “the ecstatic-recessive awayness of the body,” (Leder 1990: 70).

Describing the ways in which the body disappears, Leder believed that they were “essential to the body’s functioning.” According to the author, the “self-effacing” of the body was a necessity (Leder 1990: 69). The disappearance of the body or “being away” from the body was inherent to the normal and healthy functioning of the body, and, therefore, “forgetting about or «freeing oneself» from the body takes on a positive valuation,” (Leder 1990: 69). In this absence of the body or a certain distance from it, however, there is a hidden “the possibility of its neglect or deprecation,” (Leder 1990: 69). If this possibility is realized, we begin to experience the body as something “problematic” and “disharmonious;” the body reveals itself to us as the “Other,” opposed to the self (Leder 1990: 70). Leder wrote: “It is precisely because the normal and healthy body largely disappears that direct experience of the body is skewed toward times of dysfunction,” (Leder 1990: 86). Following Leder, we would like to draw attention to the antonymy and homonymy of the terms dys-appearance and disappearance, which as two modes of the functioning of the body, are in a deep relationship with each other (Leder 1990: 86).

Leder, who had a medical education, cited pain as the most obvious bodily dysfunction, which in his concept is an example of the body’s “dys-appearance.” The appearance of physical pain causes us to redirect all our previously undivided attention focused on a specific task to our own body. The painful body comes to the forefront, somehow diverting our attention from the tasks that were important to us and in which we were engaged at the time of the appearance of the persistent pain. All our previous projects disappear, becoming irrelevant, giving way to the experience of pain, “in an experiential sense, is already something far away,” (Leder 1990: 71). We start looking for the causes of pain in the body, and then for ways to deal with it. In *The Absent Body* we read about internal organs functioning in the body in a hidden way, “without the knowledge or control of the conscious self,” (Leder 1990: 86). They do not occupy our attention on a daily basis, they seem to be silent. Although they are very important to us because they maintain our vital functions, they remain “absent.” We are not aware of them, just as we are not aware of the physiological processes taking place in our bodies. Leder called this “depth disappearance” (Leder 1990: 53–57). Conversely, if the functioning of internal organs is in some way disturbed, we experience it as their rebellion, we lose control over them. The discomfort we experience means that the internal organs are beginning to make themselves known, to speak up, to demand action (Leder 1990: 71). We experience pain as a sensation that is located in the body (Leder 1990: 75). Pain is “sensation is one of the most intense we experience,” Leder wrote. It manifests itself through “sensory intensification” and usually appears suddenly. Unlike well-being, it is often episodic in nature, changes its intensity, and is temporary (Leder 1990: 72). Pain captures our attention in a way that no other stimulus can, which makes the experience of pain qualitatively different from other experiences related to the body. There is no volitional element here, after all. Pain contains compulsion (Leder 1990: 73).

In presenting the phenomenological meaning of pain, Leder wrote that pain “is ultimately a manner of being-in-the-world. As such, pain reorganizes our lived

space and time, our relations with others and with ourselves,” (Leder 1990: 73). Pain makes our being in the world cease to be dispersed, and we begin to be “here.” All attention is drawn to our own body, and within it to that particular part that is the source of painful sensations (Leder 1990: 75). “We are ceaselessly reminded of the here-and-now body.” It moves us from the painless past to the present (Leder 1990: 76). Pain in a compulsory way “reorganizing the experiential field inward,” (Leder 1990: 73). According to Leder, pain “is marked by an interiority that another cannot share,” (Leder 1990: 74).

Physical suffering not only limits the space-time sphere of an individual, but also their movement possibilities are narrowed due to the disability caused by pain (Leder 1990: 75). Pain causes “a certain alienation;” in Leder’s concept it appears as something that threatens our identity because it destroys our routine activities and disrupts the goals that define our identity (Leder 1990: 76). Thus, pain establishes a new relationship to one’s own body. “The sensory insistence of pain draws the corporeal out of self-concealment,” (Leder 1990: 76). But this aching body reveals itself to us as something alien.

Writing about the alien presence of the painful body, Leder described the split between the body and self, which, caused by pain, was also an adaptive response to pain. Experiencing the body as separate from the self “yields some relief,” “reestablishes one’s integrity,” (Leder 1990: 77).

The process of distancing oneself from the body concerns situations of chronic pain that cannot be eliminated. Nevertheless, the removal of pain becomes the overriding goal for the individual (Leder 1990: 79). “When in pain, the body becomes the object of an ongoing interpretive quest,” Leder wrote in *The Absent Body* (Leder 1990: 78). This area of the body that is the source of pain is subjected to analysis. The body begins to be diagnosed in all kinds of ways; it becomes the object of perception and action. In order to deal with it, acts of will are necessary here (Leder 1990: 73). All actions taken by the individual focus on finding ways to cope with pain. “The aversiveness of pain does call for change,” as the author of the concept claimed (Leder 1990: 78). In this case, it is not about acting “from the body” but “toward the body” (Leder 1990: 79).

Pain is a prelude to illness. It is often its harbinger, a signal of a sick body. Illness is the second manifestation of the “dys-appearance” of the body discussed by Leder in *The Absent Body*. The body in illness becomes visible, imposes itself on the attention of its owner. It is present. It emerges from “the corporeal field” with twice the force and, as a body experienced in its pathological dimension, becomes a forced object of interest. The analysis of illness in Leder’s concept of the “dys-appearing body” is, in fact, a deepening and expansion of the threads that the author raised when discussing the issue of pain. Pain is, after all, “a common accompaniment of disease to the point where the distinction between the two blur,” (Leder 1990: 79). In order

to avoid redundancy in the threads and analyses presented above, we will focus only on those issues that, as a consequence of qualitative differences in the experience of pain and illness, require indispensable explanations and supplements.

As for the term “disease” itself (dis-ease), Leder defined it as “the experienced loss of comfort and possibility that often accompanies physiological disruption,” (Leder 1990: 80). Disease, in comparison to pain, is characterized by “complex patterns of dysfunction,” (Leder 1990: 81).

The experience of the sick body as foreign consists of: (1) the perception of changes in the body’s interior, and (2) the perception of changes in the body’s external appearance – “as it is an object of pity or disgust,” (Leder 1990: 82).

In illness, we become more aware not only of our internal but also of our external body. The principle of the “dys-appearance of the body” in illness is bidirectional, “dysfunction and body awareness engendering one another.” Body awareness in illness causes us to seek help in order to recover, i.e., to restore the body to normal and problem-free functioning, but the same awareness of the sick body can also, through stress and constant anxiety, deepen the body’s problems and accelerate the development of the illness (Leder 1990: 85). Leder devoted much attention to the issue of dys-appearance in the course of illnesses that changed the appearance of the body and thus stigmatized it. In this situation, the troublesome body emerges from “the corporeal field,” and the more its outside appears as problematic and deviates from what is considered the bodily norm in society, the more severe and extreme measures will be taken to make the body disappear back into “the corporeal field.” Leder cited eating disorders in young girls as an example of such a situation (Leder 1990: 99). In trying to return one’s dysfunctional body to the status of an absent body, the individual may further deepen this dysfunction, causing a disease state.

The illness severs the connection with the world, which until then was well-known, and begins to reveal itself as “inaccessible” (Leder 1990: 81). The alienation experienced by a hospitalized ill individual results from the fact that the sick individual is torn away from the important context of work, home, friends, family, and even the people caring for the ill individual cannot fully understand the sick individual’s experiences and experience what he is going through (Leder 1990: 80). Space and time are narrowed to the sick body (Leder 1990: 79). The illness questions “this experience of world-as-opportunity,” (Leder 1990: 81). Lack of energy, exhaustion, and general limitations mean that the ill individual increasingly experiences the inability to engage in the world and things that surround them as in the reality before the illness. “One is simply un-able. In disease, one is actively dis-abled,” (Leder 1990: 81).

While a healthy body is “transparent” because its capabilities are clear, a sick body, or one that is “vague” by some dysfunction, becomes unpredictable, eludes our

control, as Leder said: “we become aware of it as alien presence,” (Leder 1990: 82). “As the sensation of pain is the harbinger of illness, and as illness foretells the coming of death, so the alien presence of the body expands until it can threaten the entirety of one’s world,” (Leder 1990: 83). Especially in life-threatening illnesses, dys-appearance means that the body is experienced as distant, separated from the self, because it is completely disobedient to the will of the “self.” The author used the terms “painful prison” and “tomb” to describe it (Leder 1990: 87).

Leder devoted the most space in his concept to the situation when the illness would limit us physically. The sick individual is “aware of the body in everything he cannot do;” the body’s functions have been “undermined” by the illness (Leder 1990: 82–83). The sick individual’s projects are now conditioned – “if health permits,” (Leder 1990: 83). They lose the habitual abilities belonging to the layer of the habitual body, including cooperation with objects, which, being their tools, appear in Leder’s concept as structures incorporated into the body, because they “participates in the same phenomenological structure,” (Leder 1990: 83). The sick individual longs for the lost possibilities of the body, has hopes that they will return someday, while, at the same time, experiencing fears of the deepening disability in the body. The disruption of the sick body’s relationship with the world leads to increased reflection on one’s own body and gives rise to the need for repair (Leder 1990: 86). The focus on the sick body and its functions consists in noting even the slightest changes in its motor skills and the meticulous analyses of practices undertaken towards the body in terms of their healing/harmful effects on the body. Actions aimed at repairing the sick body draw the sick individual’s attention even more inwards (Leder 1990: 81). The experience of the sick body is also affected by the distrust with which the ill individual looks at it. This distrust towards the sick body or a part of it that has let the ill individual down, may persist even after the sick individual has returned to health. The sick body does not want the attention of others either. This unwanted and troublesome, because intrusive, attention from people is something that forces the individual to implement appropriate work on the body in order to restore it to its normal state of “presence-absence” (Leder 1990: 20–27). The main drive and interest of the sick body in Leder’s concept is its return to “the corporeal field.” If this proves impossible, the developing illness brings us closer to death. Leder defined dying itself as “a physical event belonging to a bodily history I never fully intend.” In the face of death, the body treated as “a ground of vitality” is often clearly thematized (Leder 1990: 83). The symptom of approaching death becomes the deepening “unuseable” of the body. After death, the body transforms into a corpse phenomenologically understood as “the very essence of the unusable,” (Leder 1990: 84).

Stefan Timmermans and Steven Haas's appeal to sociologists to build a bodily-anchored sociology of illness

Since the experience of illness is directly mediated by the body, we consider the best summary of the naturalistic visions of the body to be the appeal to sociologists dealing with illness, which was issued by Stefan Timmermans and Steven Haas in the journal *Sociology of Health and Illness* (2008: 659–676). These two American sociologists formulated postulates for medical sociologists to refer more often to biomedical knowledge and categories.

The authors consider the first oversight of sociologists to be “refusal to grant ontological status to diseases as clinical entities,” (Timmermans, Haas 2008: 662). The reluctance of sociologists to deal with the biological aspects of illness and “ignoring the «technical» or «biological» aspects of health care,” according to Timmermans and Haas “results in gaping analytical holes,” (Timmermans, Haas 2008: 662).

Based on the study of the literature in the area of the sociology of health and illness, the authors have indicated the main tendencies of research involvement of medical sociologists in illness: (1) sociologists, when dealing with illness, do not deal with a specific disease entity in the biological dimension, but primarily focus on interactions, organizations, professions, discourses, and social control; (2) sociologists study illnesses outside the clinical context; (3) sociologists tend to formulate unjustified generalizations from the conclusions of the study of a specific disorder presented as those that apply to a wide range of illnesses; and (4) sociologists have limited knowledge of the biological determinants of illness (Timmermans, Haas 2008: 663). Writing about “sociological blinders” (Timmermans, Haas 2008: 662), the authors referred to a publication authored in the mid-1990s by Monica J. Casper and Marc Berg (1995: 395–407). The above-mentioned authors defined a social researcher as one who “stood with his or her back to the heart of medicine and studied the “social phenomena” surrounding it,” (in: Timmermans, Haas 2008: 662).

The “heart of medicine” ignored by sociologists for several decades consists of three key aspects. First, social scientists rarely establish a specific illness as the object of their research, and instead study the determinants of health at an abstract conceptual level. Second, social scientists rarely include clinical indicators of illness in their research and subsequent analyses. Third, social scientists tend to ignore the “normative purpose of health interventions,” (Timmermans, Haas 2008: 662).

The “heart of medicine” understood in this way, in the opinion of the authors of this chapter, focuses on the body in its physical dimension, together with the physical criteria of illness, such as diagnosis, symptoms, changes in the body, and changes in physiology. Conversely, the body is the most important for the sick individual as the subject of medical interventions. Once in hospital, the ill individual faces a specific disease entity, which is located in their body. To sum up, Timmermans and Haas have claimed that the sociology of medicine focuses too much on the

non-biological aspects of disease and illness, which means that sociologists dealing with illness ignore the body.

The omission of the biological dimension of illness in sociological analyses results in the social processes described by medical sociologists being “clinically unanchored” (Timmermans, Haas 2008: 659). As a result, we do not learn how the social processes studied by sociologists actually affect health. “We may know much about the effects of chronic illness on identity but fail to establish the health consequences of this identity formation,” (Timmermans, Haas 2008: 662).

The implementation of Timmermans and Haas’ postulates should ultimately lead to a rapprochement of the worlds of medical sociology and medicine through greater reception of the research results of sociologists of illness in the practice of physicians who have been skeptical of them so far. Biology must cease to be an “invisible canvas for social action,” (Timmermans, Haas 2008: 665), because biology and sociology remain intertwined. Instead of being accused of “biophobia” (Ellis 1996; Freese, Li, Wade 2003), sociologists should open up to conducting research in the trend known as the sociology of disease, which in the precise meaning of the term means “sociology of biodisease” (Skrzypek 2011: 66).

Sociologists of “biodisease” would be interested in “the dialectic interaction between social life and specific diseases, aiming to broadly examine whether and how social life matters for morbidity and mortality and vice versa.” In particular, they should focus on examining “how social processes affect the severity or course of diseases and how, in turn, specific stages of disease affect social relationships, work, neighbourhood, or family life,” (Timmermans, Haas 2008: 661). Nonetheless, this first would require sociologists to get rid of “the deeply held concern that a strong recognition of the role of biological and genetic factors in health implies the automatic devaluation of social factors,” (Timmermans, Haas 2008: 663).

The next important theoretical postulates of Timmermans and Haas focus on the need to take into account the physiological diversity of illnesses and to treat the specificity of an illness seriously (Timmermans, Haas 2008: 664), while in the study of illnesses sociologists should apply an approach focused on a specific illness (e.g., asthma, diabetes) and consciously refrain from building a sociology of chronic illnesses (Timmermans, Haas 2008: 665). In addition to theoretical postulates, Timmermans and Haas have also presented methodological proposals concerning the inclusion of clinical criteria for inclusion in research in the field of the sociology of the experience of illness, indicating diagnosis as their starting point (Timmermans, Haas 2008: 663). If sociologists of “biodisease” are to study illness as a clinical entity, it is essential to include in their research such medical indicators and parameters as clinically significant endpoints such as survival, how a given illness is contracted, or the occurrence of a specific clinical symptom. Their inclusion in sociological analysis will enable sociologists to answer the question of the “clinical efficacy of social processes,” (Timmermans, Haas 2008: 665).

We treat the postulates of Timmermans and Haas as an appeal for the presence of the body and corporeality in sociology, for taking into account the somatic

orientation in sociological research together with the biological interpretive framework. In fact, it turns out to be an appeal for close partner relations between sociology and medicine. And for the latter, the human body is an object of special interest and direct influence. It is in the body that clinical symptoms of illness manifest themselves, and the body is the target of the therapeutic actions of medical professionals. The need to rethink the relations between sociology and biological sciences was also pointed out by Michael Bury, to whom the authors of the appeal in question referred, who postulated expanding the research field of medical sociology to include the body and studying the biological dimension of experience, while rejecting the critical and sometimes even hostile attitudes of sociologists towards biology and biomedicine (Bury 1997: 199–200). Moving away from the sociology of illness in favor of sociology of disease does not mean any form of determinism. In the postulates of Timmermans and Haas focused on perceiving the biological body, the body still remains a physical component of the subject.

2.2. Constructivist approaches to the body

Constructivists who treat the body as a socio-cultural phenomenon have analyzed the way in which changes in the human body caused by illness determine disruptions in the continuity of the sick individual's identity. A body that is changed by illness is subject to a social assignment of meanings. The category of work or work in illness, strongly accepted by constructivists, also includes work on the body in the process of illness, which is to prevent the body from completely refusing to obey the person. In order to thwart its disintegration, it is necessary to exert greater control and supervision over it.

Kathy Charmaz's concept of adaptation to the somatic consequences of chronic illness

Kathy Charmaz is the author of the concept of adaptation to life with a chronic illness, which is one of the ways of living with an impairment or loss of bodily functions as the somatic effects of a disease (Charmaz 1995: 657–680).

“Serious chronic illness undermines the unity between body and self and forces identity changes.” Adaptation itself means for the sick individual “altering life and self to accommodate to bodily losses and limits and resolving the lost unity between body and self,” (Charmaz 1995: 657).

Adaptation, which turns into acceptance, cannot, however, occur without recognizing one's impairment, openly admitting to the bodily loss suffered. What forces this adaptation is the limitations of the body, which, as the illness progresses, mean the loss of further bodily functions. Thus, “ill people adapt when they try to accommodate and flow with the experience of illness,” (Charmaz 1995: 657). This often happens after many years of ignoring or minimizing the illness, sometimes

fighting it, although it also happens that adaptation to an impairment and bodily loss never occurs (Charmaz 1995: 657–658).

Outlining the theoretical framework for the research that constitutes the empirical basis of the discussed concept, Charmaz clearly articulated that she agreed with Sally Gadow's (1982) thesis about the inextricable connection between the body and the self. "Mind and consciousness depend upon being in a body. In turn, bodily feelings affect mind and consciousness." The body and the self, although inseparable, are not identical (Charmaz 1995: 659).

According to Charmaz's theoretical setting in the interactionist trend, adaptation to the loss of body function is processual and is characterized by the occurrence of three stages.

The first stage of adaptation to bodily losses caused by chronic illness consists in experiencing and defining the impairment. In the second stage, the sick individual evaluates the body, and then makes identity compromises, which are the result of a balance of gains and losses and a revision of identity goals. The third stage is submission to "the sick self," while, at the same time, relinquishing control over the illness, which, in consequence, leads to immersion in the experience of the illness (Charmaz 1995: 657).

Below we will describe each stage of adaptation to the loss of body function that has been changed by chronic illness.

The meaning of the first stage of the process of adapting to impairment is the experience of a changed body, as a result of which the impairment of the body is defined and the scope of the loss of bodily functions is determined. Charmaz wrote that "experiencing an altered body means more than having or acquiring one," (Charmaz 1995: 662). Ill individuals notice certain physical changes in their bodies and that some bodily functions have been weakened. Defining these changes means that the ill individual recognizes his illness as real and begins to consider its impact on everyday life (Charmaz 1995: 662). Chronic illness attacks the body, which makes it changed and problematic.

"The relation between body and self becomes particularly problematic for those chronically ill people who realize that they have suffered lasting bodily losses," Charmaz wrote (1995: 659). "The unity of prior embodied experience has been shaken," as indicated by comparisons of the body changed by an illness to the body before it (Charmaz 1995: 662). A sense of alienation creeps into the experience of one's own body in illness, which gives rise to the need for "rethinking explicitly their previously held notions of body and self," (Charmaz 1995: 662). The experience of losing the "past" body as an "invincible," "indestructible," and "immortal" body intensifies the sense of alienation of the body, separation from the body, in addition to the loss of oneself, and also intensifies feelings of anger and grief (Charmaz 1995: 662).

The experience of bodily losses is more painful in individuals who were in good physical condition before the illness. The loss of control over the body is experienced

as a “betrayal” of the body (Charmaz 1995: 662). It happens that at this stage, ill individuals feel guilty and ashamed because of their body’s ailments, which do not meet the cultural standards of a perfect and beautiful body (Charmaz 1995: 663). The strategy of coping with the anxiety that appears in connection with the changes taking place in the body and person of the ill individual is to separate the body, and, therefore, the illness, from oneself and one’s life (Charmaz 1995: 663).

In an attempt to take control over the body and the illness, which is perceived as an “enemy or oppressor,” the ill individual begins to fight it (Charmaz 1995: 663; see more broadly Charmaz 1980, 1994b). Treating the body as an “object to mend,” ill individuals fight for the body affected by the illness to function normally, to make “their lives «normal» to whatever extent possible,” (Charmaz 1995: 663).

At this stage, chronically ill individuals are not yet able to accept the limitations related to the illness and the identity of an ill individual, because they still hope to return to the identity they had before the illness. Ill individuals still distance themselves from their changed body and objectify it (Charmaz 1995: 663). A manifestation of objectifying the body is judging the body and blaming it for the illness, which prevents them from drawing strength from their own body (Charmaz 1995: 664). Charmaz claimed that ill individuals objectified their own bodies to a lesser extent than disabled individuals, being more open to the body itself and the signals it sent. This allowed them to maintain greater control over their lives and the illness (Charmaz 1995: 664). What stops them distancing themselves from the body is “the horror of the unknown,” which in the discussed context means disability and death. Distance from the ill body lasts as long as the ill individual recognizes that “mastering his or her body is necessary to make it acceptable,” (Charmaz 1995: 664). Abandoning such an attitude enables the ill individual to open up to bodily experiences, which is tantamount to recognizing one’s own body as a subject. For this to happen, the ill individual must also stop comparing their body to the body from before the illness in terms of its capabilities and skills. This measure must be abandoned, as must the hope that the body will still be as capable and strong as it once was. As Charmaz wrote, referring to her earlier works, “chronically ill people who move beyond loss and transcend stigmatizing negative labels define themselves as much more than their bodies and as much more than an illness,” (Charmaz 1991, after: Charmaz 1995: 660).

The second stage of adaptation to an impairment caused by a chronic illness involves the ill individual’s assessment of the changed body, which is expected to result in a change of future identity (Charmaz 1995: 659).

The appearance of the body in the course of an illness is important from the point of view of assessing the changed body. A visible and manifesting illness or disability in the body can give the individual a stigmatizing identity that begins to dominate other identities (Charmaz 1995: 660).

Ill individuals with a disability manifested in their bodies try to control the visible bodily loss to the extent necessary to limit its impact on their own goals, aspirations, and relationships with people. They protect their own identity and social identity through procedures that camouflage their bodily deficits (Charmaz 1995: 667). It also happens, though, that chronically ill individuals do not have visible symptoms and disabilities. A masked or “invisible illness” not only undermines the credibility of the ill individual with medical professionals, but also causes misunderstanding among family members who deny their identity as an ill individual. As long as the ill individual masks the symptoms of their illness, their personal and social identity will remain in conflict. As long as the bodily loss is not visible, the ill individual may also be unaware of the impairment of their body functions. In this situation – according to Charmaz – there is an obvious “tension between invisible disability and visible impairment,” (Charmaz 1995: 666).

“Bodily changes prompt changing identity goals,” claimed the author of the discussed concept (Charmaz 1995: 668). As they experience subsequent bodily losses, chronically ill individuals are forced to lower their identity goals until they correspond to both the current limitations and capabilities of the body (Charmaz 1995: 659–660).

Charmaz defined identity goals as “preferred identities” that individuals desire and hope or assume to achieve (Charmaz 1987, after: Charmaz 1995: 659). The formulation of identity goals by ill individuals serves to reconstruct normal life, to rebuild normality in their life with an illness to the greatest extent possible (Charmaz 1995: 660; see also Charmaz 1987, 1991). Identity compromises, defined as choosing one identity over another, are made by testing the body and verifying its possibilities. “Preferred identities” weaken in the course of the illness process (Charmaz 1995: 660). Charmaz also noted that ill individuals’ preferences regarding identity could be completely unattainable. Thus, ill individuals may plan to return to life without the illness, to regain their fully capable or unimpaired “self.” It also happens that the assumed identity goals are higher than those in reality before the illness or that ill individuals strive for contradictory identities. Successes in being ill, understood as an improvement in health, the remission of some symptoms or the restoration of abilities, mean that the identity goals will be raised (Charmaz 1995: 658, 660). Raised and lowered identity goals create an “implicit identity hierarchy,” (Charmaz 1995: 660; Charmaz 1987). Charmaz has noted, however, that the pace of changes in identity goals depends on what is happening in the sphere of the ill individual’s emotions and social relations (Charmaz 1995: 668). Changing identity goals is about crossing the boundaries of one’s own body. The identity goals developed and fulfilled by the ill individual at this stage, related to work and family responsibilities, must be perceived by the ill individual as more important than the illness. Conversely, when developing identity goals unrelated to the illness, the ill individual cannot forget about the body and its needs, because in this way they risk losing this already developed non-disease or extracorporeal identity. Changing identity goals imposes on the individual the obligation to constantly work on the body, take care of it and monitor it (Charmaz 1995: 669).

“But keeping bodily needs and identity goals in balance can prove to be arduous,” (Charmaz 1995: 669). Identity compromises are inevitable here, in which “the tension becomes apparent between acknowledging bodily limits and needs and constructing a preferred identity,” (Charmaz 1995: 671) is revealed. By redefining personal identity, ill individuals begin to see themselves as “residing in their bodies” but no longer feeling completely defined by them. This means that they have managed to avoid “illness without having it consume their self-concepts,” (Charmaz 1995: 671).

Summing up her work on the identity goals and choices of individuals with chronic illnesses, Charmaz wrote: “In essence then, people can move up their identity hierarchy while their move down their bodily hierarchy,” (Charmaz 1995: 671).

The content of the third stage of adaptation to impairment in Charmaz’s concept is the cessation of the desire to control the illness and opening up to the experience of the illness, which is equivalent to the unity of the body and the self. This subjective integration of the body with the self, which is determined by the cessation of the fight with the body and objectification of it, enables the recovery of a sense of the whole body, oneself and one’s life (Charmaz 1995: 659).

The third stage of adaptation to bodily losses caused by chronic illness was called by Charmaz the “surrendering to the sick body,” which means being aware of one’s ill body and its limitations, but also wanting to live with such a body (Charmaz 1995: 672–674). An ill individual “anchors bodily feelings in self,” does not ignore these feelings, does not overlook them, and does not deny them, because they do not perceive “the ill body as apart from self,” (Charmaz 1995: 672). The ill individual begins to “live with the body,” becomes familiar with it, and subjugates it (Charmaz 1995: 664).

Submission to the sick body is different from being defeated by illness or from coming to terms with illness, because these experiences consist in being taken over by an illness, which happens without one’s choice. Submission to an illness is a deliberate process in which the ill individual plays an active role (Charmaz 1995: 672). Submission to an ill body is also something different from resignation and loss of hope. Resignation means passive submission to an illness, “accepting defeat after struggling against illness,” as a result of which the ill individual gives up preferred identities (Charmaz 1995: 673). Resignation is accompanied by submission to fear, despair, depression, and internal breakdown. Resignation means that the illness has completely taken over the individual and their life (Charmaz 1995: 673). By contrast, submission to an ill body means “permitting oneself to let go rather than being overtaken by illness and despair,” (Charmaz 1995: 673). Submission to an ill body should be understood as the acceptance of oneself in the illness and of who one becomes in it. Submission to an illness is the very opposite of fighting it, of controlling it by imposing one’s own order on it, or of forcing victory. Submission to an ill body requires first learning how not to fight the illness; it requires getting rid of fantasies of recovery and dreams of life before the illness. Submission to an

illness means being in the body now, in the present moment, without fantasizing about the future (Charmaz 1995: 873). It is a full opening to the experience of the body with all its unforeseen events, to new ways of experiencing one's own body, to the authenticity of this experience, that is, to the recognition that the ill body is part of the ill individual.

Submission to an ill body means "allowing themselves to experience it [the body – note by K.K., M.S.]" (Charmaz 1995: 672). Submission to an ill body should be understood as a new perspective on oneself, in which external social commands disappear and the voice from within is heard. Submission to an ill body consists in listening to "what it needs to tell me" in observing it, but not in terms of control, but of "what it has to teach me," (Charmaz 1995: 674). When an ill individual submits to an ill body, "the illness merges with subjectivity; it becomes subjectivity," (Charmaz 1995: 673). "When surrender is complete," Charmaz wrote, "the person experiences a new unity between body and self," (Charmaz 1995: 672).

To sum up the process of adaptation to the impairment of the body in chronic disease, it is worth indicating, following Charmaz, what kind of tensions occur during the stages described above. Of course, the main opposition here is that which arises between "the self and the body." The next ones are: "struggle versus surrender; the idealized body versus the real, experienced body, social identification versus self-definitions; objective reality versus subjective experience; struggling with versus struggling against illness, invisible disability versus obvious impairment, freedom of bodily movement versus physical constraint and dependence, and bodily control versus loss of function," (Charmaz 1995: 658–659).

"Successful adaptation" to the impairment caused by chronic illness, resulting from the elimination of these tensions, means "living with the illness without living solely for it," (Charmaz 1995: 658). At the same time, Charmaz emphasized that the ill individual "remains as independent and autonomous as possible," (Charmaz 1995: 658).

Despite the experience of loss and suffering, the ill individual feels like a whole being, while maintaining the unity of the body and self (Charmaz 1995: 658). Its recovery is achieved through the experience of the ill body and the opening of the individual to the search for harmony between the body and the self (Charmaz 1995: 660).

Depending on their physical condition and social resources, ill individuals may progress quickly through the stages of the adaptation process described above or remain suspended for many years before moving on to the next stage (Charmaz 1995: 661). This hard-won unity of the body and self is not given once and for all, and has limits that are not defined (Charmaz 1995: 665). Ill individuals are forced to repeatedly adapt to chronic illness and its somatic consequences. "Adaptation seldom occurs only once," Charmaz wrote (1995: 657). As they experience subsequent losses and bodily disabilities, it becomes necessary to repeat the adaptation strategies that have already been implemented. Adaptation to physical loss tends

to develop. Those ill individuals who experience an uneven progression of illness are surprised by sudden episodes of illness and complications or the appearance of additional illnesses, are forced to adapt to their body in illness over and over again (Charmaz 1995: 658).

“Adaptation to impairment takes people with serious chronic illness on an odyssey of self,” (Charmaz 1991; Charmaz 1995: 675). What benefits does this journey provide to the ill individual? Adaptation to the physical losses caused by chronic illness gives ill individuals, above all, self-confidence. “They believe in their inner strength as their bodies crumble,” (Charmaz 1995: 675). They experience loss maturely, facing it courageously. In the process, they undoubtedly suffer physical losses, but in the end they (re)gain themselves.

Anselm Strauss’s and Juliet Corbin’s interactionist concepts of chronic illness

The issue of the human body in the context of interaction and chronic illness has been widely addressed by **Anselm Strauss and colleagues** – primarily **Juliet Corbin** – in the stream of interactionist, sociomedical research in the field of the sociology of the experience of illness. Let us now review selected theses by Strauss and his colleagues in this field.

In the chapter *Body, Body Processes, and Interaction* in *Continual Permutations of Action*, Strauss took up the issue of the body in order to illustrate a theory of human action and in this context conceptualized the relationship between the body, human action, and social interaction (Strauss 1993: 107–126).

Referring to Merleau-Ponty’s concept, Strauss saw the body as an inalienable condition of actions and interactions, and, at the same time, a medium through which an individual acquired and transmitted knowledge about the world, the objects surrounding him, about himself, but also about his own body. He concludes that “communication occurs through the body” (Strauss 1993: 109).

In Strauss’s concept of the social functions of the body, the statement that the body outlines the limits of human possibilities of action is of key importance, but Strauss distanced himself from biological determinism, stating that biological and social processes cooperated in creating human actions and interactions (Strauss 1993: 109). Nonetheless, the body in Strauss’s view is still a necessary condition of human agency (the body as an agent), necessary as an instrument of action (Strauss 1993: 110). This condition is revealed with force in a situation when the body is damaged (through injury or disease) or becomes disabled: then the dependence of the possibility of action on the body enters the scope of human experience. But the body is also an object, which can be the object of cognition by the actors of social life (Strauss pointed out here that the body could be in the field of attention to a varying degree), and can also be the object of action (this phenomenon indicated by Strauss can be seen in contemporary body modelling strategies).

According to Strauss, the uniqueness of the body is determined by the fact that the body represents the self (“it must represent the self”) (Strauss 1993: 111). The American sociologist described the mutual relations of the body with the subjective self and the objective self, which are respectively the active and passive phases of the self. Here we have a reference to George Mead’s processual concept of the self as an object and the self as a subject, where the self as an object refers to the fact that “we constitute ourselves as objects, because we can make ourselves the object of our reactions,” and the self as a subject corresponds to the “open and creative phase of the self’s activity,” (Piotrowski 1998: 50).

The presented distinction of the phases of the self, perceived processually, enable us, according to Strauss, to see that the body in illness, deformed or unable to function in an ordinary way, becomes to a greater extent a part of the objective “self” and can become a field of action of the subjective “self.” In other words, we can react to the shortcomings of the body by trying to counteract its deficiencies or dysfunctions (Strauss 1993: 112).

The issue of the body in illness appears particularly clearly when, in various situations, individuals experience limitations in the ability to control and steer the body (“there are limits to what one can command the body to do”) (Strauss 1993: 114). In the foreground there are “bodily or mental impairments” leading to temporary or permanent loss of the ability to act intentionally. As an example of a mental cause, Strauss indicated phobias, when the body “escapes” the decisions of the mind and “refuses” to perform certain actions (Strauss 1993: 114).

The issue of the visibility or otherwise the publicity of the body also emerges here: in situations where action/behavior is unproblematic, the body is a tacit, necessary condition for action, while it becomes felt when the performance of the action becomes impossible. In Strauss’s view, actions and interactions are influenced by the body state of the social actor, but also by the context of the personal biography, with both the body and the biography undergoing processual changes (the body’s course; biographical course) (Strauss 1993: 118).

Strauss has also addressed the issue of mind-body interactions and metaphors that capture this issue. He explained this issue using the example of experiences resulting from severe neurological diseases that could cause the mind to become “trapped” in a completely or partially immobile body. In this context, the researcher cited statements by individuals who had suffered a stroke or those suffering from multiple sclerosis, immobilized by the disease, who experienced a situation in which the will was unable to move the body. In such a situation, the “self” is deeply affected by the condition of the body, burdened with a critical limitation (Strauss 1993: 118–119).

A detailed account of the issue of identity in the context of living with a chronic illness can be found in Corbin and Strauss’ *Unending Work and Care*, in which the chapter entitled *Experiencing Body Failure and a Disrupted Self-image* is devoted to this issue (Corbin, Strauss 1988: 49–67). Let us now focus on Corbin and Strauss’s theses, which are based on qualitative studies of married couples in which one of the spouses suffered from a chronic illness. Intensive interviews were conducted with

these individuals to determine the problems they faced in the context of everyday life, with particular emphasis on the activities (work) implied by the chronic illness (Corbin, Strauss 1988: XI).

The issues of the impact of an illness on the self and identity were considered by Corbin and Strauss in the context of the interactionist understanding of personal identity as a socially conditioned phenomenon, linked to the interactive dimension of an individual's life. Before we delve deeper into the content of the indicated publication by Corbin and Strauss from 1988, let us first draw attention to the theses contained in an earlier article by these authors from 1985, in which Corbin and Strauss indicated biographical work as one of the three strategic types of activity undertaken in the situation of chronic illness among the types of work implied by chronic illness (the article is a discussion of the results of research among 60 married couples in which one of the spouses had a chronic illness) (Corbin, Strauss 1985: 224–247).

Corbin and Strauss have thus drawn attention to the relationship between the trajectory of being ill, understood as a phenomenon encompassing human actions implied by being ill, and the biography of the ill individual. A unique, personal identity is shaped in the course of a personal biography, and its basic material, in accordance with the interactionist paradigm, is participation in social life. Since the trajectory of being ill modifies the scope and type of activity of the ill individual and their social environment, including activities that have an interactive dimension, this means that it affects both the personal identity of the ill individual and their biography, imposing the need to reformulate it.

A detailed explanation of this issue was provided in the previously mentioned work *Unending Work and Care* (Corbin, Strauss 1988). Corbin and Strauss introduced the concept of “biographical accommodation” here, drawing attention (this thesis is close to the concept of biographical disruption by the British sociologist M. Bury [Bury 1982: 167–182]) to the fact that the consequences of chronic illness go beyond the need for remedial action in the context of everyday life towards biographical issues.

The concept of biographical accommodation means that in the context of a chronic illness, it becomes necessary to recreate the continuity of life and to give it new meanings, because the illness has caused disruptions in this area and has disrupted the continuity of the personal biography. As part of the adjustment to a chronic illness, as Corbin and Strauss have suggested, the integration of the illness and its consequences for the ill individual's life takes place in such a way that the illness becomes one of the aspects of life. However, the illness does not always dominate the biography: the position of the illness in the hierarchy of the components of the biography is subject to changes, which is related to the course of the biomedical trajectory of illness (Corbin, Strauss 1988: 51).

Corbin and Strauss pointed to three constitutive dimensions of biography, i.e., the “conceptions of self,” “biographical time,” and the “body.”

The first of the mentioned terms concerns personal identity, that is, “a self-classification in terms of who I am at this point in my life’s course,” (Corbin, Strauss 1988: 52). What should be emphasized here is that continuation, maintenance of the activities constituting the “self” (self-related tasks) requires, according to the cited authors, a properly functioning body (Corbin, Strauss 1988: 52). The concept of “biographical time” in turn draws attention to the connection between biography and the temporal context. This is because, as Corbin and Strauss (1988: 52) emphasized, “one lives in the present, comes from the past, and moves toward the future.” The creation of identity, therefore, takes place in “the stream of biographical time,” (Corbin, Strauss 1988: 53). Through the body, knowledge about the world is acquired and transmitted, communication takes place through the body, and, above all, – as mentioned above – “a body is required to perform tasks associated with the various aspects of the self,” and the condition for these actions is physical and mental fitness (Corbin, Strauss 1988: 54).

It is precisely the activities performed by the body and thanks to the body that are the material for the formation of changing and evolving self-concepts. In the context of this aspect of Corbin and Strauss’ analysis, an important statement is that “the centrality of the body lies in its capacity for action,” (Corbin, Strauss 1988: 55). Taking the analysis to this stage enables us to describe from an interactionist perspective the changes and specificity of the body in the context of chronic illness. To illustrate this issue, we will use the concept of “performance” used by Corbin and Strauss. An analysis of the semantic scope of this concept in the approach of these authors indicates that they used the term “performance” to draw attention to the “capacity for action,” but also to the perception of my appearance and my actions by other people, as well as my own self-perception (appearance). Body limitations resulting from an illness (body failure) have consequences in both of these areas and require taking remedial action to prevent the social environment from perceiving bodily limitations (Corbin, Strauss 1988: 59). A disturbance of the structure, appearance and function of the body by an illness (or just one of these aspects) may result in “failed performances” (Corbin, Strauss 1988: 52). The body may become useless, unknown, and may even become a prison (Corbin, Strauss 1988: 62, 64). The strength of the influence of the described processes on identity depends on the extent to which some activities, now impossible because of illness, performed an identity-creating function. If they performed such a function, there is a loss of the aspect of the “self” that was associated with the activity (loss of self). This reveals the close connection between the body in chronic illness and personal identity, which means that “the body is central to human action and a sense of self” (Corbin, Strauss 1988: 66).

3. Key concepts

Bodily being in the world – a concept derived from M. Merleau-Ponty’s concept, which the author used to describe the body remaining in connection with the world; it is a kind of entanglement of the body in the world, in which the body remains open to action, engages in undertaken projects and is connected with objects located in the space of its life, in the phenomenological interpretation referred to as an “extension of the body.” Merleau-Ponty considered thus understood body to be an integral part of the subject – the Self.

Dys-appearing body – D. Leder’s term used to describe a body that, owing to dysfunction (pain, illness), appears in the individual’s consciousness, becomes the center of their attention. The dys-appearing body is a body that is present because it is experienced as problematic, disharmonious, an “other” body, opposed to the self and, therefore, alien. In the experience of the dys-appearing body the subject’s entire attention is directed towards the biological body.

Sociology of biodisease (sociology of disease) – a trend in sociological research proposed by S. Timmermans and S. Haas to focus on studying the mutual relations between social life and individual diseases, taking into account their pathophysiological diversity and clinical specificity. Sociologists of biodisease should, on the one hand, study the impact of social processes on the experience of a disease, its course, and severity, which is assessed using medical indicators and parameters, and, on the other, they should study the impact of the disease process, taking into account the individual stages of the disease in the biological dimension, on the ill individual’s social relations. They should also take into account clinical criteria for inclusion in research, as well as treat the medical diagnosis of the disease as the starting point for sociological research.

Adaptation to life with a chronic illness – according to K. Charmaz, this is one of the ways of living with a bodily loss caused by an illness, which consists of a series of processual changes in a person and life of the ill individual, aimed at adapting to the somatic effects of the illness, consisting in the loss of bodily functions and impairment; this is to lead to reintegration at the body-self level.

Biographical accommodation – a concept by J. Corbin and A. Strauss used to describe the consequences of chronic illness that go beyond remedial actions in the context of everyday life, requiring intervention in biographical issues; it is necessary to recreate the continuity of the ill individual’s personal biography and give it new meanings. Biographical accommodation is an element of biographical work implied by chronic illness, which remains linked to the trajectory of the illness. As a result of biographical accommodation, the illness and its consequences are integrated with the ill individual’s life, becoming one of its aspects.

4. The most important studies

In this part of the text, we review empirical research on the issues of the relationship between the self and identity with the body. The embodied nature of the self in this relationship is evident in sociological qualitative research conducted using in-depth interviews in groups of individuals who experience dysfunctions in the body and/or its structure as a result of various health disorders.

In order to present the widest possible range of identity-creative activities undertaken by ill/disabled individuals, we have selected three problem categories for discussion, in which the specificity of the body disorder differs significantly, implying unique problems at the body-identity interface.

Firstly, we will discuss research on the identity problems of individuals with chronic illnesses, aimed at capturing the effects of the chronicity of health problems in this particular area (K. Charmaz's research), then we will present sociological research on the identity effects of a suddenly acquired disability (K. Yoshida's research), and, finally, research on individuals who have undergone mutilating surgical treatment of ulcerative colitis by means of a total removal of the colon and rectum (panproctocolectomy) with the creation of an artificial anus (ileostomy) (M. Kelly's research).

Body and personal identity in chronic illness in Kathy Charmaz's research

In order to show the research directions in which the body is described in the process of an illness, let us first focus on the work of **Kathy Charmaz**, an American sociologist who died in 2020 (with whom, incidentally, the authors of this research had the honor of corresponding), concerning the relationship between the body and personal identity in the context of experiencing chronic illness.

The common element of the concepts discussed below is that they refer to the interactional model of identity. This term draws attention to the "processuality of the self of the social subject and its direct connections with the interaction taking place here and now," (Bokszarński 2002: 254).

Early signals announcing the undertaking of the issue of the body in the context of chronic illness appeared in Charmaz's work in an article presenting the concept of the "loss of self," which was indicated as the basic form of the suffering of individuals with chronic illnesses (Charmaz 1983). This concept was developed as a result of qualitative sociological research in a group of 57 individuals with chronic diseases, staying at home (73 in-depth interviews), with serious diseases causing partial disability (the age of the respondents was 20–86 years).

The key notion that captures the specificity of chronic illness in the accounts of sick individuals is leading a restricted life. These restrictions include narrowing the pre-illness range of activities that can no longer serve as the material of identity.

Suffering related to a chronic illness is reported by ill individuals using the “language of loss” (Charmaz 1983: 191). The issue of the body does not appear here explicitly. Nevertheless, we find here a prelude to later analyses of the body in chronic illness, as Charmaz stated that “sick individuals often become highly aware of previously taken-for-granted aspects of self because they are altered or gone,” (Charmaz 1983: 170). One of the aspects of personal identity that is subject to change in the course of chronic illness is the body.

Another analysis by Charmaz, concerning the “struggling for the self,” based on research conducted in a group of 57 individuals, among whom 85 in-depth interviews were conducted (we do not have information on whether they were the same individuals interviewed as part of the “loss of self” project or different ones) (Charmaz 1987), already contains a clear reference to the issue of the body in chronic illness. Charmaz has stated that the movement of ill individuals within the “hierarchy of identity,” that is, the movement between alternative “versions” of personal identity, between those that are the most desirable and those that are less valued, takes place under the influence of changes in the physical situation of ill individuals.

Charmaz has considered the changes in physicality resulting from illness to be the most important factor modeling the work on personal identity performed by ill individuals (Charmaz 1987: 292).

This observation brings us to Charmaz’s key publication on the relationship between the body and chronic illness, *The Body, Identity and Self*, published in 1995. In Charmaz’s oeuvre, this publication documents a clear shift towards a greater appreciation of the bodily embeddedness of personal identity. After reading this article, we no longer have any doubts that the “loss of the «self»” is rooted primarily in the bodily changes resulting from the chronic illness. The cited article is based on 115 interviews with 55 adults suffering from chronic illnesses, some of whom Charmaz interviewed several times over a period of 5–10 years. The approach used by Charmaz in selecting the research sample requires commentary, where the criterion for inclusion was, in subsequent editions of her research, the broad category of a “chronic illness” that lacked common specificity, apart from the same reference to the long duration of health disorders. The study included individuals with circulatory system diseases, rheumatic diseases, neurological diseases, lung diseases, and diabetes. We, therefore, have a non-homogeneous study group, including individuals experiencing diverse bodily changes. This will

have implications in the form of limited possibilities for extrapolating Charmaz's findings on the processes of reconstructing the relationship between the "self" and the body to other groups of ill individuals.

Charmaz assumed that chronic illness disrupted the taken-for-granted assumptions about having a smoothly functioning body and disrupted the sense of wholeness of the body and self. This means that chronic illness, through the body, disrupts the ill individual's personal identity, which is, in her understanding, mediated by and embedded in the body (see Charmaz 1995: 657). Charmaz has suggested that in connection with chronic illness, and also as a result of the disability it caused (it should be noted here that adaptation to a disability suddenly acquired or existing from birth is different; this issue will be discussed in Yoshida's research), it becomes necessary to adapt to impairment, that is, to reintegrate the body and one's own self (see Charmaz 1995: 657).

On the other hand, there are also other scenarios, such as ignoring the illness, minimizing it, fighting against it, and related identifications, reconciling the "self" with the illness, or, finally, "absorbing" it. The first three of the above-mentioned strategies, i.e., ignoring the illness, minimizing it, and fighting against it, aim to return to the pre-illness sense of unity of the body and the 'self' (see Charmaz 1995: 657). The strategy of "reconciling the «self» with the illness" manifests itself in accepting the illness, but without self-defining oneself through the prism of the illness.

According to Charmaz, the "absorption" of the illness is to be the final and target phase of the multi-stage process of adaptation to the illness (Charmaz 1995: 658). This process is to result in a reduction of the tension between the body and "self," and also to lead to the development of a new concept of personal identity, a new version of the "wholeness of being," appropriate to being ill and the suffering it causes (Charmaz 1995: 658).

Based on research, Charmaz stated that the process of adaptation to chronic illness/disability was initiated by the experience of an "altered body."

The experience of an "altered body" is not only the feeling of physical changes in the body, but also the experience of their impact on everyday life. The body becomes problematic, emerges from the background of personal experiences; now it is placed in the foreground and is defined as a damaged machine, an enemy or an obstacle requiring repair (Charmaz 1995: 662).

Let us reach here for a moment to another work by Charmaz entitled *Good Days, Bad Days: The Self in Chronic Illness and Time* from 1991 (first edition), in which this issue was illuminated more fully. Namely, gaining awareness of having an "altered body" takes place precisely in the context of everyday life, because it is here that ill individuals receive "a lesson about chronicity." The significance of a body changed

by illness is revealed when ill individuals make an unsuccessful attempt to carry out their ordinary activities.

Kathy Charmaz wrote: “The meaning of disability, dysfunction, or impairment becomes real in daily life. Until put to test in daily routines, someone cannot know what having an altered body is like,” (Charmaz 1991: 21).

At the stage of the initial experience of the problematic nature of the body in illness, there are no attempts to integrate the experience of the changed body with the “self”. Rather, attempts are made to rebuild the pre-illness relationships between the “self” and the body, or there may be distancing from the body changed by the illness, or even separating the body from the concept of “self” (Charmaz 1995: 663). As a result of her research, Charmaz has revealed that in the process of adaptation to illness, specific identity compromises may occur, which consist in the fact that a chronically ill individual somehow “lowers the bar” on the scale of their identity goals, following recognition of the bodily limitations imposed by the illness (here we refer to Charmaz’s concept of “preferred identities” discussed above). However, the direction of movement in the process of adaptation to illness may also be the opposite in a situation where the body’s condition and capabilities improve. The final effect of work on personal identity, implied by a chronic illness, is, according to Charmaz, a redefinition of the relationship between the body and the “self” at a new level, adapted to the specificity of the illness and the resulting physical limitations. This is to lead to life with the real body, as it really is in the situation of illness; the body is to be subjugated, integrated again (but at a changed level) with the “self” (Charmaz 1995: 664). According to Charmaz, it will then become possible to “flow with the body.”

Submitting to the ill body is an act fundamentally different from being engulfed by illness, because it is done intentionally; it is a condition for integrating the “self” with the body changed by illness. The body becomes a part of the “self” of the chronically ill individual once again (see Charmaz 1995: 673).

Charmaz’s concepts describing the relationship between the body and personal identity should be viewed with an awareness of the contextual conditions. Here we have in mind the American context of the research, i.e., a society that highly values independence and active lifestyle, in which the disruptions of everyday life and daily activities caused by an illness constitute a particularly deep violation of personal identity (Turner 2004: 153). It seems that the identity consequences of body changes resulting from an illness would be completely different in groups of chronically ill individuals who attach less importance to active lifestyle, which does not function as a critical material of identity.

The body and personal identity in a suddenly acquired disability in Karen Yoshida's research

Karen Yoshida conducted sociological qualitative research in a group of 35 adults (28 men and 7 women) after spinal cord injury, resulting in paraplegia, i.e., paralysis of the lower limbs and parts of the upper body. The age of the subjects at the time of acquiring disability ranged from 8 to 52 years, and the average time since the injury was 22 years. The research was retrospective in nature. It was conducted using in-depth, semi-structured interviews. It focused on determining how the subjects reconstructed their lives after the injury, with an emphasis on the changes in their professional activity and participation in social life. The issue of personal identity emerged as one of the key issues during the project. Yoshida's research theoretically refers to the interactionist concept of the self and identity as phenomena created in the course of personal activity, being the effect of biographical work performed by an individual, intensified as a result of events that disrupt the course of personal biography. Yoshida has been particularly interested in this aspect of it (here Yoshida referred to the theses of Corbin and Strauss) that concerns the integration of various aspects of the "self" into a new, inclusive whole, including also those aspects of the "self" that have revealed themselves in connection with the illness. In turn, the reference to Charmaz's work concerns the concept of the "loss of self" in connection with a chronic illness. According to Charmaz, sick individuals make an effort to reconstruct their identity, moving within the "hierarchy of identity" that includes more and less desirable identities. Yoshida has undertaken the task of describing both the process of building the "self" by individuals after spinal cord injury and the effects of these activities, in particular the ways of integrating the pre-illness "self" with the disabled "self."

Yoshida (1993) has suggested that the process of reconstructing the self and identity takes the form of a "pendular reconstruction." According to her, disabled individuals oscillate between two distinct types of personal identity, encompassing "non-disabled and disabled aspects of self," and they can move in two directions, both toward the pre-injury self ("non-disabled aspects of self") and toward a self that includes "disabled aspects of self;" (Yoshida 1993: 221). Between these extremes lie intermediate stages, including the "supernormal identity," the "middle self," and the "disabled identity as an aspect of the total self."

Yoshida's account departs from the approach proposed by Corbin and Strauss in the concept of the illness trajectory because the illness trajectory captures the actions and interactions implied by an illness as occurring over time, in a single direction, defined by the passage of time. The trajectory of an illness can of course take on various shapes, in the sense that it can have a permanent downward trend (as in the case of a developing neoplastic disease) or initially downward and then characterized by stability (as in the case of a sick individual after a stroke) or other still, but the trajectory of illness always develops in time and is tilted towards the future (Corbin, Strauss 1988: 42–48). According to Yoshida, individuals with spinal cord injury move between alternative options of personal identity, both towards the version of identity

that integrates disability and towards the version of identity that is based on the situation before the injury. This process takes place over months or years.

Before we indicate the sequence of events identified by Yoshida in the process of reconstructing personal identity after spinal cord injury, let us define the specificity of the types of identity created by individuals with disabilities. Let us start with the extreme options. The concept of the “pre-accident self” (“the former self”) refers to who a given individual was before the spinal cord injury. The “non-disabled self,” depending on the age of the individual at which the injury occurred, may include those aspects of the self that make up its core (the core aspects of the self) and that will remain an important part of the identity after the injury. Nevertheless, such a situation will only apply to individuals with relatively extensive life experience gained in the period before the injury. Those individuals who were still teenagers at the time of the injury will not have an identity foundation developed before the injury on which to build a new version of identity (Yoshida 1993: 224). At the opposite extreme is the version of identity defined as “the disabled identity as total self,” with a clearly negative connotation from the perspectives of the individuals studied, which is expressed in the fact that disability becomes the main determinant of personal identity. This is manifested by the disabled individual’s expectation of help and support from the social environment, as well as experiencing anger and/or depression (Yoshida 1993: 224–225).

Between these two extremes, there are intermediate phases. The “supernormal identity” is manifested by undertaking extraordinary activities, often exceeding the typical level of activity of a fully healthy individual, while the disabled individual rejects help from others (Yoshida 1993: 226–227). In turn, the phase in the development of personal identity, defined as “the disabled identity as part of the total self,” is characterized by the fact that both the aspect of the “self” related to disability and the aspect related to the pre-illness situation are treated as fully-fledged components of personal identity, but the proportions are subject to changes depending on the current way of life in the post-accident period.

The manifestation of optimal adaptation to acquired disability is the identity phase defined as the “middle self.” It is determined by full awareness of the fact of disability (being an individual “in a wheelchair”) and that it will remain so in the future, as well as acceptance of the effects of disability, including a certain degree of dependence on others, and the material of identity is both the disabled and the “able-bodied” aspects of the “self.” This stage is also characterized by reference to the experiences of other individuals with disabilities in making personal decisions regarding everyday life and social interactions (in this context, Yoshida wrote about the “collective disabled consciousness,” Yoshida 1993: 229–230).

The phases of the reconstruction of personal identity by individuals with spinal cord injuries described by Yoshida show the process of integrating the identity effects of the injury with those aspects of the “self” that were developed before the accident,

and this process is non-linear in nature. It is related to the interpretations of one's own situation and the actions taken by individuals with spinal cord injuries. Yoshida's approach departs from the classical, interactionist, processual way of understanding chronic illness, being a proposal of a non-linear approach to the experience of health disorders, with the possibility of oscillation between specific phases.

The body changed by radical surgical treatment and identity and the "self" in Michael Kelly's research

Michael Kelly's research project, carried out in a group of 45 individuals after surgical treatment of ulcerative colitis by complete excision of the colon and rectum (panproctocolectomy), with the creation of a final fistula on the ileum (ileostomy), aimed to show the process of identity reconstruction resulting from an acquired, medically generated bodily dysfunction. The creation of an artificial anus implies a situation in which an individual experiences constant fecal incontinence (because they have no muscular control over defecation). The panproctocolectomy procedure is, therefore, burdened with far-reaching consequences in terms of everyday life. It should be emphasized that the decision regarding this treatment strategy is always justified by the threat to life implied by the exacerbation of the underlying disease.

Kelly's research refers to the sociological understanding of the self as an internal, subjective phenomenon, accessible to the self-awareness of the subject and being a product of "self-reflexivity."

Kelly has assumed that one's own "self" is characterized by stability, but, at the same time, shows the potential for change. It is composed of many aspects, the importance of which at a given moment depends on the stage of personal biography and external circumstances. One's own "self" is built in the course of activity, including interactive activity. In Kelly's view, identity is a way of understanding one's own "self" by oneself (personal identity) and by others (social identity) (Kelly 1992: 392–395).

The fundamental problem of individuals treated with panproctocolectomy is a disturbance in the control over their body, including its aspect that concerns excretion. Problems in this area appear in a period of life in which there is no social acceptance of their occurrence (unlike in childhood or old age). The problem of the loss of control over the body is located primarily in the private sphere and remains publicly invisible, and the subjects feel strong tensions between the "private «I»" and social identity, because there is always a possibility of the problem being publicly disclosed and a person being stigmatized for this reason (Kelly 1992: 391–392).

The narratives of individuals after panproctocolectomy reveal the profound impact on the self and identity due to the bodily change resulting from the surgical procedure. The way of self-definition changes. This process is initiated by the feeling of a painful change in the appearance and functions of the body. It entails a change

in the daily routine in the area of “maintenance” of the body, in the aspect that concerns excretion. It is a painful experience (lack of control over defecation, change in defecation pattern, fear of the stoma bag leaking and contaminating the body and clothes, and, thus, of publicly disclosing the problem), especially since the sphere of excretion is marked by a network of social meanings with a strongly negative connotation.

These experiences are paradoxically intertwined with a sense of relief resulting from the effective removal of the previous, initial threat to identity, which was a serious bowel disease (“... it’s not a nice thing to have, but I’m healthy and fit again”), burdened with problematic symptoms. In the experiences of the individuals studied by Kelly, a specific dualism is revealed: the feeling of the weight of the body changed by medical intervention, but, at the same time, the relief resulting from being freed from a serious and life-threatening disease. Nonetheless, the body is now diametrically different. Constant care of the stoma, putting on and wearing a stoma bag, is necessary in all life circumstances and places of residence. This issue gains the rank of a permanent aspect of the self, but there is never any certainty that the problem will remain exclusively in the private sphere, because there is always the risk of improper functioning of the stoma equipment, contamination of the body and clothes with feces and, as a consequence, public disclosure of the problem (Kelly 1992: 400–402).

Individuals with ileostomies experience tension resulting from a constant threat to their public identity. Bodily boundaries also change: the body is now perceived (due to the constant use of ostomy appliances) as attached to a foreign, external object.

The change in the function and structure of the body and its connection with medical equipment affects the social activity of the studied individuals, and, in particular, the social interactions that require the exposure and presentation of the body. The bodily change becomes a barrier to sexual contact; this is a particularly important difficulty for young people who do not have regular sexual partners. This issue is associated with painful identity consequences, especially for individuals for whom self-perception and personal identity are closely linked to the realization of sexual relations. Here, there is a fear of rejection, of a negative reaction from the partner.

The problem of sexual relations is a fragment of a broader issue of participation of individuals with an ileostomy in social relations, where the source of anxiety becomes the anticipation of rejection of a personal, private self-image.

Therefore, a problem may arise at the interface of the private “self” and the “self” presented in social interactions. In the case of individuals with a stoma, the presented “self” is different from the real “self.” The degree and scope of revealing “otherness” remains at the discretion of individuals with an ileostomy; social presentation requires constant vigilance, and in the background lurks the fear of a negative social reaction, of domination of the social identities available to the individual by the identity of an “individual with a stoma” (ileostomist) (Kelly 1992: 406–409).

To sum up, Kelly's research has revealed the social consequences of a strictly biological change in the body, generated as a result of aggressive medical therapy. In Kelly's research, we are dealing with a situation where a serious illness is cured at the price of deep bodily mutilation.

The analyzed study has brought significant added value to the state of knowledge on the bodily aspects of identity creation processes, pointing out that the causative potential in this respect lies not only in body changes caused by an illness, but also in those resulting from "iatrogenic" medical interventions (the authors use the term "iatrogenesis" here without any anti-medical connotations).

5. Summary

Research projects addressing the issue of the body in chronic illness, partial disability, as well as mutilating body changes generated as a result of medical interventions, reveal tensions concerning the issue of the "self" and personal as well as social identity, initiated and dynamized by the occurrence and perception of changes in the physicality of the body in terms of its aesthetics and/or functions (cf. Kelly, Millward 2004: 9).

The sociological qualitative studies cited in this chapter provide examples of the sociological understanding of the self and identity as processual phenomena, actively constructed by individuals in a social and interactive contexts, but always based on the bodily resources available to the individual. Michael Kelly and David Field have emphasized that the use of the concept of self and identity to describe the experience of illness enables body changes and related changes in the self-concept from a sociological perspective to be captured (Kelly, Field 1996: 247–248).

The basic driving force of identity work in the situation of illness and disability is the body, because bodily change entails a change of the identity founded on the body. Changes concerning the body imply identity work. A number of important questions emerge here: Does this always happen? What character must the body change have in order to initiate identity work? Kelly and Millward have emphasized that long-term changes in the aesthetics of the body entail changes in the scope of the "self" (Kelly, Millward 2004: 9). Certainly, those bodily changes that affect the interactive possibilities of individuals and their potential for action will also have identity effects. Conversely, the visibility of body changes seems to be irrelevant here, because even when the change remains hidden, the factor limiting the individual may be the anticipation of negative social reactions (as shown by Kelly). The course and results of identity-creative activities also depend on the temporal context: references to the pre-illness identity are important here, as well as to what extent and on what basis it was shaped (Kelly's research).

The body changed by an illness receives new meanings in the social space, which affect the "self" and the identity of the ill individual. Moreover, the ill individual experiences physical and mental limitations that can disrupt the routine of everyday

interactions. This is where the identity dilemmas described by Charmaz arise from, and which demand a resolution (Charmaz 1994). Strauss has used the concept of “biographical work” to describe them, drawing attention to the fact that the reconstruction of identity is achieved as a result of the active actions of the individual (Corbin, Strauss 1985).

Of course, the body is at the center of experiencing illness, not only through identity effects: the consequences of chronic illness are primarily biological in nature and they are the center of attention of ill individuals in their everyday lives. Sociology adds that a full understanding of the situation of chronically ill/disabled individuals requires taking into account also the social, including identity, effects of bodily changes.

The described approaches to the role of the body in the processes of identity reconstruction draw attention to the fact that the body is both a biological and a social phenomenon, and both of these aspects interpenetrate each other. The body is influenced by social factors (it is formed by society and culture), but it is also an agentive and acting body that enters into relationships and shapes them. In the light of the interactionist understanding of identity, it is at this point that the connection between the body and identity is revealed. It is worth asking whether an ill individual can build a stable sense of identity on their ill, ailing and imperfect body in late modernity. The answer to this question seems to be affirmative. Sociological research presents an optimistic picture of this issue, but it should be remembered that it is largely carried out in the context of American culture, characterized by active lifestyle, in small groups of individuals who decide to participate in research and talk about their experiences. Certainly, caution should be exercised in the matter of generalizing the reported findings.

In the conditions of late modernity, the body is becoming increasingly important for the sense of identity of the modern human being. The achievements of sociology of the experience of illness confirm that this observation applies to the healthy body, as well as to the ill or disabled one, although the specificity of identity-creative work in both these situations is of course different.

6. Review questions

1. Using the theses of M. Merleau-Ponty, explain the phenomenon of experiencing a non-existent/phantom limb.
2. What are the disturbances in the relationship of an ill body with the world according to D. Leder’s concept?
3. What theoretical postulates and methodological proposals make up the research trend proposed by S. Timmermans and S. Haas, referred to as the sociology of disease?
4. Describe the stages that make up the process of adapting to the loss of body function in the experience of chronic disease according to K. Charmaz’s concept.

5. Explain what “biographical accommodation” is in the context of chronic illness, using the theses of J. Corbin and A. Strauss.
6. Based on K. Yoshida’s research, describe how the process of reconstructing the “self” and identity takes place in individuals who suddenly acquired a disability.

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