David Cohen's Lecture Notes

MEDICALIZATION AND "DISEASE MONGERING"

1. *Medicalization* is usually defined as: defining social or personal problems in medical terms, attributing medical causes to personal/social problems, managing problems by medical means. The tendency to *biologize* (to interpret human life from a strictly biological point of view) or *pathologize* (to see abnormality in suffering or distress) is also sometimes seen as a form of medicalization. Medicalization does not primarily or necessarily involve medical professionals—most past and current trends in medicalization were driven by non-medical practitioners and interests.

2. The first discussions of medicalization focused on deviant behaviors. These discussions highlighted a powerful *moral* dimension of medicalization: that people formerly *blamed* and/or *punished* for their deviance were to be considered *irresponsible* and/or *treated*. Later discussions have focused on the medicalization of normal and ordinary behaviors, and the moral dimension is now less clear. More *commercial* and *existential* motives for medicalization are now apparent.

3. Psychiatrist Thomas Szasz (1963) and sociologist K. Irving Zola (1972) first described how in modern times psychiatry helped to *medically redefine* conduct viewed as sin or crime (e.g., excessive drinking, homosexuality, masturbation, suicide). In the 1970s, sociologists began to use the concept of *medicalization* frequently, especially in the context of a *critique* of an overmedicalized society.

4. A classic work by Peter Conrad and Joseph Schneider, *Deviance and Medicalization: From Badness to Sickness* (1980; 2nd edition, 1998), proposed a 5-step sequential model to describe the process of the *medicalization of deviance*:

1) *definition:* the behavior or conduct is viewed as morally *deviant*.

2) *prospection*: the deviance is for the first time defined as being really medical in nature, despite appearances to the contrary (e.g., "internet addiction," violence). There might appear a new medical/diagnostic term, or a study showing that a drug modifies the deviant behavior (e.g., the observation that stimulants made unruly children quiet and compliant), that gives some credence to the new medical definition.

3) *moral entrepreneurship:* representatives of various organized interests attempt to enlarge the medical territory by emphasizing the seriousness or size of the problem, by claiming rights to own and define the problem. Examples include Alcoholics Anonymous, CHADD, Veterans' Associations (Scott, 1990), drug companies (Cottle, 1999). These groups will directly benefit if the new medical perspective is adopted.

4) *legitimacy/consolidation:* the proponents of the new medicalized perspective request that the state recognize it. They seek powers of definition and management over the problem. Task forces, courts, and legislatures respond.

5) *institutionalization:* the medical definition is now "fact" and the medical perspective is the reigning *paradigm*. Medical manuals discuss it, medical treatment for it is widely available, insurance companies frequently reimburse (medical) treatment for it, institutions of social and ideological control (NIH, research councils, government committees, parts of the media) support it intellectually and financially. At the same, time, they suppress opposing/alternative viewpoints, because these institutions depend for their survival on the full acceptance and spread of the medical definition. Madness ("mental illness"), excessive drinking ("alcoholism"), suicide, prolonged use of illicit drugs ("drug abuse," "drug addiction") are among the main deviances that have been medicalized over the last 200 years. In Conrad & Schneider's theory, all are today at the institutionalized phase.

5. The sequence described by Conrad & Schneider is not fixed. For example, in the former USSR, some political protest was medicalized in the 1960s-1970s, when many political dissidents and people wanting to emigrate were diagnosed as suffering from "sluggish schizophrenia," imprisoned in psychiatric institutions, and disabled with antipsychotic drugs. This example of medicalization of deviance emerged and then disappeared quickly as immigration policies were liberalized during the *glasnost* of the 1980s.

The DSMs and Medicalization

6. The evolution of the DSM is often cited as a classic *yardstick* of medicalization of personal/psychosocial distress (Kirk & Kutchins, 1992). DSM-I (1952) lists 106 diagnoses; DSM-II (1968) 182 diagnoses; DSM-III (1980) 265 diagnoses; and DSM-

III-R (1987) 292 diagnoses. Four years before publication of DSM-IV (1994), Blashfield et al. (1990) predicted by simple linear extrapolation that it would have about 350 categories. Each diagnosis is the name of a "mental disorder," which the DSM says is *not* fundamentally different from a *medical* disorder. Critics point out that the DSM easily adds new categories because in psychiatry, unlike in other branches of medicine, one need not *discover* a disease (and then confirm its presence in patients by means of objective diagnostic tests or physical signs)—one needs simply to invent a *new label*.

Newer Medicalized Problems and Dynamics

7. Aging, male and female menopause, overeating, undereating, excessive sexual activity, rare sexual activity, smoking, gambling, erectile dysfunction, self-cutting, violence, racism, chronic fatigue, multiple allergies, involuntary civil commitment of sexual offenders to extend their incarceration after they've served their criminal sentence (Alexander, 1997)—these problems and others are at different stages of the medicalization sequence. One example of the macro- and micro-dynamics of medicalization: anthropologists Kaufert and Lock (1994) looked at representations of menopausal women in drug ads and in the media in the 1970s and 1990s. In the 1970s, menopausal women were portrayed as pale and depressed. In the 1990s, they had nice teeth, skin, hair, in too good a shape to break a hip or have a heart attack or become forgetful. The authors argue that these images don't correspond to the reality of aging for most people, but the images help to shape how aging women see themselves and how society expects them to be. Paradoxically, women are thus held *responsible* for what will *inevitably* happen to their bodies, while they are subtly encouraged to take hormones as promoted by the pharmaceutical industry.

Contexts and Factors Contributing to Medicalization

8. Until 1980s, authors generally agreed that the following trends contributed to medicalization: (a) the decline of religious thinking and faith in the Western world, along with the increase in scientific thinking and faith, in rationality and efficiency imperatives (*secularization*); (b) the increase in accomplishments, power, and prestige of the medical profession; (c) especially in North-America, the tendency toward individualized, technological solutions to social problems; and (d) a general humanitarian tendency in many Western societies that seeks to remove the assignation of "blame" (for example, removing parental blame for children's failures).

9. Conrad (2005) suggests that the "engines of medicalization" are shifting (assigned reading). He singles out (a) consumers, aided by the Internet, and (b) drug companies and their efforts to market and promote drugs. Recently also, the term *disease mongering* (introduced by the late medical journalist Lynn Payer as a quasi-synonym for "medicalization" mostly driven by drug companies to sell their products) has been used to describe: (a) framing medical or medicalized conditions as being severe and widespread, (b) turning "ordinary ailments" into diseases, (c) seeing mild symptoms as serious, and (d) seeing "risk factors for diseases" as diseases themselves. (see Moynihan et al., 2004, assigned reading). Also, the newer concept of *biomedicalization* (Clarke et al., 2003) refers to the vast commercial and techno-scientific changes occurring in medicine (especially involving genetics), that are changing how people and groups view their bodies and selves and the potential to alter these bodies and selves.

Consequences of Medicalization

10. Most theoreticians of medicalization do not view it positively. The late philosopher and social critic Ivan Illich warned, in *Medical Nemesis* (1976), that medical treatments would produce widespread *iatrogenesis* (medically-caused diseases and death). (Lazarou et al., 1998, estimated that >100,000 people die annually in US hospitals of adverse drug reactions, making it 4th leading cause of death.) Illich argued that dependence on medicine would make people *obsessed* about health as a *value* and would lead to the "medicalization of life," with a gradual loss of the right of people to self-determination.

11. Thomas Szasz (2007) argues that medicalization is one facet of the *Therapeutic State*, by which he means the alliance of Medicine and the State for purposes of social control, which replaced the former alliance between the Church and the State, uncontested for nearly 1000 years. For Szasz, just as the cause of individual and religious freedom required a separation between religious powers and state powers, so the cause of individual and medical freedom today requires a separation between medical powers and state powers.

12. For the late psychologist Theodore Sarbin (1997), medicalization contributes to the belief that people are not responsible for their actions. Although medicalization encourages us to feel compassion for people (as victims), the fabric of democracy is threatened if we define certain people as passive organisms rather than proactive beings. Sociologist Barbara Hansen (1997) identifies the ideology of *medicalism,* whose goal is to hold troublemakers blameless. As a result, there will be an endless search for medical explanations and treatments, even if these are not effective.

13. Proponents of medicalization claim that it reduces the social *stigmatization* of deviant individuals and encourages them to seek treatment (Lowenberg & Davis, 1994). They also claim that medical management is more benign than management by religious or judicial authorities. Medicalization thus appears here as a humanitarian reform. Despite the importance of the argument in favor of medicalization, very little evidence addresses it. The available evidence, however, suggests that the tendency to view distress as mental illness (a) has not greatly diminished the repression of individuals with psychiatric labels, (b) has not reduced how negatively the general population views such people, and (c) may have increased how negatively such people view themselves (Phelan, 2006; Read et al., 2006). This suggests that medicalizing a deviance changes how society defines it and manages, but may leave intact how society evaluates it *morally*.

Limits to Medicalization?

14. Medicalization is rarely an absolute, either/or process. Rather, there exist *degrees* of medicalization: certain occurrences are almost completely medicalized (such as childbirth, death and dying), some only partially (like drug abuse, menopause, learning difficulties), some minimally (like co-dependence, domestic violence). There are also instances of *demedicalization*, the most famous being the withdrawal of homosexuality as a psychiatric diagnosis from DSM-II in 1974. Also, some physicians resist the growth of their power in society, although medicalization is increasingly driven by non-medical players. Nonetheless, because of medicine's power and prestige, and because of the obvious appeal and simplicity of medical ideas, demedicalization succeeds only if there is strong organized (and well-financed) public, professional and ideological mobilization which openly challenges the medical definition and management and offers a definition and management that is judged more practical, efficient, *and* humane.

References

Alexander, R. (1997). Reconstructing sex offenders as mentally ill: A labeling explanation. *Journal of Sociology and Social Welfare, 24*, 65-76.

Blashfield, R.K., et al. (1990). Suggested guidelines for including or excluding categories in the DSM-IV. *Comprehensive Psychiatry, 31*, 15-19.

Clarke, A. E. et al. (2003). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review, 68*, 161-194.

Conrad, P. (2005). The shifting engines of medicalization. See class website.

Conrad, P., & Schneider, J. (1998). *Deviance and medicalization: From badness to sickness* (2nd ed.). St-Louis: Mosby.

Cottle, M. (2 Aug. 1999). Selling shyness: How doctors and drug companies created the "social phobia" epidemic. *The New Republic*. Retrieved on www.thenewrepublic.com

Hanson, B. (1997). *Social assumptions, medical categories*. New York: Elsevier.

Illich, I. (1973). *Medical nemesis: The expropriation of health*.

Kaufert, P. A., & Lock, M. (1994). Medicalization of women's third age. *Journal of Psychosomatic Obstetrics and Gynecology, 18*, 81-86.

Kirk, S., & Kutchins, H. (1998). *Making us crazy: The psychiatric bible and the creation of mental disorders*. New York: Free Press.

Lazarou, J. et al. (1998). Incidence of adverse reactions in hospitalized patients: A meta-analysis of prospective studies. *Journal of the American Medical Association, 279*(15), 1200-1205.

Lowenberg, J. S., & Davis, F. (1994). Beyond medicalisation-demedicalisation: The case of holistic health. *Sociology of Health & Illness, 16*, 579-599.

Sarbin, T. (1997). On the futility of psychiatric diagnostic manuals (DSMs) and the return of personal agency. *Applied and Preventive Psychology, 6*, 233-243.

Scott, W.J. (1990). PTSD in DSM-III: A case study in the politics of diagnosis and disease. *Social Problems, 37*, 294-310.

Szasz, T. (1963). *Law, liberty, and psychiatry*. New York: Macmillan.

Szasz, T. (2007). *The medicalization of life*. Syracuse, NY: Syracuse University Press.

Zola, K. I. (1972). Medicine as an institution of social control. *Sociological Review, 20*, 487-504.