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MEDICALIZATION AND SOCIAL CONTROL

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Abstract

This essay examines the major conceptual issues concerning medicalization and social control, emphasizing studies published on the topic since 1980. Several issues are considered: the emergence, definition, contexts, process, degree, range, consequences, critiques, and future of medicalization and demedicalization. Also discussed are the relation of medicalization and social control, the effect of changes in the medical profession and organization on medicalization, and dilemmas and lacunae in medicalization research.

INTRODUCTION

Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders. This article reviews the work of sociologists, anthropologists, historians, physicians, and others who have written about medicalization. While I briefly discuss some of the seminal writings on the topic, the emphasis here is on work published after 1980, because a compilation of earlier writings is available elsewhere (see Conrad & Schneider 1980a).

THE EMERGENCE OF MEDICALIZATION

During the 1970s the term medicalization crept into the social scientific literature. While it literally means “to make medical,” it has come to have wider and more subtle meanings. The term has been used more often in the context of a critique of medicalization (or overmedicalization) than as a neutral term simply describing that something has become medical.

Critics of the widening realm of psychiatry were the first to call attention to medicalization, although they did not call it that (e.g. Szasz 1963). Pitts (1968), Freidson (1970) and Zola (1972) presented the initial examinations of medicalization and medical social control. They took their inspiration from sources as different as Parsons (1951) and labeling theory. Parsons was probably the first to conceptualize medicine as an institution of social control, especially the way in which the “sick role” could conditionally legitimate that deviance termed illness. Freidson and Zola based their conceptions, in part, on the emergent social constructionism embedded in the then current labeling or societal reaction perspective.

A number of “case studies” of the medicalization of deviance were published in the 1970s: Conrad (1975) on hyperactivity in children, Scull (1975) on mental illness, Pfohl (1977) on child abuse, and Schneider (1978) on alcoholism as a disease. Other studies analyzed changes from nonmedical to medical definitions and treatments, although they did not necessarily use a medicalization framework (e.g. Foucault 1965, Gusfield 1967, Wertz & Wertz 1989). Illich (1976) used the conception “the medicalization of life” in his influential critique of medicine. Thus, by the time Conrad & Schneider (1980a) wrote *Deviance and Medicalization: From Badness to Sickness*, there was already a substantial literature to build upon.

Medicalization and Definitions

Although much has been written about medicalization, the definition has not always been clearly articulated. Most agree that medicalization pertains to the process and outcome of human problems entering the jurisdiction of the medical profession, but there are differences in the way they see the process. One of the most straightforward definitions is presented by Zola (1983:295): Medicalization is a “process whereby more and more of everyday life has come under medical dominion, influence and supervision.” In an early statement, Conrad (1975:12) sees it as “defining behavior as a medical problem or illness and mandating or licensing the medical profession to provide some type of treatment for it.” While these definitions are serviceable they both make the assumption that the problem must move into the jurisdiction of the medical profession; in certain instances, however, the medical profession is only marginally involved or even uninvolved (e.g. alcoholism). This has led to some confusion about what constitutes demedicalization.

The key to medicalization is the definitional issue. Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession. Medicalization occurs when a medical frame or definition has been applied to understand or manage a problem; this is as true for epilepsy as for "gender dysphoria" (transexualism). The interest in medicalization has predominantly focused on previously nonmedical problems that have been medicalized (and, often, thought to be inappropriately medicalized), but actually medicalization must include all problems that come to be defined in medical terms.

While the definitional issue remains central, a broader conceptual frame helps clarify the meaning of medicalization (Conrad & Schneider 1980b). Medicalization can occur on at least three distinct levels: the conceptual, the institutional, and the interactional levels. On the conceptual level a medical vocabulary (or model) is used to "order" or define the problem at hand; few medical professionals need be involved, and medical treatments are not necessarily applied. On the institutional level, organizations may adopt a medical approach to treating a particular problem in which the organization specializes. Physicians may function as gatekeepers for benefits that are only legitimate in organizations that adopt a medical definition and approach to a problem, but where the everyday routine work is accomplished by nonmedical personnel. On the interactional level, physicians are most directly involved. Medicalization occurs here as part of doctor-patient interaction, when a physician defines a problem as medical (i.e. gives a medical diagnosis) or treats a "social" problem with a medical form of treatment (e.g. prescribing tranquilizer drugs for an unhappy family life). Thus it becomes clearer that medicalization is a broad definitional process, which may or may not directly include physicians and their treatments (although it often does). Subcultures, groups, or individuals may vary in their readiness to apply, accept, or reject medicalized definitions (Cornwell 1984).

There have been general and specific critiques of medicalization. The general critiques argue that the medicalization case has been overstated and that there are considerable constraints to medicalization (Fox 1977, Strong 1979). The specific critiques focus more directly on the conceptual validity of the case studies (Woolgar & Pawluch 1985, Bury 1986). The theoretical frame underlying these cases of medicalization is a type of social constructionism (cf Spector & Kitsuse 1977, Schneider 1985), although this is not explicitly noted in all the writings. Put simply, this perspective presents reality and knowledge as "socially constructed," shaped by its human constructors, and brackets the assumption that there is any *a priori* reality "out

there" to be discovered. These medicalization studies document the historical "discovery" of a medical problem, with attention to who said what, when, and with what consequences. This requires examining the professional literature, events, and claims-making activities (cf Spector & Kitsuse 1977). It is worth noting that some studies do not argue that a medical diagnosis is merely a social construction, but rather analyze how the problem came into the medical domain.

Bury's (1986) critique is the most relevant to medicalization studies. He contends that since social constructionism assumes the relativity of all knowledge, constructionism itself is affected by the same forces as scientific knowledge. It is not an independent "judge" (as analysts seem to assume); so on what basis can we differentiate a "discovery" from an "invention?" Bury further contends this has led analysts to exaggerate the extent of medicalization in contemporary society. In a response, Nicholson & McLaughlin (1987:118) make the important point that displaying the social and contextual nature of knowledge—e.g. how medical categories emerge—does not necessarily mean the knowledge is false. It is important to distinguish between the sociological investigation of how knowledge is developed and sustained, and how the knowledge is to be evaluated. King (1987), however, aligns himself more with Bury. Using transexualism as an example, he argues that the notion of the "invention" of transexualism as gender dysphoria is no more credible than alternative (i.e. standard medical) interpretations. But he also notes that depicting the cultural production of knowledge doesn't necessarily undermine it. While Bury's critique should caution researchers about the limits of constructionism, this in itself does not compromise its usefulness for sociological studies. The bottom line is that medicalization analysts create new understandings about social processes involved in the construction of medical knowledge, which may or may not lead to evaluation of the process of that (biomedical) category or knowledge. While it is true that most medicalization analysts seem to imply overmedicalization, this evaluation is not inherent in the perspective.

Occasionally medicalization analyses are criticized for positing a social model to replace the medical model (Whalen & Henker 1977). This is a spurious criticism; it is the critics who focus on the issue of causation. Nearly all medicalization analyses bracket the question of causation of the particular behavior or condition and focus instead on how the problem came to be designated as a medical one. Medicalization researchers are much more interested in the etiology of definitions than the etiology of the behavior or condition (Conrad 1977). Indeed, this may reflect a weakness in medicalization research; analysts have offered or examined few viable alternatives to medicalized approaches to problems like alcoholism (Roman 1980b).

Medicalization has occurred for both deviant behavior and "natural life

processes." Examples of medicalized deviance include: madness, alcoholism, homosexuality, opiate addiction, hyperactivity and learning disabilities in children, eating problems from overeating (obesity) to undereating (anorexia), child abuse, compulsive gambling, infertility, and transexualism, among others. Natural life processes that have become medicalized include sexuality, childbirth, child development, menstrual discomfort (PMS), menopause, aging, and death. While the specific origins and consequences of each of these arenas of medicalization may differ, many of the issues are similar.

CONTEXTS OF MEDICALIZATION

Analysts have long pointed to social factors that have encouraged or abetted medicalization: the diminution of religion, an abiding faith in science, rationality, and progress, the increased prestige and power of the medical profession, the American penchant for individual and technological solutions to problems, and a general humanitarian trend in western societies. While factors like these do not explain increasing medicalization over the past century, they have provided the context. Sociologists have examined two important contextual aspects affecting medicalization: secularization and the changing status of the medical profession.

Secularization

Numerous writers have suggested that medicine has "nudged aside" (Zola 1972) or "replaced" (Turner 1984, 1987) religion as the dominant moral ideology and social control institution in modern societies. Many conditions have become transformed from sin to crime to sickness. In Weberian terms, this is of a piece with the rationalization of society (Turner 1984). The argument is that secularization leads to medicalization.

There is some recent evidence to support this, largely in the writings of social historians (see also Clarke 1984). Brumberg (1988:7) sees anorexia as a type of secularized salvation:

From the vantage point of the historian, anorexia nervosa appears to be a secular addiction to a new kind of perfectionism, one that links personal salvation to the achievement of an external body configuration rather than an internal spiritual state.

Although physicians had little to do with it, social responses to suicide were secularized in the eighteenth century due to a general loss in confidence in diabolical powers; according to MacDonald (1989), suicide was more or less medicalized by default. Homosexuality was medicalized in part in response to harsh religious and criminal sanctions; if it was hereditary, then the deviant behavior was not a voluntary act (Conrad & Schneider 1980a:181–85, but

also see Greenberg 1988:406–11). Infertility used to be in the realm of the gods, as evidenced by fertility votives found the world over, but now it is firmly within the jurisdiction of medicine (Rothman 1989, Greil 1991).

It is often assumed that religious groups by definition resist secularization and medicalization, since these may erode theological turf. In a recent article, Bull (1990) questions this line of reasoning. He uses the case of Seventh Day Adventists, who have developed a rather substantial medical presence. He argues that this group “promotes secularization through their implacable opposition to the public role of religion” (p. 255) and that it also “operates a dynamic and effective instrument for extending and defending medical regulation of society” (p. 256) through their health regulations and doctrines. Thus Adventists encourage both secularization and medicalization, rather than being affected by it.

In fact, medicalization may have a rather ambivalent relation to marginal religious groups. On the one hand, medicalization has been used to oppose and neutralize cults, particularly in the name of treating “brainwashed” members (Robbins & Anthony 1982). On the other hand, some healing cults among the poor and marginal classes have embraced the medical view. The symbols of some traditional Latin American healing cults fuse the power of religious healing and modern medicine by basing their beliefs and worship on the imagery of particular doctors as medical saints (Low 1988).

While it is true that medicine is in important ways nudging aside religion as our moral touchstone, the interface of medicine and religion is more complex than a simple secularization thesis would suggest.

The Medical Profession, Pediatrics and Medicalization

Although “medical imperialism” cannot be deemed the central explanation for medicalization (Zola 1972, Conrad & Schneider, 1980b), the organization and structure of the medical profession has an important impact. Professional dominance and monopolization have certainly had a significant role in giving medicine the jurisdiction over virtually anything to which the label “health” or “illness” could be attached (Freidson 1970:251). As we note later, the impact of the enormous changes in the organization of medicine in the last two decades on medicalization is an area in need of study, as well as is the reciprocal effects of medicalization on the profession (Schneider & Conrad 1980).

While it is difficult to predict future changes, a well researched historical example can provide insight.

In a provocative paper, Pawluch (1983) shows how in a changing social environment pediatricians were able to adapt their orientations to maintain their practices. In the context of an improved standard of living, public health measures, and preventive vaccinations, there were fewer sick children for

pediatricians to treat. Pawluch argues that pediatricians weathered this professional crisis by changing the focus of their practices, first by becoming "baby feeders," and recently by including children's troublesome behavior in their domain. The new "behavioral pediatrics" enabled pediatricians to maintain and enhance their medical dominance by expanding their medical territory. This led to the medicalization of a variety of psychosocial problems of children.

Halpern (1990), in an important article, contests some of Pawluch's interpretation. She argues that routinization of work, rather than market decline, preceded behavioral pediatrics. To the recently trained academic specialists, general outpatient care seemed "unappealingly routine" (Halpern 1990:30). The "new pediatrics" was a vehicle for academic generalists to secure a place in medical schools dominated by subspecialists and to make their own training and routine clinical work more stimulating. She argues that understimulated specialists in search of professional standing rather than underused clinical practitioners took the lead in medicalization. While the data cannot be conclusive, based on a review of studies, Halpern suggests that pediatricians do not seem to have increased their treatment of psychosocial disorders in recent decades. She further suggests that physicians need not treat the medicalized disorders themselves, but can become the managers of medical care, while auxiliaries and extenders provide treatments in a medical frame. Put another way, Halpern suggests that medicalization in pediatrics occurred more on the conceptual and institutional levels than on the interactional level of patient treatment (cf Conrad & Schneider 1980b).

Whether Halpern's "routinization hypothesis" or Pawluch's "market hypothesis" is more nearly correct, or some combination of both as Halpern (1990:35) seems to indicate, it is clear that medicalization is in part a by-product of intraprofessional issues that underlie the growth of behavioral pediatrics. The cases of hyperactivity (Conrad 1975, 1976) and learning disabilities (Carrier 1983, Erchak & Rosenfeld 1989) are examples of the increased medicalization of childhood behavioral problems.

MEDICAL SOCIAL CONTROL

Social control is a central and important concept in sociology. Most societies develop therapeutic styles of social control (Horwitz 1991), especially when individualism is highly valued. Durkheim (1893/1933) differentiated between repressive and restitutive controls, seeing the latter as more characteristic of complex societies. The social control aspect of medicine was conceptualized initially by Parsons (1951), when he depicted illness as deviance and medicine and the "sick role" as the appropriate mechanism of social control. Early analysts (Pitts 1968, Zola 1972) indicated that medical social control would

likely replace other forms of control; while this has not occurred, it can be argued that medical social control has continued to expand (see below, *The Range of Medicalization*). While numerous definitions of medical social control have been offered (Pitts 1968, Zola 1972, Conrad 1979, O'Neill 1986), in terms of medicalization "the greatest social control power comes from having the authority to define certain behaviors, persons and things" (Conrad & Schneider 1980a:8). Thus, in general, the key issue remains definitional—the power to have a particular set of (medical) definitions realized in both spirit and practice.

This is not to say that medical social control is not implemented by the medical profession (it generally is), or that it is not abetted by powerful forms of medical technology (it often is). It is to say that without medicalization in a definitional sense, medical social control loses its legitimacy and is more difficult to accomplish. The development of a technique of medical social control (e.g. a pharmaceutical intervention) may precede the medicalization of a problem, but for implementation some type of medical definition is necessary (e.g. Conrad 1975). More typically, however, medicalization precedes medical social control.

In the context of medicalizing deviance, Conrad (1979) distinguished three types of medical social control: medical ideology, collaboration, and technology. Simply stated, medical ideology imposes a medical model primarily because of accrued social and ideological benefits; in medical collaboration doctors assist (usually in an organizational context) as information providers, gatekeepers, institutional agents, and technicians; medical technology suggests the use for social control of medical technological means, especially drugs, surgery, and genetic or other types of screening. While these are overlapping categories, they do allow us to characterize types of medical social control. Perhaps the most common form is still "medical excusing" (Halleck 1971), ranging from doctor's notes for missing school to disability benefits, to eligibility to the insanity defense.

To these categories we can add a fourth—medical surveillance. Based on the work of Foucault (1973, 1977), this form of medical social control suggests that certain conditions or behaviors become perceived through a "medical gaze" and that physicians may legitimately lay claim to all activities concerning the condition. Perhaps the classic example of this is childbirth, which, despite all the birthing innovations of the last two decades (Wertz & Wertz 1989), remains firmly under medical surveillance. Indeed, the medical surveillance of obstetrics has now expanded to include prenatal lifestyles, infertility, and postnatal interaction with babies (Arney 1982).

Some significant developments have occurred in medical social control over the past decade. In terms of ideological control, PMS (premenstrual syndrome) has emerged as an explanation of a variety of types of female

deviance (Riessman 1983). In terms of collaboration, many work organizations have implemented Employee Assistance Programs (EAPs) (Roman 1980a, Sonnenstuhl 1986) and worksite screenings for drugs (Walsh et al 1992) and AIDS, both strategies for medical detection (identification), and in the case of EAPS, medical intervention. Forms of medical technological control which have been recently examined by social scientists include penile implants for male sexual dysfunction (Teifer 1986), hormonal and surgical treatments for transsexualism (Billings & Urban 1992), genetic screening (Hubbard & Henifin 1985), and chemical executions in implementing the death penalty (Haines 1989). Beyond the childbirth example, analysts have examined the extension of medical surveillance to the body (Armstrong 1983, Turner 1984), mental illness and homelessness (Snow et al 1986), and to a certain extent, lifestyle (Conrad & Walsh 1992; but see discussion in *The Range of Medicalization* section).

Medical collaboration and technology can have deadly outcomes. The most disturbing (and horrifying) case of medical control is the German physicians' genocidal collaborations with the Nazis, including formulating and carrying out the eradication of the "genetically defective" (Lifton 1986, Proctor 1988). These also included the medical technological interventions in concentration camp killings which were couched as medical operations (Lifton, 1986). Fortunately, most forms of medical social control are not so diabolical or lethal, but the case of the Nazi doctor exemplifies the extreme, destructive use of medical social control.

In a very different context, Bosk (1985) examines the profession's social control of itself—in terms of self-regulation and control of deviance—and finds the profession to be tolerant and forgiving of its own, as opposed to its less tolerant treatment of lay population deviance. This has been manifested recently by the emergence of the notion of "impaired physicians" as a medicalized explanation for physician deviance (Stimson 1985, T. Johnson 1988). The impaired physician concept is largely based upon the extant medicalization of substance abuse, and it allows the medical profession to "take charge of a significant amount of physician deviance, and to keep it away from the control of licensing and disciplinary bodies" (Stimson 1986:161). Thus the profession uses medicalized social control to reinforce its claims for self-regulation.

One needs to be cautious in making claims about the actual functioning of medicalized social control. While EAPs certainly appear to be a strategy for controlling deviant work performance, studies suggest that most employees using EAPs are self-referrals rather than supervisor referrals (Sonnenstuhl 1982, 1986), raising the question of whether these can be classified as a means of corporate social control.

Although analysts have written about medical social control for over four

decades, very few studies have compared medical social control to other forms of control or have examined the growth of medical control in the context of changing social control. Such comparative studies would need either historical or cross-sectional data and in all likelihood would require some type of quantification. Two studies meet these criteria. Pastor (1978) studied transportation and admission to detoxification units. He compared medical and legal approaches to public drunkenness and found that 77% of medical rescue unit contacts ended up officially processed, compared to only 14% of police contacts. He concludes that "once mobilized, medicine is a more active, committed form of control than law" (Pastor 1978:382). Melick & associates (1979), using comparative historical arrest rate data covering nearly 40 years, found the number of males with police records admitted to psychiatric facilities has steadily and consistently increased. Melick et al argue that this represents a change in societal response to deviance—from criminal to medical—but they maintain that this shift was not ideological, occurring rather out of administrative necessity (crowded prisons and available mental hospital beds). While these studies support a medicalization hypothesis, we need more such studies to better understand how different forms of social control are used and under what conditions.

Social control, however, is rarely an either/or situation. As several researchers have pointed out, changes in social control may be cyclical and are subject to change (Conrad & Schneider, 1980a). Peyrot (1984) aptly reminds us that new clinical perspectives cannot be expected to fully supplement earlier modes of social control; for example, drug addiction remains within the purview of the criminal justice system despite medicalization (see also Johnson & Waletzko 1991). Thus it is not surprising that we find medical-legal hybrids in areas like addiction, drinking-driving, and gambling.

THE PROCESS OF MEDICALIZATION

Conrad & Schneider (1980a:261–77) presented a five-stage sequential model of the medicalization of deviance based on the comparison of several historical cases. While analysts have used this model to examine compulsive gambling (Rosencrance 1985), premenstrual syndrome (Bell 1987a), and learning disabilities (Erchak & Rosenfeld 1989), there has been little evaluation or development of this conceptual model. Peyrot's (1984) reframing of the stages and cycles of drug abuse is one of the few published critiques. Perhaps the model is inappropriate for other cases or is too general to be useful; still, it is unclear why the model has been ignored rather than criticized or modified. This is not to say that analysts have ignored the process of medicalization. If there is a theme to the issues raised in the discussion, it centers on the degree to which physicians and the medical profession are active in the medicalization process. Physicians were involved as claims-

makers with hyperactivity (Conrad 1975), child abuse (Pfohl 1977), aging (Estes & Binney 1989), menopause (McCrea 1983, Bell 1987b, 1990), PMS (Riessman 1983, Bell 1987a), and the emergence of behavioral pediatrics (Pawluch 1983, Halpern 1990). Medical claims-making usually takes the form of writing in professional journals, official professional reports, activities in speciality organizations, and developing special clinics or services.

There are also cases where generally physicians are uninvolved or their initial involvement is minimal; the most obvious cases are in substance abuse—alcoholism (Schneider 1978), opiate addiction (Conrad & Schneider 1980a) and EAPs (Roman 1980a, Sonnenstuhl, 1986). At least two reported cases exist of active medical resistance to medicalization. Haines (1989) suggests the medical profession resists medical involvement in lethal injections for criminal executions, a process perceived as a threat to their professional interests. Kurz (1987) reports that there is resistance among medical emergency department (ED) personnel to the medicalization of woman battering. Some resistance to medicalization on the interactional or doctor-patient level is not surprising in situations like the ED or in busy practices where only limited medical resources are available (cf Strong 1979).

Organized lay interests frequently play a significant role in medicalization (Conrad & Schneider 1980a). Scott (1990), for example, suggests in the case of post traumatic stress disorder (PTSD) that a small group of Vietnam veterans consciously and deliberately worked along with psychiatrists to create such a diagnosis and to have it institutionalized in DSM-III. Sexual addiction, which received considerable mass media publicity, while having advocates, has never been legitimated in DSM-III or in any other "official" source (Levine & Troiden 1988). Similar lay claims-making can be seen in the cases of alcoholism (Schneider 1978) and EAPs (Trice & Bayer 1984), as well as in various challenges to medicalization described below (see section on Demedicalization).

Several authors have pointed out that patients sometimes are actively involved in medicalization. There is evidence for this from historical studies of childbirth (Wertz & Wertz 1989), homosexuality (Greenberg 1988, Hansen 1989), and more recently for PMS (Riessman 1983). It is clear that patients are not necessarily passive and can be active participants in the process of medicalization (cf Gabe & Calnan 1989).

Taken together these studies support the contention that medicalization is an interactive process and not simply the result of "medical imperialism" as well as that the medical profession can take a variety of roles and positions in the process (cf Strong 1979, Conrad & Schneider 1980b). Over the past 15 years a goodly number of cases of medicalization have accumulated in the social science literature. Detailed secondary analysis could further specify the process of medicalization. It is worth noting that few analysts have yet examined the cultural and structural factors underlying medicalization (for

significant exceptions see Roman 1988, Roman & Blum 1991, Estes & Binney 1989, Binney et al 1990).

DEGREES OF MEDICALIZATION

In most cases medicalization is not complete; some instances of a condition may not be medicalized, competing definitions may exist, or remnants of previous definition cloud the picture. Therefore rather than seeing medicalization as an either/or situation, it makes sense to view it in terms of degrees. Some conditions are almost fully medicalized (e.g. death, childbirth), others are partly medicalized (e.g. opiate addiction, menopause), and still others are minimally medicalized (e.g. sexual addiction, spouse abuse).

We do not yet have a good understanding of which factors affect the degrees of medicalization. Certainly the support of the medical profession, availability of interventions or treatments, existence of competing definitions, coverage by medical insurance, and the presence of groups challenging the medical definition, are all likely to be significant factors.

Two examples can highlight some of the issues. While the claim has been made that battering or spouse abuse is a medical problem (Goodstein & Page 1981), evidence suggests that it is only minimally medicalized (Kurz 1987). This is particularly interesting because child abuse has been more completely medicalized (Pfohl 1977). In this case, issues of competing definitions, "ownership" (Gusfield 1981 and lack of medical support seem to be factors. The dominant definition of spouse abuse is not medical but feminist; the feminist movement championed the problem and its "treatment" (battered women's shelters) and thus can be said to "own" the problem (see Tierney 1982, Wharton 1987). As a second example, general agreement exists that menopause has been medicalized on a conceptual level (MacPherson 1981, Bell 1990). Data from a cross-sectional patient survey in Canada suggest, however, that it has not been medicalized to any great extent, and the use of hormone treatments for "symptoms" is relatively low (Kaufert & Gilbert 1986). Thus medicalization may be uneven; on the doctor-patient (interactional) level, menopause does not seem highly medicalized, while on a conceptual level it certainly is.

The existence of competing definitions may affect the degree of medicalization. When competing definitions are represented by strong interest groups, as with drug addiction, it is less likely for problems to be fully medicalized. While occasionally sociologists champion competing definitions (e.g. Galliher & Tyree 1985), more often sociologists present an analysis or critique without explicit alternatives. Despite some claims to the contrary (e.g. Strong 1979), sociologists tend not to be competitors to medicalized conceptions (Roman 1980b). As is discussed below, politicized challenges to medicalized concepts can affect the degrees the medicalization as well.

There is another dimension to the degree of medicalization: how expansive is the medical category? While some categories are narrow and circumscribed, others can expand and incorporate a variety of other problems. Hyperactivity initially applied only to overactive, impulsive, and distractible children (especially boys); however, now as attentional deficit disorder (ADD) it has become more inclusive. The diagnosis has expanded to include more teenagers, adults, and hypoactive girls (Wender 1987). Despite, or perhaps because of, evidence that ADD is an inadequately specified category (Rubinstein & Brown 1984), labeling and treatment seem to be increasing. One study found a consistent doubling of the rate of treatment for ADD children every four to seven years, so that 6% of all public elementary school students were receiving stimulant medications in 1987 (Safer & Krager, 1988). The rates rose faster in secondary than elementary schools.

Another interesting case is Alzheimer's Disease (AD). Although some analysts don't use a medicalization frame (Gubrium 1986, Fox 1989), that which was historically termed senility is now a broader and more inclusive category (Halpert 1983). AD was once an obscure disorder; it is now considered among the top five causes of death in the United States. Fox (1989) suggests that the key issue in the change in conceptualization of AD was the removal of "age" as a criterion, thus ending the distinction between AD and senile dementia. This dramatically increased the potential cases of AD, by including cases of senile dementia above 60 years old. Cognitive decline now became defined as a result of a specific disease rather than an inevitable aspect of aging. Some have suggested that expanding the definition of AD has shrunk the range of what is deemed to constitute normal aging (Robertson 1990), as well as resulted in a failure to recognize the extent to which cognitive decline can be socially produced (Lyman 1989).

A final example of category expansion is alcoholism. In recent years family members of alcoholics have been partly medicalized as enablers, codependents, and "adult children of alcoholics" (Lichtenstein 1988). Worksite programs have also expanded from "industrial alcoholism programs" to Employee Assistance Programs, and EAPs now are broadened into emotional health programs that include substance abuse, smoking, family problems and work dilemmas in their purview (Sonnenstuhl 1986, Conrad & Walsh 1992). In part this may result from a "murkiness" in the disease concept (Roman & Blum 1991), which allows for a certain malleability and expansiveness.

THE RANGE OF MEDICALIZATION

Publications in the 1980s enumerated the medicalization of numerous forms of deviance and natural life processes. Studies in the past decade have particularly examined the breadth of the medicalization of women's lives: battering, gender deviance, obesity, anorexia and bulimia, and a host of

reproductive issues including childbirth, birth control, infertility, abortion, menopause and PMS. As Riessman (1983) notes, for a variety of complex reasons, women may be more vulnerable to medicalization than men. In any case, it is abundantly clear that women's natural life processes (especially concerning reproduction) are much more likely to be medicalized than men's, and that gender is an important factor in understanding medicalization.

In addition to studies of the medicalization of women's lives, considerable research on the medicalization of aging and alcoholism has been published. Estes & Binney (1989) have examined both the conceptual and policy (practice) aspects of the medicalization of aging. They note how more and more aspects of aging have come into medical jurisdiction and how the medical frame has become dominant in aging research, funding, and studies, especially as related to the National Institute of Aging. Estes & Binney point to the important role of Medicare in medicalizing problems of the elderly; because physicians are the only ones authorized to certify the need for care, increased services are seen in a medical frame. This point is illustrated by the medical shaping of Home Health Agencies (Binney et al 1990). Several authors (Binney et al 1990, Azzarto 1986) take the medicalization of elderly services as a measure of the medicalization of aging. When we include the previously discussed studies of menopause and Alzheimer's Disease, our knowledge base on the medicalization of aging broadens and deepens. Zola (1991) has recently argued that the issues of aging and disability are converging; as most people age they will develop disabilities, and barring death, most people with disabilities will age. Given the changing American demographic patterns into the twenty-first century, and the continuing insurance coverage only for "medical" problems, it seems likely that the medicalization of aging will persist and expand. And since a majority of the elderly are women, it is likely aging and gender issues will continue to converge.

The medicalization of deviant drinking and alcohol use has long been a topic of sociological interest (Gusfield 1967, Schneider 1978, Levine 1978). The emphasis of those studies has been on the impact of prohibition and repeal, the emergence of Alcoholics Anonymous, and the development of the disease concept. Work has continued along these lines (e.g. Denzin 1987), especially questioning the scientific validity of the disease concept (Fingarette 1988). But much of the medicalization-oriented writing in the last decade has focused on specific issues like EAPs and to a lesser extent, the expansion of the concept of alcoholism (Peele 1989). Some new areas may be on the horizon. Roman & Blum (1991:780) suggest that the "health warning labels" on alcohol products "increase perceived risk associated with alcoholism consumption." They may affect public conceptions of alcoholism by making the drinker more responsible for his or her health problems. This may reinvestigate the moral elements of the moral-medical balance in the definition

of alcoholism. It is likely, however, that the disease concept will continue to dominate thinking about alcoholism, with the success of Alcoholics Anonymous and the continued organizational supports for the disease concept, especially in terms of third party reimbursement for treatment of alcoholism, workplace EAPS, and encouragement from the alcohol beverage industry (Roman 1988, Peele 1989).

A key aspect of medicalization refers to the emergence of medical definitions for previously nonmedical problems. Thus when social or behavioral activities are deemed medical risks for well-established biomedical conditions, as is becoming common, we cannot say that it is a case of medicalization. There is some confusion around this, especially in terms of the recent concerns with health and fitness (e.g. Crawford 1980). In the 1980s "health promotion" and "wellness" activities were touted as increasing individual health and reducing risk of disease. For example, not smoking, low cholesterol diets, and exercising regularly could reduce the risk of heart disease. Although health promotion may create a "new health morality" (Becker 1986), based on individual responsibility for health (and lifestyle change), it does not constitute a new medicalization of exercise or diet. While the process is similar to medicalization in that it fuses behavioral and medical concerns, it may be better conceptualized as "healthicization." With medicalization, medical definitions and treatments are offered for previous social problems or natural events; with healthicization, behavioral and social definitions are advanced for previously biomedically defined events (e.g. heart disease). Medicalization proposes biomedical causes and interventions; healthicization proposes lifestyle and behavioral causes and interventions. One turns the moral into the medical, the other turns health into the moral. (Conrad 1987)

CONSEQUENCES OF MEDICALIZATION

Although medical interventions typically are judged by how efficacious they are, the social consequences of medicalization occur regardless of medical efficacy. They are independent from the validity of medical definitions or diagnoses or the effectiveness of medical regimens.

Numerous analysts have described consequences of medicalization. Conrad & Schneider (1980a:245-52) separate the consequences into the "brighter" and "darker" sides. Like most sociologists, they emphasize the darker side: assumption of medical moral neutrality, domination by experts, individualization of social problems, depoliticization of behavior, dislocation of responsibility, using powerful medical technologies, and "the exclusion of evil." The criticism of medicalization fundamentally rests on the sociological concern with how the medical model decontextualizes social problems, and

collaterally, puts them under medical control. This process individualizes what might be otherwise seen as collective social problems.

These issues have been reflected and developed in subsequent writings. For example, Carrier (1983:952) argues how learning disability theory "misrecognizes and thus masks the effects of social practices and hierarchy." This has been noted for other problems as well (Lyman 1989, Riessman 1983). Medicalized conceptions of battering can lead to therapy and distract from a focus on patriarchal values and social inequality (Tierney 1982). Medical control may also affect public opinion and social policy. Rosenberg (1988, p. 26) suggests that policymakers have a penchant for medical solutions because they are "less elusive than the economic and political measures which are its natural counterparts." In a highly stratified society, medicalization may have implications for social justice (Gallagher & Ferrante 1987, Light 1989).

A few cases of medicalization bring up different issues. Post traumatic stress disorder is an instance where the cause of the disorder was shifted from the particularities of an individual's background to the nature of war itself; it is "normal" to be traumatized by the horrors of war (Scott 1990). Also of interest is the example of medical organizing against nuclear war. By depicting the devastation from nuclear war as "the last epidemic," Physicians for Social Responsibility and later the American Medical Association turned a political issue into a medical one. This was a very successful strategy for claims-making and organizing, and allowed physicians to make political statements in the name of health. To a degree both of these examples decontextualized the issue (war), but with different consequences than those in medicalizing deviance. One of the main differences here was that the issue turned on the effects of war, more than on war itself. In general, sociologists remain skeptical about medicalization, although ambivalent in the recognition of certain gains and losses (Riessman 1983).

DEMEDICALIZATION

Medicalization is a two-way process. Demedicalization refers to a problem that no longer retains its medical definition. In the late nineteenth century, masturbation was considered a disease and was the object of many medical interventions (Engelhardt 1974). By the twentieth century it was no longer defined as a medical problem nor was it the subject of medical treatment. Some analysts have suggested that the use of medical auxiliaries (e.g. midwives or physician assistants) instead of doctors represents demedicalization (Fox 1977, Strong 1979). This, however, confuses demedicalization with deprofessionalization. Demedicalization does not occur until a problem is no longer defined in medical terms and medical treatments are no longer deemed to be appropriate solutions. Demedicalization could be said to have

taken place, for example, if childbirth were defined as a family event with lay attendants, if chronic drunkenness were reconstituted as an educational problem, or if menopause reverted to a natural life event, inappropriate for any medical intervention.

Childbirth in the United States has been medicalized for more than a century. The medical monopoly of childbirth is more recent (Wertz & Wertz 1989). In the last 15 years, the childbirth, feminist, and consumer movements have challenged medicine's monopoly of birthing. This has given rise to "natural childbirth," birthing rooms, nurse-midwives, and a host of other reforms, but it has not resulted in the demedicalization of childbirth. Childbirth is still defined as a medical event, and medical personnel still attend it. In the context of American society, even lay midwifery may not mean complete demedicalization. In Arizona licensed lay midwives have been pressured toward a more medical model of childbirth, especially through licensing and legal accountability in a medically dominated environment (Weitz & Sullivan 1985).

The classic example of demedicalization in American society is homosexuality. In response to the protest and picketing of the gay liberation movement (with some sympathetic psychiatric allies), in 1973 the American Psychiatric Association officially voted to no longer define (i.e. include in DSM-III) homosexuality as an illness. This represented at least a symbolic demedicalization (Conrad & Schneider 1980a, Bayer 1981). Here politicization of medicalization created an overt conflict which resulted in the demedicalization. Although some argue that lesbianism has yet to be demedicalized (Stevens & Hall 1991), it seems evident that today homosexuality is at least as often considered a lifestyle as an illness. As several observers note (e.g. Murray & Payne 1985), the onset of the AIDS epidemic has led to a partial remedicalization of homosexuality, albeit in a different form.

There are two other examples of demedicalization worth noting. The Independent Living Movement asserts that, in the lives of people with disabilities, "much of [the] medical presence is both unnecessary and counter-productive. . . [and] management of stabilized disabilities is primarily a personal matter and only secondarily a medical matter" (DeJong 1983, p. 15). They actively work to demedicalize disability, including reshaping its definition, and work to create environments and situations where people with disabilities can live independently and with minimal contact with medical care.

A most interesting example has emerged almost serendipitously. Winkler & Winkler (1991) suggest that single women who practice artificial insemination (AI) with "turkey basters" or other such materials, present a fundamental challenge to medicalization. This subterranean practice has been well-known in the women's health movement for sometime and apparently has proved

quite successful. Because this practice requires no medical intervention, it raises important questions about the necessity of medical expertise and control even for infertile couples. The authors contend that demedicalization is already underway and argue for the demedicalization of AI for those women without reproductive maladies of their own.

Given the stature and power of medicine, demedicalization is usually only achieved after some type of organized movement that challenges medical definitions and control. Other factors can affect demedicalization. Some types of technology can lead to a degree of demedicalization: turkey basters and take-home pregnancy tests are but two examples. And the recent upsurge in self-care erodes medical control. Changes in public policy or in insurance reimbursement eligibility can also affect demedicalization, but we do not yet have studies on how this works. For example, while due to state policy changes the mentally ill in the 1980s were clearly less cared for by psychiatry; their problems remained defined as medical, even as their needs were neglected. It is possible to have medicalized problems that remain untreated and uncared about. The ultimate key remains how the problem is defined and what types of interventions are deemed appropriate.

While evidence suggests that medicalization has significantly outpaced demedicalization, it is important to see it as a bidirectional process.

CROSS-CULTURAL RESEARCH

Most studies of medicalization have been in the American context. Its not clear whether medicalization is simply more advanced in American society or whether other societies have yet to be adequately studied.

Few cross-cultural or comparative studies have explicitly focused on medicalization. A significant exception are Lock's reports that in Japan menopause is less medicalized than in North America (Lock 1986) but that aging itself is increasingly medicalized (Lock 1984, see also Lock 1987). From a different perspective, Kleinman (1988) describes how in China patients suffering from difficulties with sleep, low energy, joylessness, and sadness are diagnosed having neurasthenia; he suggests that most could be rediagnosed as having a major depressive disorder (1988:13). In China the patients receive a physiological diagnosis, in North America a psychiatric one. While diagnosis and treatment differ, it can be argued that chronic demoralization is medicalized in both societies.

Given the dominance of Western biomedicine in the world, it would not be surprising to see the diffusion of biomedical categories to non-Western societies. Some unsystematic evidence suggests that this may be occurring for certain problems; for example, the medicalization of childbirth is increasing in societies that make medical childbirth a priority or that can afford the necessary medical resources (e.g. Colfer & Gallagher 1992). The extent to

which deviant behavior is medicalized is still unclear, however. For example, when I asked neurologists and psychiatrists in Indonesia whether they saw or treated patients with anorexia, the overwhelming response was that such a disorder did not exist in Indonesia and doctors did not treat it; Earls (1981) reports the same situation in China. Nearly two decades ago Maccoby (1974) reported finding no hyperactive children in the schoolrooms of the People's Republic of China; more recent reports suggest that it has become the most common child psychiatric disorder, and large numbers of Chinese children are being treated with stimulant medications for hyperactivity or attentional deficit disorder (Earls 1981). This raises questions about whether Western medicalized concepts are exported to nonwestern societies, about the degree to which and under what conditions they are adopted, and about the impact and meaning they have in other cultures. In another context, it is clear that infant-formula manufacturers were active in promoting the medicalization of infant feeding in the Third World (Van Esterik 1989). We do not yet have much knowledge about the role of drug manufacturers and medical entrepreneurs in promoting and exporting medical definitions and treatments.

More cross-cultural studies would expand our understanding of medicalization in new directions. For example, how are anorexia, hyperactivity, obesity, and PMS defined and treated in other cultures? What does it mean whether or not a nonwestern society medicalizes a particular problem? How does a problem's definition relate to the culture and medical belief system? When certain phenomenon are found or identified in only a few cultures, anthropologists typically conceptualize these as Western "culture-bound syndromes" (Ritenbaugh 1982, Littlewood & Lipsedge 1987, T. Johnson 1987). How does medicalization interplay with culture-boundedness? What types of cultural and structural factors in societies encourage or discourage the medicalization of life's problems?

In short, it would be most useful to expand medicalization studies cross-nationally and cross-culturally, to investigate the issues of (i) indigenous definitions of problems currently medicalized in the West, and (ii) the diffusion and exportation of medicalized conceptions and treatments to other societies.

ISSUES IN THE FUTURE OF MEDICALIZATION

Throughout this essay I have touched on a number of issues in medicalization research. Here I want to point to several that are critical for expanding our understanding of medicalization and demedicalization.

Medicine in the United States is changing. Medical authority is declining (Starr 1982); increasingly physicians are now employees (McKinlay & Stoeckle 1988). Corporate structures have increased power in terms of third-parties and the "buyers" of health services, to name only the most major

changes. These are fundamental changes in the organization of medicine. What impacts are they having on medicalization? Similarly, what is the impact of the dismantling of the welfare state (and subsequent cutbacks)? Will this engender a redefinition to “badness” rather than sickness?

What is the relationship between the economic infrastructure of health care—primarily insurance reimbursement—and medicalization? What is the effect of continuing rising health costs and subsequent policy concerns with cost containment? Does this fuel or constrain medicalization and how? What impact could universal health insurance have on medicalization? Comparative studies of other industrialized health systems would be useful here.

Few authors have yet examined the influence of the AIDS epidemic on medicalization. While it clearly has an impact on the definition and treatment of homosexuality, and probably on drug addiction as well, we know little about the impact. And since AIDS is affecting medicine and our society in many ways, how else is it affecting medicalization? For example, what does HIV testing mean for extending medical surveillance?

While cases like obesity and “chronic fatigue syndrome” are still only partly investigated, in general, I believe we need to go beyond the accumulation of cases to investigate more carefully the causes of medicalization. This includes unearthing previously undetected dimensions of medicalization and contributing to a more integrated theory.

A few specific issues call for attention. Even after nearly two decades of writing, we know rather little about the extent of medicalization. As noted above, for example, menopause is medicalized conceptually, but it is not clear that it is widely medicalized in practice. We need now also to attempt to quantify the extent of medicalization of different problems and to begin to analyze variations and comparisons. This includes more empirical comparisons of medical and other types of social control. Two recent publications (Waitzkin 1991, Dull & West 1991) have presented glimpses of practicing doctors’ views of medicalization. Given that some studies have suggested less medicalization may occur on the doctor-patient level than might be predicted by the existence of medical conceptions, research on the medicalization of perceptions and practices in everyday medical practice could be illuminating.

In sum, medicalization continues to be a rich area of sociological research and analysis. It may now be the right moment to focus more directly on investigating the structural underpinnings of medicalization, especially given the enormous changes occurring in medical organization and knowledge, and to expand our lens to examine cross-cultural dimensions of medicalization.

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