The Medicalization of Deviance:

From Badness to Sickness

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Joseph Schneider

In 1980 Peter Conrad and I published *Deviance and Medicalization: From Badness to Sickness* with the medical publisher Mosby and Company. Peter's dissertation, then article, then book, in which he examined the medical diagnosis and treatment of hyperkinesis in misbehaving school children, mostly boys, were the basis of that larger, collaborative project (Conrad, 1975, 1976). Peter, more a medical sociologist than one focused on deviance and social problems, and I, who came to both lines of work as a novice, proposed to look at how, as the book's subtitle announces, various categories of conduct and persons that/who had been seen initially as "bad" were redefined and treated as primarily sick. This "medicalization," we argued, following Talcott Parsons' (1951) notion of the sick role, lessened the burden of blame and stigma attached to such "deviant" conduct and persons and shifted primary professional and institutional oversight from the church (sin) and the state (crime) to medicine, with what we called both "bright" and "dark" consequences. In exchange for this shift away from moral opprobrium, the sick, Parsons theorized, would give themselves over as cooperative patients to a regime of medical expertise toward becoming again well and, thus, conforming members of society.

The book offers substantive and historically dense (but of course now dated) chapters on mental illness, alcoholism, opiate addiction, children, homosexuality, and crime, the latter contributed by Richard Moran. These substantive discussions are framed by theoretical chapters detailing our arguments about deviance, medicalization, and medical social control. We said the brighter side of these changes includes (a) a more humanitarian response; (b) the lessening of personal responsibility for the condition named; (c) the possibility of amelioration and the hope inherent in the therapeutic; (d) and the "positive" effects of the prestige and the flexibility of medicine in definition and treatment. We saw the darker side to involve (a) that same backgrounding of responsibility, to the extent it is present; (b) an obfuscation of the morality of medical definition and intervention effected by scientific and technical discourse; (c) the domination and "ownership" of the matters at hand by experts; and (d) the individualization and depoliticization of conflict better understood as collective, structural, and political. We ended the book with several generalizations based on the cases examined: (a) that both medicalization and demedicalization are cyclical phenomena; (b) that such designations are typically offered in opposition to the more morally freighted categories of religious dogma and the law; (c) that a relatively small segment of the medical profession was actively involved as champions or, in Howard Becker's (1973) terms, "moral entrepreneurs" of these designations; (d) that medical labels that were applied to "bad" behaviors often propose a compulsive or addictive mechanism; and (e) that such designations are, again, political and moral achievements.

When we first wrote about medicalization, the historical moment enabled us to see and describe, as well as to anticipate, a range of changes across late modernity that

traced the rise in power and prestige of medical and scientific definitions, knowledge, professions, institutions, practices, and personnel for naming and owning definitions and treatment of "problematic" persons and behaviors. The essence of what we called medicalization is the creation, rise, dispersion, and sometimes decline of "important" language categories or what Michel Foucault (e.g., 1977, 1978) called "discourse." We sought to locate such language use as actual, that is, as historically situated and thus always moved by actual people in real timespace. In this we followed Foucault in his interests in genealogy and discursive *practices* in and through which the meaning of language moves (Dreyfus and Rabinow, 1983). Similarly, we drew centrally on the interactionist work in deviance and social problems theory by Becker (1973) and by Malcolm Spector and John Kitsuse (2001).

The book won the Charles Horton Cooley Award in 1981 from The Society for the Study of Symbolic Interaction for its contribution both to understanding the particular substantive case of the medicalization of deviance, but also for its specification and elaboration of what was being called a "social constructionist" analysis—then a relatively new theoretical argument—which foregrounds the process-oriented, pragmatist-influenced tradition in sociology for which that organization is named (see Weinberg, 2014). The Cooley Award committee made particular note of how we drew on interactionist and interpretive or "micro" sociology—often then seen as less able to engage historical questions—to examine "macro," institutional and organizational actors as champions for and against these illness designations, calling into question the value of that very micro-macro distinction.

There, and subsequently in my own writing and teaching, the conception of deviance and, more broadly, morality, as an attribution that is the result of social and symbolic interactional processes is and remains central. To say "deviant," "problem," and "illness," is, in each case, to highlight how negative, devalued meanings and qualities are consequentially attached to, even constituting, the being or "object" so marked. This aims to underline the particular socialcultural processes of judgments made and their consequences as distinct from so-called "objective" qualities thought to cause the judgment itself or, more consistent with Parson's sociology, how "deviant" marks a nonconformity treated more or less as given in the world. Spector and Kitsuse distill their focus on attribution most forcefully in their use of the word "putative" in reference to these conditions and behaviors that commonly have been the focus of sociological writing on deviance and social problems. To wit, their definition of social problems is: "the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions" (Spector and Kitsuse, 2001, p. 75).

"Putative" here announces that the theory remains agnostic as to whether such conditions and behavior exist. It restricts our interest and attention to how those involved in making such claims deploy these "grounds" in the arguments, claims, and activities that they pursue (see also Hewitt and Hall, 1973). The social reality that this approach addresses, then, is limited to these empirical matters and not what might "really exist" independent thereof and from an untheorized, somehow Archimedean (e.g., scientific, religious) certainty. This understanding of deviance is the one I use here and the one Peter and I drew on—even if less consistently than we might have done—in our original argument (cf., Goode, 2004).

Deviance and Medicalization was reissued in 1992 with a new preface, has been translated into Japanese and Spanish and is still in print more than thirty-five years after it first appeared. Peter, alone and in collaboration with colleagues and graduate students, has gone on to write a long list of scholarly papers and books on medicalization—both of deviant behavior and beyond—many of which I cite here, and he arguably has become the primary scholar of medicalization studies in sociology. My own relevant work turned to the constructionist arguments in deviance and social problems and to an ongoing interest in caregiving and illness experience as moral phenomena (Schneider, 1988, 1993; Schneider and Conrad, 1980, 1983; Schneider and Wang, 1993, 2000).

The arguments we and others have made about the medicalization of deviance have had a quite remarkable viability across a wide range of scholarship in the social sciences, not to mention the attention received from journalists, social analysts, and cultural critics outside the academy. What we saw then as an emerging trend has not abated, even if it has become more complex than we then described, and a wide variety of problematic behaviors, conditions, and categories of persons have been defined in terms of medical discourse and treated by medical and health professionals (Conrad, 2007; Davis, 2010). Obviously, since our early collaboration, attention to medicalization, both of deviance and life, has stimulated a wide range of salient questions for public policy and institutional, professional, and political practice as well as a large body of research and writing.

But no concepts or theories can remain viable without close attention to changes in the actual worlds they aim to understand and critique. To be sure, the organization, economics, technoscience, and politics of medicine and health/illness in the United States

all have changed significantly since medicalization and the medicalization of deviance were introduced as concepts in 1970s and 1980s U.S. sociology. Professional debates about the continuing utility and relevance of "medicalization theory" in the twenty-first century have offered a range of conclusions, from claims that it no longer contains interesting ideas; that it is hopelessly "modern" and thus unfit for the current "postmodern" time; that the concept now obfuscates rather than enlightens the phenomena it claims to understand; and that it has been eclipsed by other related processes named "biomedicalization" and "pharmaceuicalization." Susan Bell and Anne Figert (2012) review these and various counter claims that have emerged early in the new century. They conclude that while today's medicalization is not and cannot remain the same as that originally proposed—something that Conrad and his coauthors certainly also have written—the concept and directions for inquiry it offers are still relevant to understanding how health and illness name powerful definitional practices, both domestically and across the globe.

"Mental Disorder" and Medicalization

As Conrad and Slodden (2013, p. 62) recently have written, and as Conrad and XXX detail in the present volume, the history of the definition of mental disorder or mental illness is arguably the defining example of the medicalization of deviant behavior. In Conrad's early work and then in our initial collaboration, we drew on Foucault's (1965) *Madness and Civilization* to help us see the history of medicine as a set of cultural practices and technologies—ways of seeing, opening up, and intervening in bodies and minds—that emerged as part of the modern period (see also Foucault, 1973). Foucault's is a story of how madness, as a category of strange, undesirable, and frightening behavior

came to be defined as "mental illness." Gradually, and by no means in a simple linear process, persons so seen who had been shunned, excluded, and punished under civil and legal authority came to be marked as "patients" who suffer from illnesses rather than, say, Satanic possession or "evil," and so deserved not punishment and mockery, but rather compassion, care, and treatment. As part of that gradual process and central to it, a rising cadre of medical experts emerged who were increasingly skilled and authorized as professionals by state endorsement and licensure to offer these patients treatment and care.

In that initial argument on the medicalization of deviance, we also drew on more immediate sociological and historical work by J. R. Pitts (1968), Irving Zola (1972, 1975), David Rothman (1971), and Eliot Freidson (1970), along with the forceful writing by critics of psychiatry Thomas Szasz (1961, 1970) and Ivan Illich (1976) among others. We said, building on this work, that medicalization is a process that involves *medical personnel*, especially but not only physicians; *medical institutions; medical culture*; and *medical social control,* underwritten, by growing professionalization and an increasingly powerful state as the primacy of the church and its discourse of sin waned.

Part of our initial argument in the very nominalization of the word "medical" as "medicalization" was that we were witnessing a process of medical expansion—if not imperialism—that deserved the critical attention of scholars and citizens alike. The discourse and culture of medicine and psychiatry is one of therapeutics and treatment toward melioration rather than punishment, incarceration, and correction, words that are historically more congenial to discussions of crime and deviance (Rieff, 1966). As Foucault (1977, 1978) elsewhere pointed out, power masked as knowledge and wisdom

in the name of health and wellbeing faces less popular skepticism and resistance and thus is likely to operate all the more effectively. The scholarly discourse on medicalization in this tradition—of deviance and beyond—was and remains mostly one of critique of domination with an implied or explicit call for resistance.

We noted that Sigmund Freud, writing in the early decades of the 20th century, did not focus his psycho-analysis on more severely disturbed persons (e.g., those suffering what came to be called schizophrenia and, today, bi-polar disorder), but nevertheless contributed importantly to the expansion of behaviors and persons thought to be fitting objects of medical attention. His theory and intervention, although surely medical, focused more on how illness emerged from what he saw as the inherently difficult join of human body and culturesociety than on biological and chemical explanations, accounts that were to rise to prominence in U.S. psychiatry by mid-century. Freud specified and treated a long list of neurotic conditions and patients suffering various obsessions, compulsions, anxieties, hysterias, so-called sexual deviations, as well as depressive states.

If mental illness is the original case of the medicalization of deviance, Conrad's (1975, 1976, 2006) work on hyperkinesis is arguably paradigmatic of the analyses that subsequently emerged and the expansion of medical labels to include more and more behaviors and people. It involved a "troublesome behavior" seen as widespread in society; certain enterprising physicians and a diagnostic medical label or labels to "explain" this "problem"; a drug that seemed to reduce the behavior and a drug company interested in expanding markets and profit; and "interested" non-medical advocacy groups—often made up mostly of parents of those "troublesome" children—calling for

medical intervention and treatment. The behavior in question was children's—and especially boys'—overly-active, disruptive, agitated, actions, which became grounds for excluding them from various institutionally-sited routines, especially at school. Hyperkinesis or hyperactive behavior or "hyperkinetic impulse disorder" was first used as a diagnosis in the late 1950s (Mayes and Horwitz, 2009, pp. 44-69; Laufer et al., 1957). Conrad argued that the availability of a stimulant drug, Ritalin (approved 1961 Ciba Geigy), that seemed to have the paradoxical effect of calming some children brought for treatment, was a key in the popularity and success of the diagnosis and treatment. The diagnosis appeared in The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSMII*) with the observation that such behavior "usually diminishes in adolescence." By the end of the 1970s, hyperkinesis or hyperactivity was the most common psychiatric diagnosis for children in the United States and the drug Ritalin and other similar stimulants the most commonly-prescribed medications (Conrad and Slodden, 2013, p. 64). Today, increasing numbers of very young children are diagnosed as they meet the expectations of preschool for performance and focus, and this especially so for those from the poorest families (Schwarz, 2014).

In subsequent editions of the DSM the diagnosis was revised to focus more on problems in attention than only on disruptive behavior, and more children were taken to physicians for treatment with the drugs of choice. The idea that children would "outgrow" this problem was also revised as research uncovered adolescents and even adults suffering an inability to focus their attention. *DSM III* contains language clearly relevant beyond childhood: "often acts before thinking" and "is easily distracted" (Conrad and Slodden, 2013, p. 64). The 1990s saw the emergence of "Adult ADHD" in

patients reporting at physicians' offices with the self-diagnoses they had learned from pharmaceutical advertisements in popular media (Conrad and Potter, 2004). A small professional literature grew around this now chronic diagnosis, and laypersons organized the advocacy group Children and Adults for Attention Deficit Disorder (CHADD). Such lay advocacy groups of parents had earlier been important in bringing public and professional attention to the initial diagnosis for children, a phenomenon commonly seen in other medicalization research. Citing the results of a study directed by Joseph Biderman of Harvard in 2004, Conrad (2007, p. 61) notes an estimate of eight million adults affected (and see Schwarz, 2014).

Homosexuality, Demedicalization, and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*)

The APA's *Diagnostic and Statistical Manual of Mental Disorders,* published in various numbered editions since 1952 (*DSM-I*) with the most recent edition five published in May 2013 (*DSM-V*), name all the diagnoses officially recognized by the U.S. psychiatric profession. It is possible to trace the outlines of a politics of diagnosis within psychiatry by following the detailed history of changes in the labels and categories across the volumes. This history has been an increasingly contentious one, with controversy apparent around not only the expansion of new diagnoses in each subsequent edition but over the nature of these new disorders as well. Critics, we and others both inside and outside the profession of psychiatry, have expressed concern over the seeming medicalization of arguably normal but devalued behavior (Frances, 2013; Mayes and Horwitz 2005).

The early versions of *DSM* (I and II) reflect the then greater influence of psychoanalytic theory in American psychiatry, while volumes three (1980) and after evidence the shift toward a more biochemical and now molecular/genetic focus thought more amenable to pharmaceutical intervention. Behind these changes, analysts see a complex and dynamic history involving not only physicians in debate with one another, but the growing influence of insurance industry decisions on which treatments for what conditions will be reimbursed and at what levels; of pharmaceutical companies in the creation and marketing of new drugs for both on- and off-label use; and of non-medical advocacy politics both for and against the inclusion of a given diagnostic category (Conrad, 2007; Conrad and Leiter, 2004; Conrad and Potter, 2004; Conrad and Slodden, 2013).

One illustrative case of the complexity of this politics of diagnosis is that of the demedicalization of homosexuality, culminating in the 1974 vote by the APA membership to remove that diagnosis, per se, from the next published volume, *DSM-III*. Although now more than four decades old, the story still highlights the complex relationship between conventional socialcultural morality, on the one hand, and medical morality on the other that is central to the argument that the medicalization of deviance makes.

Homosexuaity had been included in the *DSM* since its first edition in 1952, reflecting its presence also in the *International Classification of Diseases*, *ICD-6*, which was then something of a model for the U.S. profession. There it had been named a "sexual deviation" and thus an instance of "sociopathic personality disturbance." The diagnostic label appeared in *DSM-II* in 1968 similarly as a personality disorder and

sexual deviation. The story of the demedicalization of homosexuality focuses on the political confrontations from "gay liberation" activists both inside and beyond psychiatry, energized by the widespread radical politics of the late 1960s and early 1970s in the United States.

Popular and professional understandings of same sexgender desire were then in flux. The notion of "sexual deviant" itself—arguably also a *sociological* concept—was a site of struggle, and psychiatry's *DSM* designation for homosexuality became a prime target for change, a piece of the "liberation" activists sought. The details of the case, set forth in our book, make it clear that gay activists who were psychiatrists and their non-gay supportive colleagues within the profession made strategic use of the long and sad history of ineffective and egregiously invasive treatments psychiatry had brought to gay and lesbian patients. Not only were gay people then increasingly not defining themselves as ill or deviant and were functioning as full members of society despite significant prejudice and discrimination. But, they and their non-psychiatric supporters asked, what kind of medicine is it that could offer those gay patients who came to them in pain no effective treatments toward the "cure" of becoming heterosexual? Was it not the case, given this history, that this medical diagnosis was little more than a professional reiteration of a popular and pernicious prejudice? Where was the vaunted objectivity of medical science in this case and what had happened to the ethical injunction of medicine to "do no harm"?

To bring the story into the new century—in the United States at least—we have witnessed what only can be called a dramatic destigmatization of same sexgender desire around the question of marriage equality and various enactments of "family" such as

adoption and child rearing. Today in the United States, the claim that gay, lesbian, and transgender people are "sick" sounds antique (although it surely is not the case that stigma and discrimination against them here are gone). Instead, we read recent news stories of law suits filed by gay and lesbian couples against business owners who refused to provide services for weddings on grounds of religious freedom; and of Jan Brewer, the governor of the politically conservative state of Arizona vetoing a state bill, with wide political support behind her, that would have allowed such owners to do just that in the name of "freedom" (Paulson and Santos, 2014).

In a series of other court rulings and state legislative enactments across the country, the law seems to be running fast to keep up with shifting public opinion in favor of equal treatment for people of different sexualities. The slogan "marriage is between and man and a woman" now can quite simply be said not to be the case in a growing number of states. The term "lifestyle," emergent in the 1970s, along with the widely-accepted view that our sexualities are with us at birth have significantly removed the "deviance" premise on which the medicalization of deviance argument rests. Despite attempts by various religious fundamentalists to maintain the age-old stigma; despite the horrific effects of the AIDS epidemic and the attempts to paint it as the "gay plague" and punishment from an angry God; and notwithstanding the ongoing yet unsuccessful attempts to find a "gay gene" or biophysiological cause, at least in the United States and in some other parts of the world, same sexgender desire and behavior offer diminishing deviance to be medicalized (see Conrad and Angell, 2004).

At the same time, the recently passed Draconian laws against homosexuals in Uganda and in India, to name only two present cases, that harshly criminalize same

sexgender desire, behavior, and even the support thereof, offer new yet unfortunate opportunities to "test" whether or not the theoretical claim that medicalization can override the morality of stigmatizing state and religious discourse is the case. So far, in Uganda at least, solicited "medical" input on the question of the origins of homosexuality have not been sufficient to prove it other than a "choice" and hence punishable under the legal doctrine of a "free will" transgression of convention (Cowell, 2014; Hamer, 2014). It would not be the first instance in which evidence is at least equivocal for the prediction by medicalization theory that the label "sick" significantly diminishes stigma relative to "sin" and/or "crime" is equivocal (see Room, 2005; Schneider and Conrad, 1980).

Pharmaceuticalization? Biomedicalization?

Scholars have raised the question of whether the shifts in medicine, science, and biotechnology are such that the topic of study should be renamed "pharmaceuticalization" or "biomedicalization" (Abraham, 2010; Bell and Figert, 2012; Clarke et al., 2003; Clarke and Shim, 2011; Conrad, 2005). These changes have brought a medicine that is less physician-centered, where doctors' authority is comparatively limited or dispersed: more of them are "employees" today than "self-employed" owners; lowered reimbursement limits imposed by insurance companies and the federal government for their increasingly varied services (often indexed as "managed care"); the influence of new products that can be marketed directly to would be patients/consumers by the drug companies, first made legal in the United States in 1980 (Conrad, 2005; Conrad and Leiter, 2004; Figert, 2011); and the ever more important place of technoscience across the terrain of health/illness care, especially in more economically developed countries. Physicians and medical personnel today share prerogatives for

decision and action on health and illness with a variety of other professionals and interests, and that has changed the way health care operates in the United States and the power of the doctor's voice. That of course is not to say that this voice is in any sense silent or unimportant, and especially so when spoken by elite specialists compared to the general practitioner.

Pharmaceutical companies, surely, have become much more important in shaping what is defined as an illness or health condition and what the treatment of choice might be. Conrad and his colleagues have written on several cases that call attention to this shift, quite aside from how one names the process. How a pattern of arguably normal, if idiosyncratic, behavior becomes the basis for a medical diagnosis is the story of social anxiety disorder (SAD) detailed by Christopher Lane (2007) in *Shyness: How Normal Behavior Became a Sickness* (and see Horwitz and Wakefield, 2007, 2012). Lane writes about the anxiety and discomfort some people—those sometimes called "bashful," "quiet," "reserved," and "shy"—feel from routine social interaction with strangers or from being in and especially "speaking in pubic." He details how the work of a small group of elite psychiatrists and the campaign of drug development and marketing created a new illness label. Lane shows how these key players, in the context of American cultural gregariousness, crafted a new and more restrictive normality for what could be called one's "style" of engaging with others. Emerging out of the labels "social phobia" and "avoidant personality disorder" contained in the infamously expansive 1980 *DSM-III*, social anxiety disorder is further distinguished from more general anxiety problems detailed in *DSM-IV*. Lane (2007, pp. 5-6) notes a popular media report that by the early 1990s, in the wake of the pharmaceutical marketing campaigns for several drugs, the

SAD diagnosis was "the third-most-common psychiatric disorder, behind only depression and alcoholism."

What stands out in this case is the highly effective "constructionist" work done through pharmaceutical marketing, not only of a drug to treat this condition but, arguably, the elaboration, if not the creation, of the very diagnosis itself. From intensely competitive research, development, and marketing by big pharma around selective serotonin reuptake inhibitors (SSRIs) for the treatment of depression beginning in the late 1980s, the company SmithKline Beecham, now named GlaxoSmithKline, drew on these emerging but vague anxiety disorders within psychiatry to imagine a new market for their drug Paxil (paroxetine hydrochloride; see Lane, 2007, p. 105; and see Dumit, 2012). As Conrad and Slodden (2013, p. 66) note, "The first thing on the agenda was to convince physicians and the general public that social anxiety disorder is an illness and not just a personality trait." The strategy here was to avoid contesting with already-established drugs like Prozac and Zoloft for depression, but rather to market the existence of the separate and serious illness, social anxiety disorder, from which they and their product offered relief.

Conrad (1992) and Davis (2010, pp. 228-231) identify another set of cases of medical intervention aided by drug companies and the development of surgical technologies that is aimed at what might be called enhanced normalization or, even, hyper- or super-normalization. Cosmetic surgery (Sullivan, 2001), using human growth hormone to increase height in children (Conrad and Potter, 2004), and pharmaceutical performance enhancement (Wolpe, 2002), including the improvement of cognitive performance (Greely et al., 2008; Outram, 2010) are examples. This foregrounds the

arguably universal vulnerability of human life to what Foucault (1977), perhaps echoing Emile Durkheim, called normalization. It demonstrates again that conditions or measures that might be considered "within the normal range" can become ever more specific objects of judgment and targets for desired change. New medical and biomedical, neurological, and genetic technologies come not only to serve that end but even create it as a possibility, inextricably wedding technology and desired change (Cartwright, 1995; Barad, 2007).

Foucault's (1991, 2003) writings on biopower and governmentality help us connect these developments not only to the treatment of individual human bodies but to notions of the health and wellbeing, if not the "quality," of populations and "society." Writing on medicalization, at least in U.S. sociology, has not often engaged questions framed in these terms. With the increased importance of molecular genetics and the neurosciences, not to mention emerging synthetic biology, where the unit of analysis is, surely, at the sub-individual level far beyond questions of the "intention" or "will" of the human being involved, we should think medicalization also in these terms.

Biotechnology, Risk, and the Protection of Society

Adele Clarke (2003, 2010) and her colleagues and students have written in counterpoint to Conrad's view that "medicalization" remains the preferred characterization of the topic of study. They argue that while the insights from the 1980s writing are foundational, they now should be supplemented by both a recognition of how medicine and health and indeed life have been transformed by biotechnology.

Clarke and Shim (2011, pp. 179-180) characterize the history of U.S. medicine as divided into three periods: a period of origin and rise, from about 1890 to 1945; a time of

"medicalization," from 1940 until about 1985, which saw an expansion of the boundaries of the medical and that corresponds closely to what Conrad and I called the medicalization of deviance and social control; and the period since 1985, which they name "the biomedicalization era," characterized by a significant presence of cutting edge biotechnology "not only for treatment but increasingly also for health maintenance, enhancement and 'optimization'" (p. 180; and see Burri and Dumit, 2007, p. 5). Nikolas Rose (2007a; and see Rose and Abi-Rached, 2013) has called this latter aim part of each person's individual responsibility to "make the best of" our human being that we can.

Rose's (2007b, p. 700) argument, like Clarke's, is that we have moved "beyond medicalization" and its unmitigated critique of the medical profession's expansion, fueled if not led by biotechnology and biocapital's search for new markets and more profits (see Dumit, 2012). It's hardly the case of course that there is too little here to critique or that corporate interest in biotechnology—as though these could be separated—isn't also primarily about more and bigger markets and profits before it is about health. But there is not here the tone of political and ideological critique that characterized what Clarke and Shim call the period of medicalization. Without denying the force of a "new biology of control," Rose (2007a, p. 248) recommends hesitation before too easily seeing capital and technology as bad and an unmitigated resistance to them as good. In *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*, he examines instances of the imbrication of biology, medicine, science, politics, technology, and control as they appear at the beginning of this new century, a century that rather quickly became not that of the gene but rather of molecularization and even neuromolecularization to underscore a thoroughgoing material pluralism, constant

contingency, and modulation of "the object" of medicalization research. Indeed, it is here, as Rose and Joelle Abi-Rached (2013, p. 209) suggest in *Neuro: The New Brain Sciences and the Management of the Mind*, that we may see one sense in which questions collected under the terms medicalization and biomedicalization become "postmodern" in the backgrounding of the individual or subject of humanism. That subject suffers an additional "humiliation" at the hands of these developments in that she or he is divided or subdivided into sub-individual capacities, potentials, and vulnerabilities that become the bases for future practices of intervention and policy (and see Clough, 2007 on affect).

Rose gives attention to a familiar but still relevant supposed link: the alleged, claimed, and challenged connection between crime and brain as seen in the new biological criminology. While he has called this field "one key site for the biologization of the human soul," he also argues that there is no evidence that these new biological sciences of the brain or body are likely to unseat the cultural doctrine of "free will" and the conception of individual responsibility for wrong doing (Rose, 2007a, p. 225). While research and popular media give much attention to the relevance of this work for policy, courts historically and still have been quite resistant to accepting the details of this science as grounds for the exculpation of criminal responsibility. They have been more open its relevance in sentencing and in the criminal justice practices that surround adjudication (cf., Morse, 2010).

Where Rose and Rose and Abi-Rached see a more potentially consequential relevance of the biology of social control, which Rose (2007a, pp. 226-229), insists is not a new eugenics movement, is in its contribution to the larger discourse and practice of risk identification, assessment, and reduction and to "social protection" (Rose, 2007a, pp.

241-248; Rose and Abi-Rached, 2013, p. 190). Congenial to Foucault's characterization of strategies and practices to ensure and protect the security or "good order" of society, this arguably updates the "classic" approach to medicalization—and the medicalization of deviance in particular—that Conrad and I helped launch. And in this, Rose tweaks Foucault's argument away from the a focus on the control, oversight, and health of populations. Although the aims of biopower that Foucault describes—the health and regulation of society—remain, these authors argue that in this new neurobiology of control and the reduction of risk, we can see a return of the clinical gaze to the individual or, in fact, to biophysiological, chemical, electrical, and physical capacities of the human being that, in entwinement with social and cultural location and experience, are thought to produce the self or subject who is or becomes "a problem" not only for him- or herself but for those in his or her social surround.

Rose and Rose and Abi-Rachid underline how this concern with the identification and management of risk linked to biology, genetics, and neurobiology focuses attention on the future. This is also a central theme of Joseph Dumit's (2012) *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Through their use and control of clinical trials (see also, Cooper and Waldby, 2014), pharmaceutical companies pursue ever-expanding markets for bock-buster drugs and their "me too" clones in search for expanding profits. Similar to but apparently considerably more developed than the search for what Rose and Abi-Rached (2013, p. 167) call "pre-criminals" and "pre-delinquents" with neurological biomarkers for violent and impulsive behavior, the drug companies that Dumit studied have succeeded where the neuroscientists have not, at least at this point. Their resources have been anxieties about risks to health; direct to consumer

advertising; unimpeachable objective data from their clinical trials; and ever-more compliant and constrained general practice physicians to create and market diseases for which they then offer the perfect drug. "Talk to your doctor about your number. Turn it up," advises a television commercial for AndroGel, a product to help men with "Low-T" or low testosterone levels (April 13, 2014). A website (www.androgel.com) for the drug offers "a Low-T symptoms quiz" to help viewers diagnose. And, Dumit (2012, p. 81) notes, when patients do ask their doctors about a brand name drug for a condition they may well have self-diagnosed, again with big pharma's help, doctors typically comply. Here, the normal is redefined objectively as "predisease" and properly in need of treatment.

In the case of such "risky individuals" or "individuals at risk," even unbeknownst to themselves, Rose imagines the responsibility of "officials" to identify persons who have been flagged as carrying potential for impulsive or violent—or, perhaps, only troublesome—behavior and then moving to intervene before this prediction comes true, completing the "screen and intervene" logic that has emerged in the "risk society" in which we live (Beck, 1992). For those of high risk for such presumably biologically-based behavior or for those who have demonstrated it, depending on its severity, it becomes the protection of society from these individuals that is the aim. And, indeed, Rose has called proposed mass screenings of this sort by medical and therapeutic personnel using cutting edge technology "crime control as public health" (Rose, 2007a, p. 249; Rose and Abi-Rached, 2013, p. 190). In the parallel case of otherwise healthy people who have been identified as carrying various and often heritable "risk factors" for future serious health problems, Dumit (2012) describes how this responsibility already has in

fact become that of the "expert patient" him- or herself to take matters into hand to self-medicate. Health increasingly means, Dumit argues, taking drugs for life even in the absence of symptoms or diagnosis. Here is a "new normal," for sure.

A brief consideration of recent events in the United States involving mass shootings, bombings, and the lurking figure of the "terrorist" broadly and regularly covered in the media, would seem a context ripe for Rose's informed speculations. In casual public conversations, for instance, about greater control of guns in the wake of such events, "mental illness" is offered by various interested parties to account for the badness. It is, as one forceful lobby insists, after all, "people who kill other people, not guns." What we must do, the argument goes, is to develop policies and practices that find those who are at and in risk of such violent and destructive acts, who suffer such abnormalities of brain, body, genome, protein, chemical, electrical functioning, and so on, and contain this risk.

The complexity of the circumstances described in this work does not productively yield to simple critiques of biological determinism or reductionist explanation, arguments that Rose insists are, for the most part, also rejected by the molecular geneticists, neuroscientists, and medical experts who actually do the research that grounds biological criminology and parallel sciences. Instead of a too facile critique, Rose urges careful and open consideration of who benefits and who is threatened by these practices and the technologies involved; a careful review of "gains" and "costs" for, and to, whom. To paint these developments with too broad a brush, and to paint them all thus, with a disagreeable color, only serves to cloud our understandings of how science and medicine might be understood as relevant to building a future in which human difference in all of

its contradiction—and often its unavoidable pain and suffering—can coexist with at least some degree of flourishing.

Thinking Deviance in the Wake of Medicalization

Rose's claim that "medicalization" today points to no singular process or logic and that medicine and medical technology or biomedical technology have become inseparably entwined with the lives we lead seems sound. Given its history, it risks missing important developments in the worlds and processes it aims to highlight (Rose 2007b, pp 701-702). Moreover, as he notes, physicians and medical personnel, with a few important exceptions, "do not force diagnostic labels on resistant individuals" (Rose, 2007b, p. 702). Even in the case of pharmaceutical company marketing, Rose insists, our understandings are not deepened by seeing patient-consumers as hapless and passive "victims" of either capitalist behemoths or self-serving, entrepreneurial physicians. Indeed, as Dumit's analysis shows, patients are surely "active" in their "jobs" as consumers, crafted, or as Louis Althusser (1984) might say "hailed," as the expert patients that big pharma asks them to become.

"In the molecular biopolitics of our present," Rose (2007a, p. 253) writes, "many aspects of our human vitality have already become technical, opened up to manipulation and modification in the operating theater, the clinic, the schoolroom, the military, and in everyday life." Much of what once was taken as given—as "natural" and "biological," as "normal" and "pathological"; even "life itself"—has been opened to reconsideration. The interest in biological risk, its molecularization and neuromolecularization, and the specification of entities demonstrating or subject to it is, surely, not a story with one theme. The enabled biotechnological intervention to "repair or even improve an

organism, and hence a life, that would otherwise be painful, short, or suboptimal" is as much a part of the promise here as are horror stories of questionable treatments with iatrogenic results (Rose, 2007a, p. 253).

Every such intervention, however, requires multiple judgments around shifting standards of normalization and hence seems relevant to the kinds of questions Conrad and I originally raised with our writing on deviance and medicalization. It seems more than apparent that scholarly and critical attention to the complexities of such moments of decision and judgment, and to the question of who benefits and who loses from such decisions and how, is more than worthwhile. As Rose notes, we live in a time when our fleshly bodies in all of their minute detail and connections beyond our skin are open to new intentional modulations in which "questions of judgment have become inescapable." It is an age, he says, of "biological citizenship, of 'somatic ethics,' and of vital politics" (Rose, 2007a, p. 254).

As for the relevance of these developments to a sociology of deviance, Foucault's well-known argument about the centrality of normalization in modernity through and in which biopower flows can perhaps breathe life into and broaden what some have seen as a subfield of academic sociology sagging in its popularity. Foucault's view of normalization and its ubiquity is congenial to the sociological traditions of interactionist and constructionist theory I noted at the beginning of this chapter and that grounded our early work. Medicalization invites a link between deviance and the sociology of science and science studies, which focus attention precisely on how knowledge and facts are produced, how the thresholds and lines are drawn in the clinical trials that Dumit and Cooper and Waldby describe in the endless hopes of screening for risk in the fantasy of

achieving ever more fine-grained control, regulation, and security. Whether this tradition of work is best called medicalization, pharmaceuticalization, biomedicalization, or neuromolecularization seems somewhat beside the point. What does seem clear is that the general form of the original argument of the medicalization of deviance, which I take to be normalization, is very much alive and well in each.

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