

# DEVIANCE AND "MEDICALIZATION

**FROM BADNESS TO SICKNESS**

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# 10 A THEORETICAL STATEMENT on the MEDICALIZATION of DEVIANCE

**T**his chapter serves as both a conceptual summary of the various cases discussed in this book and as a theoretical statement about the medicalization of deviance in American society. In essence, we propose here a general sociological account, grounded in the historical data we have presented and drawing on common themes and patterns. The chapter offers not a formal, positivist "explanation" but rather an attempt to draw out what we perceive to be the major analytic or theoretical insights about the social and historical processes we have discussed.

In this theoretical statement we attempt to account for the rise and fall (but mostly the rise) of medical designations of deviance. Any such general sociological understanding of medicalization should also, of course, include demedicalization, although there is considerably less historical data about the latter on which to base generalizations. Thus we propose that our "theory" is neither definitive nor exhaustive but rather that it represents an attempt to specify what general lessons we may learn about the rise and dominance of, and occasional challenge to, medical definitions and controls of deviant behavior. We divide the chapter into three parts: a review of the general historical and conceptual background of medicalization, an inductive theory of medicalization, and, finally, a section containing some of our more speculative hunches and hypotheses.

## HISTORICAL AND CONCEPTUAL BACKGROUND

As is evident in the various chapters of this book, the medicalization of deviance has a long history, beginning at least as early as ancient Greece. The ideas that disease can cause deviant behavior, that deviant behavior can lead to disease, and that such conduct is itself an illness or a symptom thereof have existed in various forms for thousands of years. It is, however, only in the 19th and 20th centuries that we see medical designations of deviance become the dominant definitions of deviant behavior. We must, then, first examine the general conditions in these centuries that appear to have created an environment fertile for medicalizing deviance. Although many factors contributed to the emergence of medicine as the dominant definer of deviance, we believe the most important for the modern medicalization of deviance were the rise of rationalism, the development of determinist theories of causation that arose in the 19th century, and the growth and success of medicine in the 20th century.

The European Enlightenment of the 17th and 18th centuries nurtured the ideas of individual and collective progress. The dominance of theological definitions and explanations for human behavior, including deviance, were seriously challenged by thinkers who posited rational and scientific principles by which to understand and then govern individual behavior and society. Rousseau, Voltaire, and Cesare di

Becarria made important contributions to the new rational philosophy. The criminal in Becarria's classical criminology was depicted as a rational actor and considered to have free will (see Chapter 8); in short, to be responsible for his or her own behavior. In this view of rational action, behavior was generally seen as turning on a pleasure-pain calculus; people were believed to seek pleasure and avoid pain.

The Enlightenment also nurtured the development of science as a method for understanding the world. By the 19th century, scientific theories advanced the idea that behavior, and even society, were determined by "forces" over which individuals had little control. Classical criminology was challenged by the development and ascendance of *determinist* theories of criminality and deviance. These theories took two general forms: social (environmental) determinism and biophysiological determinism. Social determinism, such as the theories of environmental cause postulated by the American asylum superintendents (see Chapter 3), and later theories based on the work of Marx, gained considerable popularity. Toward the middle of the 19th century, biophysical theories such as that of Lombroso echoed the new discoveries of Darwin and proposed that the causes of deviance could be found in one's constitution and/or biological heritage. These determinist theories, in their many forms, became the dominant explanation of deviant conduct and persons. People were "bad" not so much because they chose to be but rather because they had no alternative: they became "objects" at the mercy of powerful social or biophysiological forces.

These determinist scientific explanations "made sense" of deviance in such a way that punishment for such conduct became somewhat less important as a strategy for controlling deviant behavior. It was considered incapable of affecting this social or biophysiological fate by which the deviant was believed to be determined. "Treatment," rather than punishment, became increasingly popular as the more humane and preferred way of controlling crime. As we have noted, this change has been called the divestment of the criminal law—the relinquishing of legal jurisdiction over many

forms of traditionally "criminal" conduct—and has occurred in the United States over the past century (Kittrie, 1971).

As we pointed out in the first chapter, medicine did not become a dominant, prestigious, and successful profession until the turn of the 20th century. Medicine's own determinist theory, the germ theory of disease, became popular and dominant after about 1870 and provided medicine with some of its greatest clinical achievements. It proved to be the key that unlocked the mystery of infectious disease and provided the major perspective in terms of which physicians viewed illness. It was, however, the actual control of infectious disease (which, incidentally, had little to do directly with the discovery of the germ theory [Dubos, 1959]), along with the consolidation and monopolization of medical organization and practice about the turn of the century that enabled the medical profession to achieve a position of social and professional dominance.

Many analysts and students of Western society have suggested the great importance of certain major historical transformations in shaping the nature and contours of modern society. These various developments are used commonly to account for a broad range of other social and cultural changes. The list is somewhat standard and includes industrialization, the decline of religion, the demise of the extended family, the loss of traditional authority, increased geographical mobility, the development of technology, the professionalization of society, and the increased value of humanitarianism. Medicalization, too, has been explained at least in part by reference to some of these historic shifts. One difficulty with such explanation is that it often provides only limited understanding of how in fact a certain change in practice or policy took place. Saying, for example, that medicalization is caused by the professionalization of society leaves us wondering just what that might mean. These global developments that are themselves used to define modern society could be used to account for virtually any changes that followed them in time. This is not to argue that they are meaningless or that they should be ignored in attempting to

understand the medicalization of deviance and its rise. Rather, we have attempted in the chapters of this book to give these abstractions a degree of life by identifying them as values used by real people making claims for a certain change, or at least by trying to define them on a more empirical level. We have tried to show that changes, even such massive ones as these, do not just happen; they must be championed, their themes invoked and defended against challenges, and renegotiated.

With this in mind, we can say that the rise of rationalism, science, and the popularity of determinist theories of deviance, as well as the professionalization and monopolization of medicine, were general social conditions that appear to have given impetus to medicalization. That is, people who championed these and related ideas tended also to support and sometimes to actively promote medicine as a way of defining and dealing with personal problems and deviant behavior. In terms of the history of ideas, medical theories of deviance grew out of the same materialist determinism that spawned the work of Darwin, Marx, and, later, Freud. And the medicalization of deviance in particular flourished in the United States. In the following discussion we explore some features of American society that have been supportive of medical theories of deviance.

#### **American society as fertile ground for medicalization**

The medicalization of deviance has been nowhere more pervasive than in the United States. This is not to say that medicalization is unknown elsewhere; numerous instances can be cited. For example, we have alluded to the medicalization of madness and opiate addiction in Great Britain and to the 19th-century medicalization of homosexuality by German physicians and of crime by European positivist criminologists. American society, however, and especially since the late 19th century, has provided a particularly hospitable environment for the medicalization of deviance. In this discussion we point to some general cultural and organizational features of American society that have contributed to this nurturant context.

The United States, more than its European counterparts, has a strong heritage of experimentation and utopianism. Some have called America itself a "noble experiment." It has been a society regularly open to new ideas and innovative ways of doing things and solving problems. One might even suggest that the "new"—the latest and the best—has become a fetish with many Americans. In addition, the value of humanitarianism is deeply ingrained in the American ethos. Indeed, Americans have been espousing this value of humanitarianism since the Declaration of Independence, although not following it consistently as a society. But along with idealism and humanitarianism, Americans have shown a strong penchant for pragmatism and particularly for pragmatic solutions to human problems. Rather than engaging in philosophical or even scientific debate toward a more full understanding of such problems, Americans are more likely to ask, "What can be done about it?" Another dominant value used to describe life in the United States is individualism. Although all societies and social groups must strike some balance between the individual's needs and those of the collectivity, in America the balance usually is tipped in favor of the individual. Certainly in terms of solving social problems, typical solutions are nearly always those which involve intervention not in the established institutions of the society but rather in individuals' lives. Such a strategy is based on the dubious assumption that the source of the problem in question rests somehow in the person rather than in the diverse and often conflicting social and cultural environment (see Ryan, 1971a). In a general sense, the American values of experimentation, newness, humanitarianism, pragmatism, and individualism have all contributed to a nurturing crucible for medicalization, for the medical perspective on deviance contains elements of all these values.

Max Weber (1904-1905/1958) argued persuasively for the importance of the Protestant Ethic in the development of capitalism and the rationalization of Western society. He located the root of the Protestant Ethic in early Protestant asceticism, and particularly in the Calvinist doctrine of predestination. Predestination, in

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Calvinist terms, meant that those who were among the "elect" and would thus be "saved" had been identified or selected by God when they were born. Nothing that one did on earth could change this divine ordination. Hard work, frugality, and thrift, however, were important values of Puritan life, and it was believed that certainly those whom God would choose would be those who lived their lives according to such desirable standards. Such conduct, if followed devoutly, also led ultimately to material success and accumulation, and although one could in no sense "work" one's way into heaven, such material achievement was believed to be a reasonably good sign that a person was one of God's chosen. No one, of course—at least none of the respectable members of the community—wanted to be considered among the damned; so Calvinists in general worked hard and accumulated much. Work, thrift, and material accumulation thus became important ends in themselves. This, according to Weber, provided the "spirit" conducive to the development of capitalism.

Mordechai Rotenberg (1978) suggests that Weber's thesis may be extended to account for the Western, and especially American, way of defining and treating deviance. He suggests that the Protestant ethic of predestination leads to a fundamental division of people into two camps: the righteous-elect and the wicked-damned. Since their selection is predetermined, there is little confidence in the possibility of change. In these terms, failure or deviance is the converse of success, as damnation is the opposite of election. Rotenberg suggests that the Protestant Ethic creates a "spirit of failure" that profoundly affects the manner in which we think about deviants and the techniques we use to treat them:

More specifically, I have posited that just as the Protestant Ethic had a general impact on the Western world in terms of economic development and increased achievement behavior—as Weber [1904-1905/1958] and others have posited—the covert belief that deviance and failure are symptoms of an innate and irreversible state of damnation is equally pervasive in Western culture, since both tenets are traceable to Calvin's influential doctrine of predestination. (p. 23)

Rotenberg contends there is a historical link between the damnation metaphor and the contemporary medical model of deviance. He observes that the latter, which classifies people as healthy or sick, reflects the same dichotomous assumptions as do the Calvinist notions of elect and damned. Furthermore, the Protestant ethic of predestination is at least partly "responsible for the belief in man's inability to change," which underlies much of the biophysiological determinism of the medical model (Rotenberg, 1978, p. 2). One could also suggest that both the notions "damned" and "sick" focus attention on the individual's condition apart from social context and portray deviance as innate, determined, and largely irreversible. To the extent that the Protestant Ethic pervades American society (see Merton, 1957), it can be argued that it is a cultural condition conducive to the medicalization of deviance.

American society has cultivated an extraordinary faith in science, both as a way of making sense of experience and as a source of dazzling and problem-solving technology. As a way of understanding human behavior, this scientific legacy has been almost wholly positivist—it has involved adopting natural science assumptions to understand and account for the way human beings behave in the social world. As one might suspect, that has produced a good deal of misunderstanding in social science and particularly in the sociology of deviance. This positivist heritage has also been the kind of science adopted by nonsociologist officials, politicians, and bureaucrats, as well as the public at large, to define and "explain" deviant behavior. David Matza (1969) has called this the affinity model of explaining deviance—where conduct is portrayed as determined by an individual's affinity or "predisposition" to it. Such predisposition (sounding suspiciously like "predestination") is believed to be a product of the circumstances in which deviant actors find themselves and over which they have little control. Deviant actors have been seen by science as in general the product of various kinds of "forces"—not at all unlike the medical determinist theories just discussed. In short, this positivist view of social behavior and specifically deviant behavior reinforces the rigid and

categorical thinking that is the heritage of the Calvinist idea of predestination. Deviants and their conduct may be explained, then, not only by God's will but by "natural laws" as well.

Science also has enabled us to do things and solve problems much more easily—more efficiently, with less effort and time. It has, in short, allowed the development of an amazing array of sophisticated technologies, including electricity, automobiles, airplanes, radio, television, computers, and space satellites. Medicine's technological achievements have been no less spectacular. Americans have been pioneers in technology and have adopted a pervasive belief in science as both "good" and essential to "progress."

Our society pays official tribute to democratic political participation and public debate. This allows for challenges to dominant viewpoints and established interests, both in and out of conventional political arenas. Challenges to criminal and medical definitions of deviance may emerge under such conditions. Since the Progressive era, however, more influence and "credibility" have been given to those designated as "experts." As Richard Hofstadter (1963) notes, "In the interests of democracy itself, the old Jacksonian suspicion of experts must be abated" (p. 197). In the rush to the dependence on various kinds of experts that we have witnessed in this century, perhaps the leading example has been the physician as the expert par excellence on matters of health and illness. Translated into less abstract terms, this means the physician has become the premier expert on personal problems, both of the body and the mind.

As we discussed in Chapter 1, the monopoly of medical practice and the development of medicine as a profession gave physicians relative independence and functional autonomy (Freidson, 1970b). The "miracles" of modern medicine and the growing status of the physician-expert brought a considerable charisma to the medical profession. At the same time, and perhaps not unrelated to this, health has become a primary value in American society. Health is used as a justification for controlling powerful corporations (e.g., through air pollution and occupational safety regulations) and as a cri-

terion for defining activities as deviant (e.g., cigarette smoking and alcohol drinking). For some, a commitment to health has become almost a "leg up" on immortality or salvation. It is perhaps not surprising to find that in a society where such a high value is placed on health, the sick are considered "deviant" and the deviant are considered "sick." In both cases, this commitment to health serves as a justification for the treatment and control of such undesirable persons.

Finally, medicine can be highly profitable in a capitalist society. Medicalization can create new markets for products and services. This is true not only for medical practitioners but, perhaps more important, for entire industries. The pharmaceutical, health insurance, and medical technology corporations, as well as other medical industries, have achieved phenomenal growth in the past three decades. Although we make explicit connections to the pharmaceutical industry in three of our cases (madness, opiate addiction, and hyperkinesis), we contend that the profitability of medicine in American society has contributed in both specific and general ways to the medicalization of deviance.

In summary, important American values align well with the medical model of deviance. In recent years health itself has become a predominant value. American society, with its democratic system, is open to challenges of new definitions of deviance. Medical practice is independent and expansive. In a capitalist society, medicalization can create new markets and be highly profitable. In short, in American society medical conceptions of deviance have a cultural resonance both with dominant values and the organizational apparatus to promote and sustain them, creating a fertile environment for medicalization. In the following discussion we begin to develop a model of how this medicalization of deviance occurs.

### AN INDUCTIVE THEORY OF THE MEDICALIZATION OF DEVIANCE

Social conditions conducive to medicalization are alone insufficient to produce new definitions of deviance. New deviance designations do not emerge by themselves but are the product of collective enterprise and claims-making

activities (Spector & Kitsuse, 1977). As we argued in Chapter 2, the process can be called "the politics of deviance designation." Throughout this book we have emphasized the socially constructed nature of deviance definitions and designations and the role of individuals, organizations, social movements, and other interests in creating and implementing them. In this section we outline an inductive theory of the medicalization of deviance grounded in the cases we have examined.\* Given the variety of cases, actors, and circumstances we have discussed, it is not possible to construct a theory that accounts for all aspects of every case. We attempt rather to develop a theory of the medicalization of deviance that can be maximally generalized, yet that does not do violence to the empirical reality of our cases. In our discussion we will make note of cases that deviate or vary from the model proposed. We present our theoretical outline in two parts: a sequential model and grounded generalizations.

### A sequential model

Before our sequential model is presented, three points need to be made. First, we caution the reader to keep in mind that it is a theoretical model, and the stages delineated are not always distinct and separated clearly in practice. Second, it is important to understand what we mean by medical "deviance designation." When we say claims-makers promote a new deviance designation, we do not necessarily mean that the claim is presented in this manner, that is, by claiming that the deviant behavior is "sickness, not badness." Rather, medical claims are couched in terms that *attempt to conceptualize deviance as a medical problem* and may be presented as a medical diagnosis or etiology and/or treatment for the deviant and the deviant's behavior.

\* Conrad (1976, pp. 93-97) presented an initial statement toward a theory of the medicalization of deviance based largely on his study of hyperkinesis. In it he outlines five antecedent and two contingent conditions of medicalization. Although that statement may still have some utility, the one presented here, drawing on comparative and historical data, is more broadly based and theoretically developed and modifies some of the earlier tenets.

Third, our sequential model of medicalization takes as its point of departure the recent work of Malcolm Spector and John Kitsuse (1977) on the sociology of social problems (recall our discussion in Chapter 2). We use, for example, Spector and Kitsuse's concept of claim in two related yet distinct ways regarding the medicalization of deviance. First, after these authors, we consider a claim to be a medical demand, contention, or assertion, such as claiming that opiate addiction should be treated by physicians. Our second usage, going beyond this first meaning, defines claim in the metaphor of a miner engaged in prospecting land. Like the miner claiming that a portion of the land is his or her own, a medical "claim" of legitimate jurisdiction may be "staked" over a particular segment of social, personal, or even geographical "turf" as something that "belongs to" medicine and physicians as a professional group. An example of this latter use of claim would be the early 19th-century official medical control of access to and regulation of asylums in England. The first kind of claim is primarily a matter of words and images; the second more a question of "making good" such definitions by usurping or taking charge of a particular procedure or territory as medicine's own.

We propose a five-stage sequential model for the medicalization of deviance: (1) definition of behavior as deviant; (2) prospecting: medical discovery; (3) claims-making: medical and nonmedical interests; (4) legitimacy: securing medical turf; and (5) institutionalization of a medical deviance designation.

1. **Definition of behavior as deviant.** In nearly all the cases we examined, the behavior or activity in question was defined as deviant *before* the emergence of medical definitions. Madness, chronic drunkenness, homosexual conduct, delinquency, and criminal activities were all defined as highly undesirable before any medical writings or perspectives appeared. Prior to the Harrison Act, for example, opiate addiction was, by and large, not considered particularly deviant. The Harrison Act criminalized, and thus made deviant, opiate addiction. Opiate addiction was thus deviant prior to attempts to remedicalize it in the 1960s. Child abuse and hyperactivity are somewhat more am-

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biguous cases. Most likely, child battering, when it was so defined, was considered deviant. Yet among physicians and the general public alike it was rarely recognized or construed as such (Pfohl, 1977). This suggests that the medical discovery of child abuse was at least in part the invention of a new form of deviance. Hyperkinesis presents a similar situation. Restless, disruptive, and overactive children are surely defined as deviant in most school classrooms; yet it was the discovery and promotion of the medical label that gave shape to this vague form of deviant behavior. To recapitulate, behavior is generally defined as deviant before medical designations are proposed.\* As Erich Goode (1969, p. 88) observes, negative evaluations of behavior precede explanations of it, or, put differently, explanations follow attitudes. We might suggest that medical designations of deviance reflect and give shape to commonly held definitions of deviance, rather than defining deviance anew out of whole cloth. In a sense, medical designations validate commonsense definitions of deviance. This highlights the continuity between badness and sickness designations: they are both negative moral judgments.

2. **Prospecting: medical discovery.** The "discovery" of a medical conception of deviant behavior is first announced in a professional medical journal (or, more rarely, in a book or at a conference). It appears in the form of a description of a new diagnosis (hyperactivity, child abuse), the proposal of a medical etiology of deviant behavior (alcoholism, homosexuality), or the report of a new medical treatment for problem behaviors (methadone, psychosurgery). Any of these may be used to promote a medical deviance designation. These articles are usually the product of the work of a limited

number of physicians, generally researchers, who are specializing in the problem and who often are professional colleagues.

We call this stage "prospecting" for two reasons. First, many articles about medical conceptions and treatments of deviance are published in professional journals but never subsequently become ammunition in claims-making activities. They may be ignored, buried, or quietly refuted. Second, such articles are, by and large, formal and informational and, although they represent a viewpoint, constitute a "challenge" only in the most academic sense.

As we pointed out in earlier chapters, publication of scientific and professional articles, even in prestigious medical journals, does not assure a new deviance designation's recognition or acceptance. It needs champions and moral entrepreneurs to carry the banner and bring the new problem or definition to public attention. When this happens, the claims-making stage begins.

3. **Claims-making: medical and nonmedical interests.** This is a key stage in the emergence of new deviance designations. It is at this point that champions, moral entrepreneurs, and organized interests begin actively to make claims for a new deviance designation and attempt to expand the medical social control turf. Both medical and nonmedical interests engage in claims-making activities.

The medical professional interests involved in making claims for a new deviance designation usually comprise a specialized group. They are either medical researchers of a specific problem (as in stage 2) or are administratively involved in treating the deviant behavior in question. By "administratively involved" we mean that these physicians either operate a special clinic treating the behavior in question or are attached to an institution mandated to deal with the problem. These physicians are not typical of the medical profession in general, and their activities and concerns are far removed from the rank and file of medical doctors. The latter are rarely if ever involved at this stage. In fact, aside from receiving information about "important discoveries" and claims published in journals or presented at professional meetings, most physicians are completely removed from such claims-making activities.

\* In the 19th-century example of abortion, summarized in Chapter 1, although *not* a case of medicalization, it appears physicians were instrumental in defining that activity as deviant. However, in the case of masturbation in Victorian times, physicians clearly medicalized commonsense deviance definitions of this activity (see Englehardt, 1974). George Becker (1978) notes that the negative and deviant definitions of "mad" genius preceded the development of the medical definitions. These cases seem to support our contentions in stage 1.

The small group of active medical claims-makers are, by and large, not organized specifically around the promotion of a new medical deviance designation but come together primarily because of their similar professional interests and viewpoints. Although medical professional claims-making may seem like an organized activity, in its early stages it is composed generally of individuals or small groups engaged in promoting the new designation. Their activities are more parallel than in concert. One type of concerted claims-making that medical champions do engage in is the organization of professional forums and conferences at which to display their claims. These include institutes, seminars, workshops, and various meetings designed to publicize and promote their views to others, especially the nonmedical personnel who deal regularly with the problem behavior. Exemplars include the Yale Center Summer School program on alcoholism and the series of National Conferences on Methadone Treatment.

This loose alliance of claims-makers with similar interests is at first primarily an intellectual or professional one, but as claims-making in and out of the profession progresses—sometimes in response to the rise of an opposition—the alliance becomes increasingly politicized. One aspect of this politicization may be an attempt to prevail on their professional organization (e.g., the American Medical Association, the American Psychiatric Association) to support their claims.\* To the extent that medical claims-making is organized, those making claims for a deviance designation attempt to use the existing professional organizations for their own benefit (e.g., securing passage of a supportive resolution or getting the organization to issue a position statement substantiating the claim). Occasionally physicians organize themselves into special interest "caucuses" to promote their viewpoint within

\* Occasionally the professional claims-makers may start their own organization to represent their viewpoint; for example, the American Orthopsychiatric Association to promote the medical view of crime and the American Society of Bariatric Physicians to promote a medical conception and treatment of obesity.

the professional organization, but physicians' claims-making is generally not that organized or politically overt. If the champions of a particular viewpoint are successful in convincing their professional organization to support their claims, the professional society itself becomes an important force for staking a claim.

Professional investigatory committees are often established to evaluate the claims about a new deviance designation. Professional societies establish such committees in response to its member-champions requesting that the organization support a particular claim or in response to outside criticism and public pressure to take a professional stand on the issue. Sometimes these committees are initiated at government request and organized under the auspices of an agency such as the Department of Health, Education and Welfare (e.g., in 1970 for hyperkinesis and 1975 for psychosurgery). The people chosen to serve on these investigative committees are designated "experts" on the subject and not infrequently include those most active in claims-making activities. The investigatory committee's report, regardless of whether it was professionally or bureaucratically initiated, is often supportive to the new deviance designation (with qualifications) and becomes important ammunition in the promotion of the new medical claim.

The activities of nonmedical claims-makers are more overt. Usually drawing on already-made professional medical claims, nonmedical champions and vested interests play an important role in the promotion of new medical deviance designations. Nonmedical claims-making groups in the cases we have examined include corporations (e.g., the pharmaceutical companies), professional and lay organizations (e.g., the Association for Children with Learning Disabilities, the National Council on Alcoholism), government bureaucracies, (e.g., Department of Health, Education and Welfare), and self-help groups (e.g., Alcoholics Anonymous). These groups, in different ways, promote new designations by engaging in publicity campaigns, lobbying in legislatures, and supporting litigation and judicial challenges. These organizations are generally already in existence, and either publicize or expand on the

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medical claim and become its most ardent supporters. These groups have a direct interest, be it economic, moral, administrative, or therapeutic, in the adoption of the medical perspective of deviance. They align and intertwine with medical claims and claims-makers; for example, by frequently calling on the medical champions to lend "scientific" credence to their claims.

These nonmedical claims-makers are important in establishing new deviance designations, since they initiate activity with the public, legislatures, and in court in a way that medical professionals usually do not. They are perhaps freer to promote their position and challenge their opponents, less constrained by "professional ethics" or "scientific" credibility. In short, they use the medical claims as ammunition to battle for the new deviance designation and become its foremost advocates. This allows physicians to take the more dignified role as "experts" rather than overt partisans.

Although claims-makers may use the popular media to advance their cause, publicity seems to play a less significant role in the politics of deviance designation than in the successful emergence of social problems (see Spector & Kitsuse, 1977), largely because the politicking occurs on a professional, administrative, or legislative rather than a public level.\* The popular media can play a role in disseminating information or creating public pressure for a new designation of deviance (or creating a demand for a new medical treatment), but, generally speaking, this is peripheral rather than central to the political struggle. Although the media may occasionally take editorial positions supporting one designation over another, this influence appears to be limited. The media play a more significant role later in this stage and the next by "reporting" the challenges and the "victories" in the designation battle.

The supporters of a medical designation of deviance must, in most cases, appeal to the state for legitimation of their perspective. With

this, the politics of deviance designation moves to the next stage.

4 **Legitimacy: securing medical turf.** This stage begins when proponents of the medical deviance designation launch an instrumental, as opposed to merely rhetorical, challenge to the existing deviance designation. This usually involves some type of appeal to the state, as arbiter of jurisdictional disputes and "official" legitimator of deviance designations, to recognize the medical viewpoint. The arenas of challenge, or "battlegrounds," include legislatures, special investigatory committees, federal bureaucracies, and courts. Often confrontation occurs simultaneously on a number of fronts. Some challenging deviance designations of course never reach this stage, withering in the verbal battles and challenges of stage 3. In some cases, such as homosexuality, appeals to the state play only a minor role, and the arenas of challenge lie elsewhere. In the face of active resistance, however, most medical claims-makers must seek state legitimacy.

The most common arenas of conflict are legislatures and courtrooms. Legislatures, including Congress, may hold hearings on deviance designations (in relation to proposed legislation) and hear arguments from the designation's champions and opponents. A "victory" here for the medical designation means passage of laws supportive of the medical viewpoint and not uncommonly granting medicine official jurisdiction over the question of social control (e.g., madness, child abuse, juvenile delinquency). Judicial decisions, especially from the Supreme Court, may affirm the dominance of one designation over another and, in effect, at least partially legitimize the designation (e.g., madness, opiate addiction, alcoholism). Special investigatory committees, organized by legislatures or part of the state bureaucracy, can weigh evidence and present a report more or less favorable to a deviance designation (e.g., hyperkinesis, psychosurgery). This can be seen as an "official" recognition of one viewpoint over another. In our metaphor of prospecting, it is somewhat akin to being given the "deed" to an identifiable and bounded piece of "property." Needless to say, however, such "victories" are rarely total, such "deeds" not with-

\* The recent "gay rights" referenda are something of an exception, although they are not per se battles about deviance designations.

out conditions and being shared with other "owners" of the property in question. In fact, most cases involve grafting the challenging "sickness" designation onto some parts of older "badness" designations. Winning these "battles" does not necessarily mean achieving exclusive control or jurisdiction over the deviance in question, but medical claims, for the reasons stated earlier, have become increasingly dominant. The battles to define and redefine deviance, however, will continue.

It is important to note the connection between the rise of medical deviance designations and the state. Generally speaking, in the face of entrenched criminal definitions of deviance, the medicalization of deviance cannot occur without some type of approval by the state. The professional dominance of medicine does not extend to the authority to override existing criminal definitions of deviance; thus successful appeals to the state are necessary for legitimation. It is the state that grants medicine the right to a particular social control turf.\* Medicine, in fact, may become the agent of social control for the state, as with opiate addiction and child abuse, or replace problematic parts of the state control apparatus, as with chronic drunkenness. This highlights the complex interface of medical and legal social control agencies.

When the significant battle or battles are won and medical claims-makers and their supporters achieve legitimacy for their deviance designa-

\* This is unnecessary when there is no prior criminal claim to a social control turf, as with hyperkinesis. Similarly, when a particular form of social control is only rarely deployed (e.g., arrest for homosexual behavior), the proponents of the new designation may bypass appeals to the state. It is important to remember, however, that the state maintains ultimate control over this resource of legitimacy. Indeed, medical practice is itself premised on the continued viability of this state-issued mandate. Moreover, in those cases in which there has been a distinction between "criminal" and "sickness" behavior, physicians have often adopted a position that explicitly supports the state's system of criminal categories (e.g., public homosexual behavior is against the law, as is driving under the influence of alcohol), quite aside from whether such illegal activity is thought to be a product of sickness.

tion, we can say that a claim has been successfully staked. Although such claims are of course open to new challenges, if they become institutionalized, they are more resistant to challenge.

5. **Institutionalization of a medical deviance designation.** When a deviance designation is institutionalized, it reaches a state of fixity and semipermanence. The medical viewpoint has been legitimated and now becomes an accepted category in the official order. We find two general types of institutionalization: codification and bureaucratization.

When a deviance designation is codified, it becomes an accepted part of the official medical and/or legal classification system. It is written into law, supported by court decisions, or is included as an official diagnosis in official manuals such as the American Psychiatric Association's *Diagnostic and Statistical Manual*. This provides both a symbolic and instrumental acceptance of deviance as a medical category.

Bureaucratization, the creation of large-scale organizations, is another form of institutionalization. Large social control bureaucracies are constructed that in effect provide institutionalized support for medicalization. Examples include the federal agencies such as the National Institute of Mental Health and the National Institute of Alcohol Abuse and Alcoholism, special programs such as SAODAP, informational "clearing houses" such as the National Center of Child Abuse and Neglect, and, in a different way, the state mental hospital system itself. These bureaucracies support medicalization in one sense by providing research monies, technical assistance, and other institutional benefits to supporters of a particular viewpoint of deviance. On the other hand, they are bureaucratic "industries," with large budgets and many employees, that depend for their existence on the acceptance of a particular deviance designation. They become "vested interests" in every sense of the term. A designation with such a supportive bureaucracy is more securely anchored against challenges and becomes more resistant to change.

When a deviance designation is institutionalized, one could say, adopting Thomas Kuhn's (1970) terminology, it has become the reigning

paradigm for viewing deviance. It is, of course, open to new challenges, especially when anomalous data become available as ammunition for new claims-makers with a different definition or designation of deviance. In the model we present here, when new challengers begin to make their claims, we may return to stage 2 or 3 and continue to observe the politics of deviance designation.

To make one final point, in most cases of medicalization of deviance, public acceptance "lags behind" professional and bureaucratic support. The public remains more skeptical about medical designations than professionals, especially in the cases of alcoholism, opiate addiction, and homosexuality. This skepticism provides a reservoir of potential support for future challenges to medical deviance designations.

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Although this sequential model proposes to explain "how" deviance is medicalized, it does not directly confront the questions of why or when. We begin to address these questions in the generalizations we have drawn from the cases presented earlier.

### Grounded generalizations

In this discussion we present five theoretical statements that could be called grounded generalizations in as much as they emerge from our analysis of the cases in Chapters 3 to 8. We offer these as propositions that seem to us to be suggested in our data.

**Medicalization and demedicalization of deviance are cyclical phenomena.** We have argued that the medicalization of deviance, as reflected in this book's title, is increasing in American society. Although we believe this represents the dominant trend, our investigation also has revealed a cyclical dimension to medicalization. In other words, the changes in deviance designations do not all flow in one direction; there is a movement back and forth between badness and sickness designations.

Let us recall a few examples. In Chapter 5 we described the change in opiate addiction from a medical problem to a crime and back again to a medical entity. In Chapter 7 we

traced the definition of same-sex conduct from immorality to sickness to its symbolic demedicalization (followed, apparently, by a resurgence of an antihomosexual moral crusade). In Chapter 3 we saw a series of more subtle changes, an oscillation between "social" and "biological" emphases in medical designations of madness. Thus we can say that the movement of deviance designations has a cyclical quality.

We ought not be surprised at the fluidity between badness and sickness designations, since this ebb and flow occurs in a common sea of "immorality." As we argued earlier, to define a deviant activity as sickness leaves its negative moral evaluation intact. Because the direction of the moral evaluation of the behavior does not change—it is still disreputable and untoward—under proper circumstances sickness can be redesignated as badness. Unless a behavior or activity is vindicated and no longer defined as deviant, both medicalization and demedicalization take place on a moral, or more properly, an immoral continuum.

This ebb and flow of deviance designations, although played out in various arenas of conflict, sometimes creates jurisdictional compromises and marriages of convenience. Deviance designations may become hybrid badness-sickness amalgams, such as with opiate addicts and sexual offenders, and the social control turf is then shared or divided.

What factors spur a cyclical shift in deviance designations? It seems that medical-sickness deviance designations emerge as a dialectical response to extreme criminal-badness designations. A clear example is the reemergence of medical designations of opiate addiction at precisely the same time in the 1950s that the severest criminal penalties for addiction were passed into law. Other examples include (1) the appearance of medical designations of homosexuality during the same period in the 19th century that saw a sustained drive against homosexual conduct and (2) the recent reascendance of a "biological" model of madness after the domination of "social" definitions during the 1960s community mental health movement. Perhaps similarly, the disease concept of alcoholism emerged right after the repeal of Pro-

hibition. The cyclical nature of deviance designations has a distinctly dynamic and dialectical quality. In short, the extreme of one designation creates fertile conditions for the challenge and emergence of counterclaims. This is related clearly to our next generalization.

**Medical designations of deviance are more often promoted as a "foil" against criminal definitions than as ends in themselves.** Since medical designations arise at an extreme point in criminalization, their emergence appears to be related to this criminalization. Medical designations have been used regularly to mollify the harshness of criminal definitions of deviants and in general as a foil against such designations.

In many of the cases examined, we found the champions of medical designations presenting their claims specifically as a critique of the dominant or ascending criminal definition. K. M. Benkert, the Hungarian physician who proposed a congenital theory of "homosexuality," argued directly against the growing legal repression and harsh punishments for homosexual behavior contained in the Prussian legal code. The mid-20th-century critics of America's criminalization and harsh treatment of opiate addicts used the medical model of addiction, especially as evidenced in the British system of addiction control, as a foil with which to attack the injustice of the criminal treatment of addicts (e.g., Lindesmith, 1947; Nyswander, 1956; Schur, 1965; Duster, 1970). The 19th-century champions of the asylum movement as well as the late 19th-century child savers used medical rhetoric to promote their causes. Time and again, medical and, perhaps especially, nonmedical reformers championed medical conceptions as a critique of harsh and punitive practices. These claims-makers often promoted medical definitions, not for their own sake as more "valid" or "true" conceptions of reality, but as "humanitarian" challenges to what they saw as excessively punitive practices.\* This, of course, underlines the political nature of the

\*One reason reformers chose the medical model as a critique is because it is the only reduced-blame and nonpunitive alternative model of deviance available (recall our discussion in Chapter 9).

medical claims, to which we have alluded many times.

2. **Only a small segment of the medical profession is involved in the medicalization of deviance.** In nearly all the cases examined, only a small specialized segment of the medical profession is ever involved in the politics of deviance designation and the promotion of medical definitions of deviance. Although these claims-making physicians are few in number, their participation is central and critical to successful medicalization. It is their conceptualization of the behavior or condition as a medical problem that provides the rationale and justification for medical designations of deviance, as well as supplying ammunition for claims-making battles. The nonmedical champions rely on and use these medical claims and formulations in their own claims-making activities.

The debates about deviance designations are far removed from everyday medical practice. Rank and file physicians, for the most part, are uninformed about the debates and battles and, furthermore, do not much care about them. Most of the "deviance" discussed in this book simply is not a significant part of the majority of medical practices, and, by and large, most physicians do not wish to deal with such problems.

This requires modification of such general notions as "medical imperialism" as an explanation of the medicalization of deviance. Medical imperialism, to the extent that it exists, is not usually initiated or even supported by the medical profession en masse. The nonmedical interests, be they political, economic, or "moral," aligned with a small segment of the medical profession, constitute the major claims-makers of new medical social control turfs. It is only when a medical claim is successfully staked and becomes part of standard medical practice that most physicians have much to do with it.

3. **When medical designations of deviance are proposed, they most likely will be based on the notion of "compulsivity."** For most cases examined, definitive and uncontestable evidence of biophysiological causation does not exist. In lieu of such evidence, or

in addition to ambiguous organic data, some type of "compulsivity" is proposed as the cause of the deviant behavior. The notion of compulsivity is a central justification for the medical claim.

All concepts of addiction have this notion of compulsion at their core. Medical explanations of homosexuality and psychopathology, and, to a lesser degree, of hyperkinesis and child abuse, indicate the idea of compulsion in their conceptualizations.\* Compulsivity denotes that the individual "cannot help it," since the behavior is caused by forces beyond his or her control. Compulsivity, in effect, removes motivation or cause from the will and locates it in the body or mind. By proposing that the behavior is caused by "forces" beyond both a person's understanding and control, and is therefore not the individual's fault, compulsivity aligns well with our sociological understanding of what constitutes sickness.

Let us explore for a moment the notion of compulsivity in a cultural context. In Western society, moderation and control are important moral values. To be immoderate, excessive, and "out of control" is to be potentially deviant, regardless of the effects of one's behavior. Extreme immoderation is viewed as irrational behavior. Our rational orientation to the world makes understanding such conduct difficult and puzzling. This quasimedical conception becomes then an explanation for the "puzzle" of immoderate and irrational conduct: the behavior is caused by a compulsion, which is itself an illness. Furthermore, compulsivity posits an explanation that is determinist, individualistic, and has a scientific aura, all consistent with the important American values discussed earlier.

Compulsivity, then, becomes a useful and significant part of medical designations of deviance, since it allows for a medical explanation without requiring conclusive evidence for

organic cause. With the exception of opiate addiction, where the notion has been demystified and unmasked as rational behavior to reduce withdrawal pain, most medical claims for compulsivity have not been subjected to rigorous scientific testing. Indeed, it is not entirely clear how such a scientific "test" of the compulsion hypothesis might be constructed, given the vague and circular definitions of it that have been offered (e.g., alcoholism as a product of "loss of control").

The historical sources of compulsivity as a medical explanation for deviance are many and diverse. For example, 18th-century physician Benjamin Rush called inebriety a disease of the will; physicians in the 19th-century depicted masturbation as a compulsive disease; and Freudian theorists have composed several variations on this theme. Yet compulsivity and loss of control are *not* by themselves medical or biophysiological concepts—jurisdiction over compulsions must still be "won" by medical claims-makers.

† **Medicalization and demedicalization are political and not scientific achievements.** We have mentioned the political aspects of medicalization so frequently throughout this book that it seems almost redundant to say it again here. We would like to review what this means and draw out a few additional significant points.

Medical designations of deviance that have been proposed either challenge existing claims or seek to carve out new deviance territory. While the medical claims are proposed in the name of science, they have not been in general subject to the scientific rules of evidence. Although science and medicine add prestige and authority to any claim, supporters must still engage in the contests necessary to get their claim recognized. This is always a political process. Because medical claims are couched in the language of science, yet rarely subject to empirical evaluation, scientific research can threaten as well as support medical deviance designations. With methadone maintenance, for example, early reports were highly supportive of its efficacy in treating heroin addiction; later reports, based on more rigorous research, were increasingly critical. Proponents and opponents

\* Recently obesity and gambling have engendered medical explanations of compulsivity. George Becker (1978, p. 76) notes that in the 19th-century medical conceptions of the "mad" genius "the image of the creative process was to acquire a decidedly compulsive and irrational characteristic."

of deviance designations may use scientific evidence to support their claims. In such situations it is ironic to see scientific research used against medical claims that were themselves proffered in the name of science.

Let us briefly recall several examples that highlight the political nature of the medicalization and demedicalization of deviance. The 19th-century contest for the control of moral treatment and regulation of madhouses can be seen as a key "victory" for the medical conception of madness. The physicians were organized and were able to convince Parliament to support their definitions over lay definitions, although these physicians essentially had no specific or unique knowledge about or ability to treat madness. It was in every sense a "political" achievement. The modern disease concept of alcoholism was intentionally proposed by its champions at the Yale center not for its scientific validity but for its moral and political implications. The two cases of demedicalization we examine in some detail, opiate addiction in the early 20th century and homosexuality in the 1970s, underline with special clarity the political nature of deviance designations. The Harrison Act, and the subsequent challenges by the Treasury Department (supported by a variety of Supreme Court cases), successfully "defeated" the medical designation of opiate addiction. The recent American Psychiatric Association decision that homosexuality is no longer officially an "illness" was achieved in large part by the overt politicization of the issue by gay rights activists and a few psychiatric sympathizers. In our judgment, defining behavior as an illness is always a political achievement, although the actual politics are sometimes subtle or obscured and difficult to sort out.

We wish to make one final observation in this section. We were surprised at the apparently small significance of medical technique or technology in the politics of deviance designation that we have studied. Medical technology—drugs, surgery, or other medical treatments—played a relatively minor role in the cases we examined. Only for hyperactivity and the remedicalization of opiate addiction (with methadone) did technology play a dominant role in the political contest about designa-

tion. This is not to say that medical technique was not offered as evidence to support medical claims, but rather that it cannot be seen as the singular explanatory variable for medicalization that some have suggested. We believe, however, that with increasing research and reliance on medical technology, especially in the form of drugs and technological medical practice (especially surgery), technique will play an increasingly important role in the medicalization of deviance. A few medical claims for deviance based on technique were pointed out in Chapter 8, and one need not go far to include drugs and surgery for obesity and tranquilizers for everyday anxieties as additional examples. This leads us directly to study who is promoting medical technique and with what consequences (see the discussion of hunches and hypotheses later in the chapter).

### S Sociologists as challengers

It seems fitting to include in this discussion a reflexive note on the role of sociologists in the politics of deviance designation. Sociologists, rather than being "objective" bystanders in the contests about deviance designation, are sometimes active participants. Not only do sociologists collect data about deviance and chronicle the claims-making activities of others, they often become active challengers in these activities. With one exception, sociologists in recent years have challenged rather than promoted medical deviance designations. Sociologists such as Alfred Lindesmith (1947), Edwin Schur (1965), and Troy Duster (1970), among others, supported the medical designation of opiate addiction against the dominant criminal designation. But in most of the other cases reviewed here—including, for example, madness (Goffman, 1961; Scheff, 1966), alcoholism (Gusfield, 1967; Schneider, 1978), child abuse (Gelles, 1973; Gil, 1970), and hyperkinesis (Conrad, 1975, 1976)—sociologists' analyses and viewpoints stand as clear challenges or at least alternatives to medical deviance designations. Although many other sociologists do adopt the medical model in their research, sociological analyses represent a consistent potential challenge to medical claims. The social and contextual nature of the sociological perspective, perhaps most espe-

cially in its interactionist and Marxian modes, is in fundamental ways opposed to the more individualist and reductionist medical perspective.

### Hunches and hypotheses: notes for further research

In this discussion we note briefly a number of "hunches and hypotheses" that emerge from our investigation of the medicalization of deviance. Although we do not presently have sufficient data to call them conclusions, these propositions are based on our analysis and are presented both as "informed" speculations and directions for further research. We separate them for the sake of clarity.

1. It appears that the medicalization of deviance increases after a failure or crisis in previous systems of social control. Although we must be somewhat cautious about generalizing, our examination reveals several instances where this occurred. In the 19th century, when asylums were becoming greatly overcrowded, the degeneration hypothesis was proposed as a medical explanation and a justification for custodial care. Following the repeal of Prohibition, which could itself be seen as a crisis in social control, the disease concept of alcoholism was proposed. As the "drinker" rather than the "drink" became the object of social control, alcoholism as a disease became an idea that attempted to justify a more humanitarian control of alcohol-related deviance. In the activist 1960s, "drugs" became a symbol for rebellious and alienated youth. By the end of the decade "hard" drug use was spreading rapidly in middle-class communities. The extant social controls—resident self-help groups and imprisonment—had had only small success and were too limited to accommodate the increasing number of addicts. A social control crisis was partly averted by "sentencing" adjudicated opiate offenders to a variety of newly created outpatient methadone maintenance clinics.

2. As a particular kind of deviance becomes a middle-class rather than solely a lower-class "problem," the probability of medicalization increases. There seems to be a historical proclivity to define deviance that is thought endemic to lower-class life as badness, but when

it becomes evident that it is also a middle-class phenomenon, it is likely to be defined as sickness.\* When chronic drunkenness was thought common only to the lower-class skid row alcoholic, badness designations prevailed. But as increasing research evidence and public recognition found problem drinkers in respectable middle-class homes, it became difficult to maintain the skid row image of drunkenness. As more middle-class people were defined as deviant drinkers, the notion that alcoholism is a disease increased in acceptance and popularity. Similarly, when opiate addiction left the ghetto and became a middle-class problem in the late 1960s, there was a rapid increase in its medicalization. Some existing evidence indicates that hyperactivity is a diagnosis disproportionately used for middle-class and suburban schoolchildren. Perhaps poorer inner-city children are expected to be overactive, restless, and distracted, but when suburban children behave this way, they are deemed "sick." Finally, we suggest that the medicalization of abortion resulted partly because middle-class women were among the largest recipients of abortions in the 1960s. In short, as public perceptions move from a lower-class problem to a middle-class problem, deviance designations tend to change from badness to sickness.

3. Medicalization increases directly with its economic profitability. This is a significant dimension of the medicalization of deviance that we have touched on several times in this book but have not pursued in depth. We can isolate three ways in which profitability encourages medicalization. First, medicalization can create new and profitable markets for large and powerful medical industries. As we noted in earlier chapters, the pharmaceutical corporations garnered considerable profits from the medicalization of hyperkinesis and opiate addiction and from the increased use of medications for madness. We can extend these examples to include the promotion of psychoactive drugs for everyday anxieties (Radelet, 1977b), obesity, "senility," and other human problems. The corporate profits from medicalizing deviance are yet uncalculated but un-

\*We are indebted to Ralph Childers for this insight.

doubtedly enormous (based on the little data we do have available). Second, the medicalization of deviance can be a highly profitable enterprise for specialized groups of physicians. For example, in the *Newsletter* of the American Society of Bariatric Physicians (a professional organization of physicians specializing in treating obesity), advertisements appear offering bariatric practices for sale with six-figure salaries and short working hours. Third, the medicalization of deviance indirectly supports certain corporate interests. The alcoholic beverage industry, for example, vigorously supports the disease concept of alcoholism, which focuses attention on the individual drinker and away from the industry's advertising and marketing techniques. The health insurance industry is playing an increasing role in medicalization politics. The role of the corporate sector and the profitability of medicalization, only touched on here, are fertile areas for research. Although the necessary data are difficult to acquire, studies directed at a more specific understanding of the political economy of medicalizing deviance could provide an important extension to our analysis as well as evaluating the speculations presented here.

### A CONCLUDING REMARK

The medicalization of deviance is an abiding feature of contemporary American society. It will not disappear or even decrease perceptibly in this century and, indeed, is likely to expand. Medical definitions and treatments for deviance undoubtedly will continue to be proposed, and contests in the politics of deviance designation will persist. Barbara Wootton's (1963) remarks nearly two decades ago remain poignant today:

We may well be on the brink of an age in which the power of science to influence behavior will achieve a new dimension. Yet the question of what behavior is to be influenced, and in what directions, remains, and will remain, as obstinate as ever. (p. 202)

### SUMMARY

In this chapter we presented a theoretical statement on the medicalization of deviance. It serves as a conceptual summary of our analysis and as an inductive and historical sociological explanation.

First, general historical and cultural conditions that have provided a foundation for the medicalization of deviance were reviewed. The most important factors appear to be the rise of rationalism, the development of science, the emergence of determinist and biophysiological theories of causation, and the growth and apparent success of medicine. American society has proven particularly hospitable to medicalization. The medical perspective of deviance aligns well with a number of dominant American values, including experimentation, newness, humanitarianism, pragmatism, and individualism. Furthermore, the cultural conceptions related to the Protestant Ethic, an abiding faith in science, a democratic political system, the organization and monopolization of the medical profession, and the profitability of medical treatment under capitalism are all facilitating social conditions for the medicalization of deviance. But, as we have noted numerous times, deviance designations do not emerge by themselves but rather are a product of collective enterprise and claims-making activities.

In the second part of this chapter we presented an inductive theory of the medicalization of deviance. Basing our analysis in the politics of deviance designations described in Chapter 2, we develop a sequential model of medicalization and offer five grounded generalizations. The stages are analytically distinct and describe the process of medicalization. The grounded generalizations begin to provide a sociological explanation of the medicalization of deviance.

In the final discussion in this chapter we propose three hunches or hypotheses as directions for future research: the medicalization of deviance increases after a failure or crisis in previous social control; as a particular kind of deviance becomes a middle-class rather than solely lower-class "problem," medicalization increases; and medicalization increases directly with economic profitability. We note the importance of developing an analysis of the political economy of medicalization.

Our concluding remark suggests that the medicalization of deviance will continue and is likely to expand and that the questions raised in this book will remain pertinent in the future.

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