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1 MEDICALISATION: AN ENDURING CONCEPT

Introduction

Over the past few decades, the medicalisation of everyday life has grown to encompass much of what was once considered to belong in sociopolitical and moral domains. In tandem with this trend has been the seemingly ever-increasing number of categories of mental illness and the correspondingly large number of people diagnosed as mentally unwell. Emotions such as grief, sadness, shyness and worry are becoming medical conditions. Behaviours such as alcoholism, gambling and shoplifting, once considered minor transgressions or expressions of all too human weaknesses, are now increasingly defined as mental disorders. This is not a straightforward process. There is consumer pressure for 'ways of being' to be categorised and given medical sanction; there are also pharmaceutical pressures, as well as the increasing hegemony of the Diagnostic and Statistical Manuals (DSMs).

Foucault (1979, 1981a, 1981b) used the term 'discourse' to explore the ways in which language, power and institutional practices come together at historical points in time and serve to define what we take for granted. Dominant discourses provide meanings, prioritise particular knowledge frameworks and establish how we view aspects of living. Foucault did not view discursive power as operating in a hierarchical or top-down manner, rather its parameters are social relational, taking place in everyday life by means of micropractices or routine interactions. This is just one way of analysing power and knowledge frameworks; however, it does emphasise that medicalisation has many facets, as well as a range of influencing factors, and that we all can be seen to contribute towards prevailing understandings and ways of operating.

The concept of medicalisation: Historical antecedents

Zola (1972: 487) defined medicalisation as the process of making 'medicine and the labels "healthy" and "ill" relevant to an ever increasing part of human existence'. He observed medicalisation as a process similar to societal changes such as democratisation, industrialisation and urbanisation; a process later

sociologists declared to be ‘one of the most potent social transformations of the last half of the twentieth century in the west’ (Clarke et al. 2003: 161).

Zola (1972: 487) believed that medicine was replacing religion and law as the major institution of social control, ‘as the place where absolute and often final judgments are made by supposedly neutral and objective experts. And these judgments are made in the name of health.’ An influence on Zola was Eliot Freidson’s study of the medical profession, from which Zola quoted in his paper: ‘the medical profession has first claim to the jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively’ (Freidson 1970: 251).

Zola (1972: 500) noted a significant consequence of medicalisation was that ‘the labels health and illness are remarkable “depoliticizers” of an issue’, by which he meant that in ‘locating the source and treatment of problems in an individual, other levels of intervention are effectively closed’.

Zola and his fellow sociologist Freidson (1970) were proposing an understanding of illness as socially defined or constructed – a perspective that has become a dominant theoretical framework in medical sociology. Clearly, social constructionism is a broad area, and Burr (1995) has provided a definitive list of key assumptions. These are fourfold and are as follows:

- 1 The critical interrogation of ‘taken for granted knowledge’.
- 2 Social, historical and cultural contexts being seen as paramount with understandings being related to the particular circumstances of the period.
- 3 Knowledge regarded as a result of social processes.
- 4 Interactions, understandings or knowledge frames being linked to social action.

All these facets can be usefully applied to understandings of medicalisation.

From a Marxist perspective, Scull (1979) saw the rise of medicalisation as being related to industrialisation, urbanisation and the expansionist tendencies of medicine emanating from the Enlightenment – the 18th-century movement that sought to categorise and classify the social and natural world. It is notable that the period from the 1950s to the end of the 1970s has been called the ‘golden age of doctoring’, when the dominance of the medical profession was at its height (Maturio 2010: 231). Freidson (1970) characterised the expansion of medicine’s sphere of influence during this time as medical imperialism and suggested that doctors played an active role in this through their search for new illnesses:

The profession does treat the illnesses layman take to it, but it also seeks to discover illness of which laymen may not even be aware. One of the greatest ambitions of the physician is to discover and describe a 'new' disease or syndrome and to be immortalised by having his name used to identify the disease.

(Freidson 1970: 252)

However, Zola (1972: 487) did not agree that medicalisation was the result of the empire building of doctors; rather, he suggested the cause might be found in an 'increasingly complex technological and bureaucratic system ... which has led us down the path of the reluctant reliance on the expert'.

During the 1970s, Ivan Illich, a Catholic priest, social theorist and activist, drawing on Marxism and political economic theories, was critiquing what he saw as an overindustrialised society. One influential strand of his writing concerned a critique of medicine and medicalisation (Illich 1975a). He observed that medicine's dominant role in healthcare had grown into an 'empire of the health professions' expropriating people from their own health through what he called the 'medicalisation of care' (Illich 1975b: 66, 77). Further, he argued that the consequences of this medical imperialism were not productive for health:

The proliferation of medical agents is health denying ... because they produce dependence. And this dependence on professional interventions tends to impoverish the non-medical health supporting and healing aspects of the social and physical environments, and tends to decrease the organic and psychological coping ability of ordinary people.

(Illich 1975b: 77)

Illich claimed that the decline in the major epidemics with high mortality rates and changes in the age structure of the population were not 'significantly related' to medical services; he argued, for example, that 'longevity owes much more to the railroad and to the synthesis of fertilisers and insecticides than it owes to new drugs and syringes' (Illich 1974: 920).

Illich (1970) introduced the concept of 'iatrogenesis' to promote his argument that under capitalism the healthcare system was producing adverse outcomes, or harm. He proposed three types of iatrogenesis – clinical, social and structural:

- Clinical iatrogenesis concerned the adverse outcomes of medical treatment.
- Structural iatrogenesis related to the dependence produced in society by reliance on health professionals.
- Social iatrogenesis refers to medicalisation or medical colonisation, whereby 'medicine has colonised aspects of life once not considered pathological' (Maturio 2010: 230).

Illich outlined the consequences of this medicalisation, for example, in an increase in the number of diseases as medicine creates labels for conditions such as pregnancy, menopause and old age, and ‘the lowering of levels of tolerance for psychological discomfort or sadness which [as later critics have observed] brought about a steady increase in the diagnosis of depression’ (Maturio 2012: 123; Horwitz and Wakefield 2009). Illich (1975b: 75) also suggested that the extent of medicalisation could be measured by the rising costs of healthcare, citing figures in the US of ‘90 billion dollars a year for health care ... equivalent to 17.4 % of the GNP’.

Illich (1975) shared Zola’s (1972) concern that the extension of medical labels was depoliticising in its location of problems within the individual. He maintained that medicine had ‘grown beyond tolerable bounds’ and become ‘a device to convince those who are sick and tired of society, that it is they who are ill, impotent and in need of technical repair’ (Illich 1975a: 11). However, Illich was more strident than Zola in his attack on medicine, claiming that medicine had become a ‘major threat to health’ (Illich 1975: 11).

Illich’s (1975) critique of medicine and medicalisation was based on libertarian, political and collective values. Thomas Szasz, a psychiatrist, shared these values, but his concern was specifically a critique of psychiatry. In 1960 and 1961, Szasz wrote a paper and a book claiming that mental illness was a myth (Szasz 1960, 1961). Szasz argued that mental illness only existed as an illness if it were a physical illness, that is, a brain disease such as Alzheimer’s, or an infection caused by syphilis (Busfield 2011: 111). All other conditions, including schizophrenia, were ‘problems in living’.

Szasz (1960) wished the term ‘mental illness’ to be removed from the category of illness. He defined the concept of illness ‘whether bodily or mental’ as ‘deviation from some clearly defined norm’, and ‘the norm from which deviation is measured whenever one speaks of mental illness is a psychosocial and ethical one’ (Szasz 1960: 114). He observed that the troubles of people are real. His concern related to the ‘labels we give them ... and having labelled them, what we do about them’ (Szasz 1960: 116). He outlined the process by which judgements are made about an individual having a mental illness and, in so doing, described medicalisation and its consequences for psychiatry:

the finding of a mental illness is made by establishing a deviance in behaviour from certain psychosocial, ethical, or legal norms. The judgement may be made as in medicine, by the patient, the physician (psychiatrist), or others. Remedial action, finally, tends to be sought in a therapeutic – or covertly medical – framework, thus creating a situation in which psychosocial, ethical, and/or legal deviations are claimed to be correctible by (so-called) medical action. Since medical action is designed to create only medical deviations, it seems logically absurd to expect that it will help solve problems whose very existence has been defined and established on nonmedical grounds.

(Szasz 1960: 115)

Szasz (1960) went on to suggest that the process he described raised questions about the usefulness of tranquillisers and other medications in remedying or solving ‘problems in human living’.

A number of criticisms of psychiatry accompanied the work of Szasz, and an antipsychiatry movement developed, most notably in the UK, where the leading proponents were the psychiatrists R.D. Laing (1960, 1961) and his colleague David Cooper (1967). While Laing came to share Szasz’s conclusion that the concept of mental illness should be abandoned, Szasz did not want to be identified with Laing and the antipsychiatry movement generally. Although the antipsychiatry movement called into question a range of psychiatric practices, the excesses of its founders and the links to drug culture served to devalue their analysis and to some extent belittle the work of others who critiqued the expansion of psychiatry (Fawcett and Karban 2005).

The medicalisation of mental and behavioural deviance

It was sociologists who further developed the work of Szasz when they explored ‘the medicalisation of mental and behavioural deviance’ (Busfield 2017: 7). In *Being Mentally Ill* (Scheff 1966), Thomas Scheff conceived of mental illness as a label for a range of deviant behaviours, deviance being defined as ‘behaviour that violates social norms’ (Germov 2010: 243). This analysis drew on two very different theoretical perspectives – Talcott Parson’s concept of the sick role and Howard Becker’s interpretation of labelling theory.

From a functionalist perspective, Parsons (1951a, 1951b) ‘first specified the connections between deviance and illness in his conception of the sick role which exempts people from fulfilling their normal social duties’ (Germov 2010: 244). Parsons (1951a: 430) argued that all illness was a disturbance in the normal functioning of the individual, as ‘it incapacitates for the effective performance of social roles’. However, as Germov (2010) points out, in taking on the sick role, a new set of social rules are imposed on the individual through medicine’s therapeutic management of the illness.

Becker (1963), from a different sociological position, located deviance not in an action, but in the societal reaction to it:

social groups create deviance by making rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders ... deviance is a consequence of the application by others of rules and sanctions to an ‘offender’. The deviant is one to whom that label has been successfully applied, deviant behaviour is behaviour that people so label.

(Becker 1963: 9)

This view of deviance directed attention away from the person and their apparent deviance and placed it on the ‘social audience who defines, reacts to, labels, and punishes behaviour and individuals as deviant’ (Germov 2010: 243). For Scheff (1966: 25), the ‘social audience’ became psychiatry, with symptoms of mental illness being ‘labelled violations of social norms’, and chronic mental illness becoming a social role. He saw these as being violations of ‘residual rules’ – informal and situationally specific rules – ‘so taken for granted that they are not explicitly verbalized’ (Scheff 1966: 39). Scheff (1966) observed that, once an individual is labelled as a rule breaker, they are at risk of taking on the social role of a mentally ill person, especially if they are marginal and powerless and, thus, less able to resist the labelling process.

Conrad’s (1975) seminal analysis of the medicalisation of deviant behaviour concentrated on medicine’s development of new psychiatric disorders.¹ He argued that medicine had become one of the most effective forms of social control, citing contemporary theorists such as Zola (1972), Pitts (1968) and Foucault (1965). The example he provided was the transformation of recklessness and overactivity in children into the disorder of ‘hyperkinesis’ to be treated by psychoactive medication (Conrad 1975). This disorder, which appeared in the 1968 DSM-II, was further transformed in the 1980 DSM-III into ‘attention deficit hyperactivity disorder’ (ADHD), with attention deficit becoming the key symptom. In more recent times, adult ADHD has been added to this disorder category.

Conrad (1975) explained the appearance of the new category of hyperkinesis as the result of two social factors; the pharmaceutical revolution and government action. In the US, since the 1930s, there had been a huge growth in the discovery of psychostimulants, which were prescribed for those with severe mental illnesses, and which, by the 1950s, were becoming widely used for a range of less severe behavioural disorders, including childhood disorders. Two government reports on the treatment of schoolchildren with psychostimulants had the objective of ensuring the appropriate use of these drugs. However, paradoxically, they ‘served as blue ribbon approval for treating hyperkinesis with psychoactive medications’ (Conrad 1975: 20).

Conrad (1975: 16) identified the principal agents in this process of medicalising the overactivity of children as the pharmaceutical industry, which, since the middle of the 1960s, had extensively marketed stimulant medications for this new disorder: ‘Medical journals and the free “throwaway”

1 Conrad has become the sociologist at the forefront of the study of the changing aspects of the medicalisation of society. He first became aware of medicalisation in the 1970s when he was writing a thesis on the factors identifying hyperactive children who had been referred by schools to a paediatric hospital where they were diagnosed with a new medical condition known as ‘hyperkinesis’ (1975). Half way through his thesis he read Zola’s (1972) article, which used the term ‘medicalisation’. Conrad (2013a) described this as a life-changing moment when he realised that what he was studying in his thesis was medicalisation, that is, the medicalisation of deviant behaviour and the social control of this behaviour through the prescribing of stimulant drugs.

magazines contained elaborate advertising for Ritalin and Dexedrine'. These drugs were discovered to have an effect on behaviour, and the new disorder of hyperkinesis was, therefore, harnessed to the promotion of a pre-existing drug treatment. For the company that had developed Ritalin, this produced a \$13 million profit in 1971 (Conrad 1975: 17). The other agent Conrad identified was parental pressure, specifically the Association for Children with Learning Disabilities. This US association was made up of parents and professionals and, according to Conrad (1975: 17), played a major role in sensitising 'teachers and schools to the conception of hyperkinesis as a medical problem'.

Conrad (1975: 17) observed that the 'medical model of hyperactive behaviour [had] become very well accepted in our society'. He noted some of the benefits of this medicalisation of deviant behaviour. These included the minimising of parental guilt and children experiencing less stigma as their behaviour became more socially acceptable in the classroom. He stated that, at times, 'medical treatment [constituted] more humanitarian social control than the criminal justice system' (Conrad 1975: 17).

However, Conrad (1975) outlined four negative consequences arising from the medicalisation of deviance:

- 1 *The problem of expert control*: by defining a problem as medical, it becomes a matter for medical experts and the public are excluded from any discussion of the problem.
- 2 *Medical social control*: the medicalisation of deviant behaviour legitimates medical forms of control, such as psychoactive drugs, which 'restrain individuals from behaviour and experience that are not complementary to the requirements of the dominant value system' (Lennard et al. 1971: 57).
- 3 *The individualisation of social problems*: the medical perspective focusses on the individual, diverting attention away from the family and the school 'rather than seeing certain deviant behaviours as symptomatic of problems in the social system' (Conrad 1975: 19).
- 4 *The depoliticisation of deviant behaviour*: 'by defining the overactive, restless and disruptive child as hyperkinetic we ignore the meaning of behaviour in the context of the social system' (Conrad 1975: 20). The 'problem' becomes individualised, and social, cultural, environmental and context-specific factors, such as the management of the classroom, school or school system, are rendered irrelevant.

Conrad continued his analysis of the medicalisation of deviance. *Identifying Hyperactive Children* ([1976] 2006) examined 'hyperactivity', the new label for hyperkinesis. He drew on Friedson's (1970) distinction between disease and illness, further developing a social constructionist perspective that conceives of illness as a social construction, in opposition to disease as a biological condition. Busfield (2011: 124) observed that, in this work, Conrad proposed:

the conditions under which deviant behaviour came to be medicalised: the problem in question was seen as needing remedy; other traditional forms of social control were inefficient or unacceptable; and there were some ambiguous data that could be seen as its source.

Gendered medicalisation

In the 1970s and 80s, the movement of second-wave feminism led to political activism concerning women's health. Women's health collectives were set up, and women waged campaigns against the dangers of Valium addiction and the harmful side effects of the contraceptive pill (Tone 2009: 187). Feminist scholars developed a critical perspective on the increasing medicalisation of women's 'normal body processes and life events' (Ballard and Elston 2005: 232). Characterising medicine as a powerful agent of patriarchy, their initial focus was on medical dominance – on the 'power doctors (still then usually male) exercised over women in relation to matters such as menstruation, birth control, pregnancy, abortion and childbirth' (Busfield 2017: 5). Obstetricians were replacing and marginalising the role of midwives and, in the process, defining the difference between an 'abnormal' and a 'normal' pregnancy. Anne Oakley (1984: 14), in her examination of the medicalisation of childbirth, observed that the medical profession had 'constructed a schema of pregnancy which systematised what was taken to be the everyday experience of pregnant women'. The routine medical monitoring and intervention that was set in train suggested to Oakley (1980) that 'obstetricians have ... placed undue emphasis on the probability of abnormality and thus on the need for all women to be dependent on medical care' (Ballard and Elston 2005: 232).

Feminist analyses of the medicalisation of the menopause followed. This was a time when the menopause was defined as a 'deficiency disease' and hormone replacement therapy (HRT) was promoted as the appropriate treatment (McCrea 1983; Bell 1987). McCrea (1983) argued that medicalising 'the change' resulted in women feeling an obligation to take HRT 'to prevent future ill health'. More recent feminist scholars have questioned the inclusion of 'premenstrual syndrome' as a psychiatric disorder in the DSM (Caplan et al. 1992) and the emphasis placed on the medicalisation of menstrual hygiene in South Asia (Lahiri-Dutt 2015).

In their early studies, feminist scholars tended to depict women as the victims or passive recipients of medical interventions. Catherine Reissman (1983) was one of the first feminist writers to suggest that this depiction of women reinforced sexist medical ideologies about women. She argued that women gained as well as lost from medicalisation, and presented evidence of women actively participating in the medicalisation of childbirth, with working-class women wishing 'to be relieved from lingering incapacity following child birth', and middle-class women 'desiring to be free from pain

and to choose the kind of delivery they would have' (cited in Ballard and Elston 2005: 233). Later writers observed that there was some resistance to the medicalisation of the menopause, with women investigating and questioning the use of HRT (Lewis 1993; Griffiths 1999). However, female consumer/patient self-help groups have also, in some instances, demanded medicalisation, campaigning for recognition of 'distressing symptoms' through medical labelling of 'the contested diagnoses' of chronic fatigue syndrome and repetitive strain injury (Arksey 1994; Broom and Woodward 1996). These latter examples of medicalisation portray the social relational aspects of medicalisation and the part played by consumer pressure on doctors (Broome and Woodward 1996). Ballard and Elston (2005: 228) suggest that feminists' earlier focus on medicalisation as medical dominance needs to be reconfigured, because "medicalisation" is a much more complex, ambiguous, and contested process than the "medicalisation thesis" of the 1970s implied'.

In the 21st century there has been an increasing shift towards the medicalisation of men's bodies as well as women's bodies (Bell and Figert 2012; Riska 2003, 2011; Rosenfeld and Faircloth 2006). It is argued that the pharmaceutical industry, in creating markets such as Viagra and Ritalin for males and Prozac and cosmetic surgery for females, has engaged in 'gender segmentation'. Conrad (2005) asserts that gender segmentation plays a role in defining problems as new medical disorders and selling the drugs to treat them. He maintains that it can be 'a propitious strategy for defining problems and promoting medical solutions, both exploiting and reinforcing gender boundaries' (Conrad 2005: 11).

Changing concepts of medicalisation

There have been major changes in medicine in the decades since 1980. A globalised pharmaceutical industry has been at the vanguard of the growth of privatised and corporatised medicine. In the field of psychiatry, changes in medicalisation can be seen to have occurred 'in tandem' with the phenomenon of an increasing 'biologisation' (Conrad 1992; Horwitz 2002), where biological explanations for much of human behaviour and mental processes are becoming increasingly dominant in medicine and society. Greenberg (2013) maintains that the publication in 1980 of DSM-III signalled a move to a biological paradigm that now underpins the field, despite the lack of biological markers for the proliferation of mental disorders that have followed this paradigm shift.

Clarke and Shim (2011: 175) note that, since the 1980s, the focus for Conrad (1992, 2005, 2007) and his colleagues (Conrad and Schneider 1980) has been on 'how a phenomenon is discursively defined – socially constructed – as falling within medical jurisdiction and how that is elaborated'. Writing about changes in the medicalisation process in the 21st

century, Conrad (2005: 3) articulated what he saw as the key aspect of medicalisation: ‘The essence of medicalisation ... [had become] the definitional issue: defining a problem in medical terms, usually as an illness or disorder or using a medical intervention to treat it.’ Conrad’s (2013a, 2013b) recent work identifies shifts in medicalisation. He maintains that the new key movers or ‘engines’ driving medicalisation are now the pharmaceutical and biotechnology companies, as well as consumers and private health insurance schemes. As a result, he sees doctors being relegated to the role of gatekeepers.

In the US, the pharmaceutical industry’s aggressive marketing is greatly facilitated by direct-to-consumer advertising (DTCA). Conrad identified this in 2005, giving as an example campaigns that have ‘increased the medicalising of anxiety, inferring that shyness and worrying may be medical problems’ (Conrad 2005: 7). As a consequence, an anxiety market has been created, greatly expanding the market for antidepressants beyond their original approved uses. Such is the reach of the industry’s influence that it has been described as being involved in ‘disease mongering’ (Moynihan et al. 2002: 886; Frances 2013a: 29), that is, ‘marketing diseases and then selling drugs to treat those diseases’ (Conrad 2005: 6). Similarly, biotech companies’ research into genetics has boosted a market for genetic tests, which ‘may create a new medicalised status, that of the “potentially ill”’. Conrad (2005: 6) sees a future market in the promotion of biomedical enhancements as further increasing the medicalisation of ‘human problems’.

Resistance to medicalisation can often go hand in hand with the active promotion of medicalisation. Many people have become patients/consumers, and advocacy groups have been formed for the medical recognition of post-traumatic stress, alcoholism and adult behaviour problems. It is notable that adult ADHD had its origins in adults going to doctors asking to be evaluated and medicated for symptoms associated with ADHD in children. Heavily sponsored by the pharmaceutical industry, the US advocacy group Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) lobbied for the inclusion of adult ADHD into the DSM classification system. In the US and New Zealand (but not in Australia, the UK or European countries) there has been DTCA, which has actively promoted self-diagnosis and self-medication. The advent of the internet has also produced checklists of the symptoms of mental disorders and has made the promotion of new medications more readily accessible to individuals who increasingly see themselves as consumers rather than patients. As a consequence, the demand for specific medical solutions for problems which previously were regarded as part of the human condition has increased significantly.

In the US, the delivery of health services through private health insurance and a system of managed care has also driven medicalisation into becoming ‘an arbiter of what is deemed medically appropriate or inappropriate treatment’ (Conrad 2005: 10). In psychiatry, insurance payments are

much more readily available for medication, while insurance cover for psychotherapy has been 'severely reduced'. Managed care has contributed to the enormous increase in the use of psychotropic medications for adults and children (as evidenced in the increased rates of diagnoses of ADHD in the US).

Challenging the concept of medicalisation: Biomedicalisation

The rise of psychopharmacology over recent decades has resulted in the exponential growth of the global pharmaceutical industry. So dominant has the pharmaceutical industry become that some sociologists, most notably in the UK, have identified a process or processes of pharmaceuticalisation, 'by which social, behavioural, or bodily conditions are treated or deemed to be in need of treatment, with medical drugs by doctors or patients' (Abraham 2010: 604). Further developments in what is regarded as a changing concept define pharmaceuticalisation as 'the translation or transformation of human conditions, capabilities and capacities into opportunities for pharmaceutical intervention' (Williams et al. 2011: 711). Debate has followed as to whether pharmaceuticalisation is part of medicalisation or a distinct process. Conrad (2013a, 2013b) acknowledges the greater role of the market and hence the pharmaceutical industry in the 21st century, but he sees 'pharmaceuticalisation as a subset of medicalisation and not as a competing concept' (Conrad 2013b: 201).

In the 1990s, a group of sociologists in the US proposed the concept of 'biomedicalisation', a perspective that has been put forward as competing with conceptualisations of medicalisation. These sociologists saw 'classic medicalisation theory' as inadequate in its capacity to explain the technoscientific changes that were occurring in the whole field of biomedicine. The term 'biomedicalisation' refers to 'complex, multisided, multi directional processes of medicalisation ... [which] are being extended and reconstituted' (Clarke et al. 2003: 162). Whereas

Conventional medicalisation practices typically emphasise exercising *control over* medical phenomenon – diseases, illnesses, injuries, bodily malfunctions – biomedicalisation practices, in contrast, emphasise *transformations* of them by technoscientific means ... through quick high-tech interventions not only for treatment but increasingly also for enhancement or optimization.

(Clarke and Shim 2011: 173)

Transformations for enhancement (and health maintenance) are promoting 'optimisation', that is, 'the growing sense of individual obligation or responsibility to literally "make the best" of oneself' (Clarke et al. 2011: 180; Rose 2007a).

Clarke and colleagues (2011: 166) outlined the dynamics of biomedicalisation as taking place through five processes. These are: major political economic shifts; 'a focus on health, risk and surveillance'; 'the technoscientization of biomedicine'; transformation of biomedical knowledges; and transformations of bodies and identities. These theorists situate biomedicalisation in a three-stage history of the development of American medicine. The first era signalled a major transformation of medicine with the rise of scientific medicine (1890–1940); the second era (1940–85) was one of medicalisation; and the third era has been characterised by biomedicalisation. In the current era, developments in science, such as in molecular biology and genetics, and biotechnologies and nanotechnologies, are remaking medicine as the site of biomedical practices. It has been argued that so pervasive have these practices become that they have been characterised as 'the biomedicalisation of society' (Burri and Dumit 2007: 5).

Biomedicalisation: The influence of Foucault

Clarke and Shim's (2011: 181) argument is that the situation of medicine has changed, necessitating biomedicalisation theory, which goes beyond medicalisation theory. They argue that this understanding has its origins in the work of Foucault, in that biomedicalisation theory draws on Foucault's understandings of the nature of power; in particular, the concept of 'biopower', which he saw as a product of modernisation and industrialisation in the West (Foucault 1975, 1984). Clarke and Shim (2011) maintain that, in contemporary society, biopower is a new kind of 'microphysics of power', in which the disciplinary power of knowledges and technologies produces 'surveillance and control over human bodies and behaviours, sensations, physiological processes, and pleasures – both individually and in terms of populations' (Clarke and Shim 2011: 181). They draw from Foucault's initial emphasis on disciplinary power, which created 'a normalizing imperative that effects the self-judgement and self-regulation of individuals (through 'technologies of the self') [and] regulation ... of groups and populations' (Clarke and Shim 2011: 181).

Nikolas Rose (2007a) maintains that in the 21st century 'we are inhabiting an emergent form of life'. Foucault (1970) posed the question 'What is life?', and today Clarke and Shim (2011: 181) argue that we are confronting 'changes in the nature of life itself'. They claim that, during the last half of the 20th century, the study of life processes has moved from cellular levels to molecular levels. Accordingly, accelerating technoscientific developments in the 21st century are bringing about changes in the 'conditions of possibility' of life, which Rose (2007a) conceptualises as the 'vital politics' of 'life itself'. This 'vital politics ... is concerned with our growing capacities to control, manage, engineer, reshape, and modulate the very vital capacities of human beings as living creatures' (Rose 2007a: 5–6). Rose (2007a) argues that

society is currently ‘in the midst of an epistemic shift from the clinical gaze to the molecular gaze’, in which medicine is penetrating every aspect of our lives including ‘life itself’. Individuals, collectives and populations are engaging in life itself while developments in the biological sciences are encouraging the move ‘towards ideals of individual perfectability and enhancement’ (Clarke and Shim 2011: 184).

Critiques of biomedicalisation theory

Conrad has been the major critic of the concept of biomedicalisation. While admiring the scope and ambition of Clarke et al.’s (2003) theorisation, Conrad argues that the concept has been painted with ‘a very broad brush’ and, in attempting to be so comprehensive, ‘the focus on the process of medicalisation is lost’. In particular, he argues that the centrality of the definitional issues, the essence of medicalisation, has disappeared. Conrad agrees that there have been major changes in medicalisation; however, he does not see these as transformations, but rather as shifts in the ‘engines that drive medicalisation: biotechnology, consumers and managed care’. Medicalisation has changed but has not become ‘a qualitatively different phenomena’ (Conrad 2005: 5).

Busfield (2017) also questions whether the changes in American medicine since 1985 have constituted a major transformation. She regards Clarke et al.’s (2003) efforts to distinguish the eras of medicalisation and biomedicalisation as resulting in ‘an over complex framework that tries to encompass too much’ (Busfield 2017: 10) She notes the assertion of Williams et al. (2012: 213) that biomedicalisation is a ‘catch all notion’, alongside Conrad’s (2013b: 202) similar criticism of the overcomprehensiveness of the concept.

Further, Busfield (2017: 10) argues that “‘medicalisation’ refers to a process that can occur across time and place’, casting doubt on whether the terms ‘medicalisation’ and ‘biomedicalisation’ can be used as labels for specific periods in the development of medicine. She notes that the term ‘biomedicalisation’ has a certain attraction in drawing on Foucauldian theory but ‘this is not in itself a justification for the addition of “bio” to “medicalisation”’ (Busfield 2017: 11). Busfield (2017: 11) concedes that the term ‘biomedicalisation’ is useful for referring to ‘certain distinctive changes in the character of medicine’, but argues that the term cannot be a substitute for the existing concept of medicalisation.

Concluding remarks

‘Medicalisation’ as a term and a concept has become part of the discourse of popular culture and is referenced in prestigious medical journals. More significantly, the concept ‘identifies an important process that is still occurring’

and, as Conrad (2013b: 10) argues, has intensified during the 21st century. DSM-5 (APA 2013), the most recent edition of the DSM, provides examples of the ongoing extension of medicalisation with the creation of new mental disorders based on behaviours previously regarded as the domain of misfortune or character – such as gambling disorder, hoarding disorder, binge eating disorder and disruptive mood dysregulation disorder. At the same time, the thresholds of other disorders have been lowered, in particular ‘the removal of the bereavement exclusion clause from the criteria for major depressive disorder’ (Busfield 2017: 11–12).

Sociologists such as Conrad have characterised the process of medicalisation as being one of the most potent social transformations of the last half of the 20th century. With the digital revolution, we are now living through another even more profound transformation. Medicalisation is increasingly entwined with the new technologies as digital technology becomes a new engine of medicalisation. The importance of this new area of research has been shown in the recent work of Italian sociologists, who have examined the growing use of mental health apps and demonstrated the role of these self-tracking and self-measuring apps in not only promoting, but also accelerating the medicalisation of mental health (Maturo et al. 2016).

The social theorists and sociologists we have examined in this chapter have identified the pathologising of ‘normal’ life events, behaviours and human emotions; the extension of the power of the medical domain to control and regulate individuals and populations; and the attempts to transform human life itself. Medicalisation has continued to be the conceptual tool that ‘draws attention to the social causes underpinning the extension of medicine’s domain and to its impact’ (Busfield 2017: 12). As earlier social theorists demonstrated, medicine’s focus on the individual deflects attention from the ‘wider social and institutional context of individuals’ physical and mental states and behaviours and the deficiencies of the society in which they live’ (Busfield 2017: 13).

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