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** Chapter ONE **

DEVIANCE AND MEDICALIZATION

FROM BADNESS TO SICKNESS

EXPANDED EDITION,
WITH a NEW AFTERWORD by the AUTHORS

PETER CONRAD

JOSEPH W. SCHNEIDER

Foreword by **Joseph R. Gusfield**

Illustrated

Recipient of 1981 SSSI
Charles Horton Cooley Award



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1 DEVIANCE, DEFINITIONS, and the MEDICAL PROFESSION

A slow but steady transformation of deviance has taken place in American society. It has not been a change in behavior as such, but in how behavior is defined. Deviant behaviors that were once defined as immoral, sinful, or criminal have been given medical meanings. Some say that rehabilitation has replaced punishment, but in many cases medical treatments have become a new form of punishment and social control. This transformation is certainly not complete and has not been entirely unidirectional. These changes have not occurred by themselves nor have they been the result of a "natural" evolution of society or the inevitable progress of medicine. The roots of these changes lie deep in our social and cultural heritage, and the process itself can be traced through the workings of specific people, events, ideas, and techniques. We believe that, aside from its technical and intellectual aspects, this change is surely profoundly political in nature with real political consequences. This book presents an analysis of the historical transformation of definitions of deviance from "badness"* to "sickness" and discusses the consequences of these changes. It focuses on the medicalization of deviance in American society.

In this first chapter we introduce our study of deviance. We delineate the two major orienta-

tions to deviance and illustrate the interactionist view of deviance with the example of the infamous episode of deviance in 17th-century Salem Village. We discuss the universality and relativity of deviance and define the concept of social control. Because this book focuses on the importance of medicine in the changing definitions of deviance, we offer a capsule analysis of the development and structure of medicine in American society. The criminalization of abortion serves as an example of medical involvement in deviance definitions. Finally, at the end of the chapter we present an overview of the rest of the book.

SOCIOLOGICAL ORIENTATIONS TO DEVIANCE

There are many ways to study what sociologists call deviance. Even if we limit ourselves to sociological perspectives, there is a great variety of assumptions, definitions, and research methods from which to choose. We believe, however, that there are two general orientations to deviance in sociology that lead in distinct directions and produce different and sometimes conflicting conclusions about what deviance is and how sociologists and others should address it. We call these two orientations the positivist and the interactionist approaches. Others have made similar distinctions using different labels: correctional and appreciative (Matza, 1969), absolutist and relativist (Hills, 1977), scientific and humanistic (Thio, 1978), and objectivist and subjectivist (Goode, 1978). Such labels are merely signposts that summarize content. It is to the substance of these two orientations that we now turn.

The *positivist* approach assumes that deviance is real, that it exists in the objective experi-

* Although perhaps a bastardized term, we believe "badness" expresses best the *general* unequivocal morality typical of virtually all traditional major deviance designations, for example, "sin," "crime." Our subtitle, *From Badness to Sickness*, allows us to emphasize precisely the kinds of changes we believe inherent in the medicalization of deviance, that is, a shift from explicit moral judgments of deviants to the implicit and subtle morality of "sickness."

ence of the people who commit deviant acts and those who respond to them. This view of deviance rests on a second important assumption—that deviance is definable in a straightforward manner as behavior not within permissible conformity to social norms. These norms are believed part of a moral or value consensus in society that is both widely known and shared. Positivists devote much of their study of deviance to a search for causes of deviant behavior. In sociology such causes are usually described in terms of some aspect of social and/or cultural environment and one's socialization. Positivists outside sociology typically search for causes in physiology and/or psyche. In medicine, for example, this search is called etiology.* The major questions about deviants the positivist might ask are, Why do they do it? and How can we make them stop?

The *interactionist* orientation to deviance views the morality of society as socially constructed and relative to actors, context, and historical time. Fundamental to this view is the proposition that morality does not just happen; since it is socially constructed, there must be constructors. Morality becomes the product of certain people making claims based on their own particular interests, values, and views of the world. Those who have comparatively more power in a society are typically more able to create and impose their rules and sanctions on the less powerful. In consequence, deviance becomes actions or conditions that are defined as inappropriate to or in violation of certain powerful groups' conventions. Such deviance is believed to be caused not by mysterious forces beyond the individual's control but rather the consequence of particular definitions and rules being applied by members of certain groups to other people and/or situations. The interactionist view assumes that the behaviors called deviant are by and large voluntary and that people exercise some degree of "free will" in their lives. Deviance is then a social definition, and research focuses on how such definitions are constructed, how deviant labels are attached to particular people, and what the consequences

are both for those labeled and the authors of such attributions. The major questions about deviants an interactionist might ask are, Who made these deviants? How did they do it? and With what consequences?

This classification, of course, simplifies some complex and contentious theoretical issues. Some of these will be evident in later discussions. General categories such as these necessarily do a certain degree of violence to reality, but we believe this distinction is essentially faithful to broad patterns of sociological theory and research. Finally, we do not mean to suggest that these two orientations are never combined in research on deviance; in fact, some of the best studies have adopted elements of both.

The approach taken in this book is decidedly interactionist. Our main concern is with changing definitions of deviance and the consequences of these changes. The interactionist study of deviance usually focuses on the social processes of defining and labeling deviants in contemporary society. Only rarely have interactionists ventured into history and attempted to use similar assumptions to understand the development of historical definitions of deviance. What makes this book different from most interactionist studies is that we focus explicitly on the sociohistorical development of the definitions of deviance. To the extent we succeed in adding this *historical dimension* to the interactionist study of deviance, we have made a contribution to the development and clarification of the interactionist approach.

This book is a study of deviance, but it is also a study of morality. In the interactionist view the morality of a society—the application of notions of "right" and "wrong"—are relative and socially constructed. There is no absolute morality, although in a world of competing moralities we may prefer some over others because they seem to us more human and life-supporting. Morality and deviance are both products of complex social interaction. In our study of changing definitions of deviance we are also studying changing morality. The individuals and collectivities engaged in defining deviance are at the same time defining morality. Although we mention this several times throughout this text, it might be useful to keep in mind

that this is as much a study of morality as it is a study of deviance.

A word should be said about the term "deviance." We use it in its technical, sociological sense to refer to behavior that is negatively defined or condemned in our society. When we use the term, we do not imply any specific judgment or that we think the behavior is bad or sick. On the contrary, in some cases a considerable disjunction exists between our views and the dominant societal view. We use the term "deviance" to depict how the behavior or activity is generally defined in society.

To introduce our study of deviance and morality, we turn now to an event of 17th-century Massachusetts: the witchcraft phenomenon of Salem Village. Our intention is to illustrate what deviance is and how it is created in a particular social setting.

WITCHCRAFT IN SALEM VILLAGE

In 1692 in the New England community of Salem Village occurred one of the most remarkable and notorious episodes of deviance production in American history.* In the cold January winter of that year a number of young girls were stricken with a strange malady and began to behave in alarming ways. The first two affected were Betty Parris (age 9) and Abigail Williams (age 11). Betty became forgetful, distracted, and preoccupied. She sometimes would sit staring fixedly at an invisible object and, if interrupted, would scream and begin an incomprehensible babble.

[Abigail] too was absent-minded . . . and began to make babbling and rasping sounds. . . . She got down on all fours and ran about under the furniture, barking and braying, and sometimes fell into convulsions when she writhed and screamed as if suffering the torments of the damned. (Starkey, 1949, p. 40)†

In addition to the "fits," the victims frequently

suffered a temporary loss of hearing and loss of memory and often felt as if they were being choked and suffocated. Vivid and frightening hallucinations tormented and terrified them. Whatever this fearful malady was, it was also contagious. Other girls soon were stricken.

The girls were taken by their parents to physicians who examined them but found no medical problems and were puzzled by this strange behavior. A local physician, however, believed that he understood the problem but that it was out of his realm of expertise. "The evil hand is on them," he announced. The girls were victims of witchcraft.

The Devil was at work in Salem Village. Within a short time half a dozen young girls were stricken. Fears and suspicions mounted. Who, the community leaders asked, were the Devil's accomplices? Who had afflicted these poor children? Ministers from nearby communities were summoned to help Salem Village deal with its emergency. These observers confirmed the community's worst fears: the girls' maladies were real and resulted from supernatural forces.

"The motions of their fits," wrote the Reverend Deodat Lawson, "are preternatural, both as to the manner, which is so strange as a well person could not screw their body into; and as to the violence also it is preternatural, being much beyond the ordinary force of the same person when they are in their right mind." The Reverend John Hale of Beverly confirmed Lawson's description. "Their arms, necks and backs," he wrote, "were turned this way and that way, and returned back again, so it was impossible for them to do of themselves, and beyond the power of any epileptic fits, or natural disease to effect." (Hansen, 1969, p. 11).

The community leaders and the ministers reached a decision. "The girls must be induced to name their tormenters; the witches must be ferreted out and brought to justice" (Starkey, 1949, p. 45).*

With little urging, the girls named the three witches who were terrorizing them: Tituba, a slave from the West Indies who was acquainted with voodoo and magic; Sarah Good, a pipe-

*Our discussion provides only a brief summary of the events at Salem. For more detailed description and analysis, see Marion L. Starkey (1949), Kai T. Erikson (1966, pp. 137-59), Chadwick Hansen (1969), and Paul Boyer and Stephen Nissenbaum (1974).

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*It may be helpful to remember throughout this book that the medical model of deviance is essentially a positivist or correctional one.

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smoking woman known for her slovenliness and begging and considered neglectful of her children; and Sarah Osborne, a woman of higher standing, but who was negligent in her church attendance and had scandalized the community a year or so earlier by living with a man for a short time before he became her husband (Erikson, 1966). The accused women were all marginal members of the community; in effect, they were outsiders even before the accusations.

The preliminary hearings took place in the meeting house. They were presided over by colony magistrates, who were to ascertain whether enough evidence existed for an actual trial. This was serious business in Salem because the Puritans took literally the biblical injunction "Thou shalt not permit a witch to live." Conviction of witchcraft meant sure death. Certain rules of evidence were agreed on.

They would accept as proof of guilt the finding of any "teat" or "devil's mark," that is to say any unnatural excrescence on the bodies of the accused. They would accept as ground for suspicion of guilt any mischief following anger between neighbours. And most important of all, they would accept the doctrine that "the devil could not assume the shape of an innocent person in doing mischief to mankind." (Starkey, 1949, p. 53)*

It was this final criterion of evidence that was critical. It simply meant that the Devil could not appear in the form of anyone who was not guilty of witchcraft. This was called "spectral evidence." It enabled hallucinations, dreams, and visions to be accepted in court "as factual proof not of the psychological condition of the accuser but of the behavior of the accused" (Starkey, 1949, p. 54). It was evidence that was impossible to disprove, for if one of the girls accused a person's "specter" or "shade" of haunting them, the accused was left without a defense. It was *prima facie* evidence for association with the Devil and thus guilt of witchcraft.

The hearings must have been quite a scene. There was a somber excitement in town, and

many people packed the meeting house to see the alleged witches examined. The afflicted girls were given a place of honor in front of the hall. When the accused were brought in, the girls began to yell, writhe, and convulse in apparent agony. When questioned, the girls pointed to specters of the accused flying around the room, pinching and tormenting their victims. (Of course, none of the observers could see these specters.) Sarah Good and Sarah Osborne categorically denied their guilt. But when Tituba spoke, a hush settled over the meeting house, for Tituba was confessing to consorting with the Devil. For 3 days she told the astonished court about the "invisible world" of spirits and apparitions with which she had contact. She suggested there were still others in the community with whom she (and the Devil) had consorted. These three women were dispatched to jail to await trial, but the witch-hunt had only begun.

Salem Village was in crisis. Somber excitement was giving way to fearful panic. The Devil was out to take people's souls, and the good God-fearing people of Salem must fight him to the hilt. The afflicted girls were the instruments through which the dastardly witches could be discovered. They performed their witch-finding chores with zeal and gusto. The girls seemed to relish all the attention they received and the power they were given. Within the next 6 months this troop of young girls accused nearly 200 people of consorting with the Devil. Some righteous and upstanding citizens were accused, as well as individuals from distant communities. Farmers, grandmothers, children, even a reverend; if the girls claimed the individual's specter was haunting them, the accused was taken to prison to await a hearing. The community was stunned, but the fear of witchcraft prevailed.

Dozens of the accused were brought to trial, and before the year was out, 19 witches had been executed by hanging, two had died in jail, and one was crushed to death during an interrogation. When the girls began to accuse some of the town's most respected individuals, however, doubts about their infallible judgment began to grow. Toward the year's end people were openly expressing concern about the trials

and executions and especially about the validity of "spectral evidence." After the magistrates reversed their earlier decision and decided to disallow spectral evidence, there remained no way other than confession to ascertain guilt in witchcraft. Nearly all those still accused were acquitted. The hundred or so yet residing in jails were released, and the few who had confessed or had been found guilty were granted reprieves. The witchcraft hysteria of Salem Village was over.

Witchcraft as deviance is a fascinating subject to study. Numerous scholars have attempted to understand what happened in Salem Village in 1692. Most agree that the girls' behaviors today would be diagnosed as "hysteria," a psychological disorder rather than a result of witchcraft, and that nearly all the accused were innocent. Several theories have been postulated as to the causes of the witchcraft outbreak. Starkey (1949) suggests that it was a case of mass hysteria caused by Puritan repression and guilt. Erikson (1966) theorizes that the witch trials were an attempt to resolve a "crisis" over the social boundaries of the changing Puritan colony. Hansen (1969) asserts that there were undoubtedly a few practitioners of witchcraft in Salem, and the girls' fear of bewitchment made them hysterical. We need not choose between these theories here because we present the Salem witchcraft example only to illustrate the social construction of deviance rather than to explain the behaviors involved. The example will serve us through the next few pages as we begin to develop our study of deviance.

UNIVERSALITY AND RELATIVITY OF DEVIANCE

What is deviance? For the moment, let us say simply that deviance consists of those categories of condemnation and negative judgment which are constructed and applied successfully to some members of a social community by others. We intentionally avoid the notion that the essence of deviance is in actors' behaviors; rather, we argue that it is a quality attributed to such persons and behaviors by others. For example, "witchcraft" and all it entailed in 17th-century Salem Village was deviance. We

will develop this concept of deviance considerably as we proceed.

Deviance is a universal phenomenon. All societies have definitions of some behaviors or activities as deviant or morally reprehensible. The very notion that a society has social norms or rules ensures the existence of deviance. There can be no deviance without social rules (and, as far as we know, there can be no society without rules and norms, either). As Emile Durkheim (1895/1938) pointed out, deviance is "normal" to society. "Imagine a society of saints," wrote Durkheim,

a perfect cloister of exemplary individuals. Crimes [or deviance], properly so called, will there be unknown; but faults which appear venial to the layman will create there the same scandal that the ordinary offense does in ordinary consciousness. If, then, this society has the power to judge and punish, it will define these acts as criminal [or deviant] and will treat them as such. (pp. 68-69)*

Durkheim touches on many important aspects of deviance in this short passage: deviance is universal, deviance is a social definition, social groups make rules and enforce their definitions on members through judgment and social sanction, deviance is contextual, and defining and sanctioning deviance involves power. Let us consider these one at a time.

1. Deviance is universal, but there are no universal forms of deviance. There are few acts, if any, that are defined as deviance in all societies under all conditions. Incest probably conforms most closely to a universal definition of deviance. Yet different societies consider different activities to be incest: some societies prohibit only brother-sister relations, whereas others consider relations between third cousins to be incestuous. A few societies encourage sexual relationships between parents and children, and in several, siblings may engage freely in all sexual activity until puberty. Premeditated murder is also considered deviant in most societies, but there are societies in which a man who kills an-

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*From Durkheim, E. *Rules of the sociological method*. New York: The Free Press, 1938. Copyright 1938 by the University of Chicago. (Originally published, 1895.)

other man for committing adultery with his wife is deemed justified. Even incest and murder are not universally deviant.

Deviance is also relative. Different societies define different activities as deviant. In contemporary American society the young girls of Salem might find their behavior defined as deviant (i.e., hysterical) rather than the behaviors of those they accused of witchcraft. Certain forms of homosexuality were acceptable among the cultural elite in classical Greece, but in America such conduct is condemned and stigmatized. Suicide is considered deviant and ungodly in most of the Christian world, whereas in Imperial Japan it could be an honorable act. The extremely suspicious and treacherous behavior of the Dobu of Melanesia would be labeled "paranoid" by modern psychiatric standards, but it would be the accepting and unsuspicious individual who would be a deviant among the Dobu. Ruth Benedict's (1934) notion of "cultural relativity" is useful here: each society should be viewed by its own conceptions and standards. What is deviant for a society is relative to that society: witchcraft among the Puritans, hysteria and paranoia in American society.

2. Deviance is a social definition. That is, deviance is not "given" in any behavior, act, or status. It must be so defined intentionally by "significant" actors in the society or social group. In Erikson's (1966) words, "Deviance is not a property *inherent* in any particular kind of behavior; it is a property *conferred upon* that behavior by the people who come into direct or indirect contact with it" (p. 6). Deviance may be seen as a label attached to an act or behavior or as a category by which certain behaviors are defined. Thus deviance is a socially *attributed* condition, and "deviant" is an *ascribed* status. Deviance does not inhere in the individual or the behavior; it is a social judgment of that behavior. In short, it is not the act but the definition that makes something deviant.

This view of deviance allows us to separate the *definition* of the behavior and the *behavior* itself. Each may be studied separately. In this light we see deviance as a *system of social categories* constructed for classifying behavior, persons, situations, and things. Puritan society in-

herited a long tradition of defining certain behaviors as witchcraft (Currie, 1968). Witchcraft, regardless of whether we believe in it, was a generally accepted category for "deviant" behavior to the Puritans. In Puritan society there were certain more or less agreed-on criteria for assignment to this deviant category (p. 4, just as we have criteria for applying our contemporary definitions of deviance. As sociologists we may study the origins of witchcraft as a category of deviance, as well as study the "causes" of witchcraft behavior. In other words, we may examine the etiology of social definitions of deviance separately from the etiology of the behaviors labeled as deviant. We can ask, for example, how it was that abortion was defined as deviant until recently rather than ask what caused people to have or perform the abortions (we present this example later in this chapter). Again, the definition is separated from the behavior or act. Deviance definitions may change over time. Witchcraft is no longer a relevant type of deviance in American society, but juvenile delinquency, opiate addiction, and child abuse, unknown to the Puritans, are well-accepted contemporary categories of deviance. The approach we take in this book is to analyze the changing definitions of deviance, which may or may not be related to actual changes in "deviant" behavior. We develop this further in Chapter 2.

3. Social groups make rules and enforce their definitions on members through judgment and social sanction. Although we view deviance definitions as social categories, in reality they are not separate from their use and application. Definitions do not create themselves: "social groups create deviance by making the rules whose infraction constitutes deviance, and applying those rules to particular people and labeling them as [deviants]" (Becker, H. S., 1963, p. 9). The leaders of Salem Village "created" deviance by making and enforcing rules whose infraction constituted deviance. (Had they ignored the girls' behavior, the witch trials probably never would have occurred.) Admittedly, most instances of deviance are not nearly as clear examples of the creation and application of rules to produce deviance as the Salem episode, but collective rule making, social

judgment, and the application of sanctions (penalties) are central to all types of deviance. What is important to remember is that "societies" do not make rules and define deviance; people acting collectively do.

4. Deviance is contextual. By this we mean that what is labeled as deviant varies by social context—especially according to such conditions as society, subculture, time, place, who is involved, and who is offended. Willfully taking another's life usually is considered deviant, but not on a battlefield when the victim is defined as the enemy. Marijuana smoking is by law deviant in most states, but in many youth subcultures it would be the nonsmoker who would be defined deviant. Masturbation was defined as a sin and disease in Victorian times but today is considered healthy. Suicide by an 80-year-old man with terminal cancer may be considered by many as justifiable, whereas a suicide attempt by a college student ordinarily is seen as deviant and usually leads to psychiatric treatment. Thus "what" and "who" are "deviant" depends significantly on social context.

5. Defining and sanctioning deviance involves power. In general, powerful people and groups are able to establish and legitimate their morality and definitions of deviance. Those belonging to the more powerful groups in society, in terms of social class, age, race, ethnicity, profession, sex, etc., can enforce their categories of deviance on less powerful groups. It is seldom vice versa. In the witchcraft example the community and religious leaders of Salem Village (all men) were able to implement their categories of deviance on the accused witches (mostly women). Similarly adults make rules children must live by, the middle and upper classes define deviance in the lower classes (perhaps that is one reason why so much deviance is found among the lower classes), and a prestigious profession such as medicine makes rules whose violation is nearly universally termed sickness. We shall discuss the power dimension further in Chapter 2.

In summary, deviance is universal yet widely variable. It is in essence a social judgment and definition and therefore culturally relative. Deviance is socially created by rule making and

enforcement, usually by powerful groups over people in less powerful positions.

SOCIAL CONTROL

Social control is a central and important concept in sociology. Developed by Edward A. Ross (1901) around the turn of the century, the term was used to describe the processes societies developed for regulating themselves. Social control meant social regulation. In the past two decades, however, its common sociological usage has changed. Perhaps dating from the work of Talcott Parsons (1951), social control began to be used in a narrower sense to mean the control of deviance and the promotion of conformity. This is the common usage today, although there are some who call for a return to its original meaning as societal regulation (Janowitz, 1975).

Social control is usually conceptualized as the means by which society secures adherence to social norms; specifically, how it minimizes, eliminates, or normalizes deviant behavior. Even when we limit our discussion of social control to the control of deviance, it is still a broad and complex topic. We introduce here a few dimensions of social control most directly relevant to our argument in this book (for more complete discussions see Pitts, 1968, and Roucek, 1978). Social control operates on both informal and formal levels and through "positive" and "negative" forms. Informal controls include self-controls and relational controls. Self-controls reside within individuals (although their source is external and therefore social) and include internalized norms, beliefs, morals, self-concept, and what is commonly called "conscience." Relational controls are a regular feature of the face-to-face interactions of everyday life. They include such common interactions as ridicule, praise, gossip, smiles, disapproving glances and "dirty looks," mythmaking, group ostracism and support, and essentially any negative or positive sanction for behavior. Informal controls both inhibit individuals from behavior that might be considered deviant and encourage conformity by positive sanction. In most cases these informal controls do not lead to an individual being defined and labeled as deviant, for we are all subject to these

controls daily. Formal social control is less ubiquitous in everyday life, but its consequences are usually much more profound and enduring to the individual and society. (Sociologists have studied negative and formal social control far more thoroughly than informal and positive social control, perhaps because the latter are much more difficult to study.) Formal social controls are institutionalized forms of social control. Although they include "the 'official' laws, regulations, and understandings that are supposed to encompass all the members of a group or society" (Buckner, 1971, p. 14), sociologists usually think of formal social control in terms of *institutions* and *agents* of social control. They may be depicted as social control apparatuses that operate, explicitly and implicitly, to secure adherence to a particular set of values and norms, and in this work, to sanction deviance. In our society we usually think of the criminal justice system, with the police, courts, correctional facilities, and auxiliary personnel, as the major institution of social control. Other institutions such as education, welfare, the mass media, and medicine are also frequently depicted as having social control functions.

The greatest social control power comes from having the authority to define certain behaviors, persons, and things. This right to define may reside in an abstract authority such as "the law" or God but is implemented commonly through some institutional force such as the state or church. Such institutions, then (or, perhaps better, the people who represent them), have the mandate to define the problem (e.g., as deviance), designate what type of problem it is, and indicate what should be done about it. In our witchcraft example, representatives of the church (ministers) and the state (magistrates) agreed on the definition of the problem, witchcraft (so, incidentally, did the physician), but it was essentially a theological definition that prevailed (i.e., it was a question of witchcraft, or consorting with the Devil). As we mentioned earlier, a modern psychiatrist might have defined the problem as the young girls' being "hysterical," but there were no psychiatrists with any authority in Salem to challenge the witchcraft definition.

Social control, then, can be seen as the power

to have a particular set of definitions of the world realized in both spirit and practice. To the extent that such definitions receive widespread and/or "significant" social support, this power becomes authority and thereby considerably more secure from attack and challenge. This authority, not uncommonly, may become vested in a dominant institution. For example, during the Middle Ages and through the Inquisition the Church had the authority and power to define activities as deviant. With the decline of the Church and the subsequent secularization, the state increasingly gained authority to define deviance. When an institution (e.g., the church, state, medical profession) gains the power and authority to define deviance, that is, to say what kind of a problem something is, the responsibility for dealing with the problem often comes to that institution. In this sense we can say institutions can define their own social control "turf." Representatives of an institution may linguistically stake claims to deviance territory and thus attempt to justify their authority and legitimacy. In areas where an institution's definitions become dominant and accepted, it is capable of defining the territory of its work. The institution and the practitioners within it become designated "experts" in dealing with the problem, or at least stewards of its social control.

It is important to remember that any given "problem" can be viewed by different eyes and thus may be defined and analyzed in different ways. For example, the problems of deviant drinking can be seen as "caused" by sinfulness, moral weakness, psychological disturbance, genetic predisposition, adaptation to stress, or other influences (the problem could also be defined as caused by the promotion and distribution of the liquor industry). What the problem "really" is may be debated and argued; deviant drinking is not obviously one certain type of problem. The right to define a "problem," and thereby locate it within a particular social control turf, is achieved typically through enterprise, strategy, and struggle. We will encounter numerous examples of this throughout the book.

This book examines how increasing forms of deviant behavior have been defined as medical problems and thereby properly under medical social control. We examine how medicine

achieved the authority to define problems as "sickness" rather than "badness" and analyze the consequences of this transformation. We begin this discussion in the next chapter. Before we start this examination, however, it is important to review briefly medicine's rather recent rise to dominance in American society.

THE MEDICAL PROFESSION AND DEVIANCE IN AMERICA

Since the dominant theme of this book concerns the change in definitions of deviance from badness to sickness and the expansion of medicine as an agent of social control, it is important to have some understanding of the historical development of medical practice and the medical profession. Medicine has not always been the powerful, prestigious, successful, lucrative, and dominant profession we know today. The status of the medical profession is a product of medical politicking as well as therapeutic expertise. This discussion presents a brief overview of the development of the medical profession and its rise to dominance.

Emergence of the medical profession: up to 1850

In ancient societies, disease was given supernatural explanations, and "medicine" was the province of priests or shamans. It was in classical Greece that medicine began to emerge as a separate occupation and develop its own theories, distinct from philosophy or theology. Hippocrates, the great Greek physician who refused to accept supernatural explanations or treatments for disease, developed a theory of the "natural" causes of disease and systematized all available medical knowledge. He laid a basis for the development of medicine as a separate body of knowledge. Early Christianity depicted sickness as punishment for sin, engendering new theological explanations and treatments. Christ and his disciples believed in the supernatural causes and cures of disease. This view became institutionalized in the Middle Ages, when the Church dogma dominated theories and practice of medicine and priests were physicians. The Renaissance in Europe brought a renewed interest in ancient Greek medical knowledge. This marked the beginning of a

drift toward natural explanations of disease and the emergence of medicine as an occupation separate from the Church (Cartwright, F. F., 1977).

But European medicine developed slowly. The "humoral theory" of disease developed by Hippocrates dominated medical theory and practice until well into the 19th century. Medical diagnosis was impressionistic and often inaccurate, depicting conditions in such general terms as "fevers" and "fluxes." In the 17th century, physicians relied mainly on three techniques to determine the nature of illness: what the patient said about symptoms; the physician's own observations of signs of illness and the patient's appearance and behavior; and, more rarely, a manual examination of the body (Reiser, 1978, p. 1). Medicine was by no means scientific, and "medical thought involved unverified doctrines and resulting controversies" (Shryock, 1960, p. 52). Medical practice was a "bedside medicine" that was patient oriented and did not distinguish the illness from the "sick man" (Jewson, 1976). It was not until Thomas Sydenham's astute observations in the late 17th century that physicians could begin to distinguish between the patient and the disease. Physicians possessed few treatments that worked regularly, and many of their treatments actually worsened the sufferer's condition. Medicine in colonial America inherited this European stock of medical knowledge.

Colonial American medicine was less developed than its European counterpart. There were no medical schools and few physicians, and because of the vast frontier and sparse population, much medical care was in effect self-help. Most American physicians were educated and trained by apprenticeship; few were university trained. With the exception of surgeons, most were undifferentiated practitioners. Medical practices were limited. Prior to the revolution, physicians did not commonly attend births; midwives, who were not seen as part of the medical establishment, routinely attended birthings (Wertz and Wertz, 1977). William Rothstein (1972) notes that "American colonial medical practice, like European practice of the period, was characterized by the lack of any substantial body of usable scientific knowledge" (p. 27). Physicians, both educated and otherwise, tended to treat

their patients pragmatically, for medical theory had little to offer. Most colonial physicians practiced medicine only part-time, earning their livelihoods as clergymen, teachers, farmers, or in other occupations. Only in the early 19th century did medicine become a full-time vocation (Rothstein, 1972).

The first half of the 19th century saw important changes in the organization of the medical profession. About 1800, "regular," or educated, physicians convinced state legislatures to pass laws limiting the practice of medicine to practitioners of a certain training and class (prior to this nearly anyone could claim the title "doctor" and practice medicine). These state licensing laws were not particularly effective, largely because of the colonial tradition of medical self-help. They were repealed in most states during the Jacksonian period (1828-1836) because they were thought to be elitist, and the temper of the times called for a more "democratic" medicine.

The repeal of the licensing laws and the fact that most "regular" (i.e., regularly educated) physicians shared and used "a distinctive set of medically invalid therapies, known as 'heroic' therapy," created fertile conditions for the emergence of *medical sects* in the first half of the 19th century (Rothstein, 1972, p. 21). Physicians of the time practiced a "heroic" and invasive form of medicine consisting primarily of such treatments as bloodletting, vomiting, blistering, and purging. This highly interventionist, and sometimes dangerous, form of medicine engendered considerable public opposition and resistance. In this context a number of medical sects emerged, the most important of which were the homeopathic and botanical physicians. These "irregular" medical practitioners practiced less invasive, less dangerous forms of medicine. They each developed a considerable following, since their therapies were probably no less effective than those of regulars practicing heroic medicine. The regulars attempted to exclude them from practice; so the various sects set up their own medical schools and professional societies. This sectarian medicine created a highly *competitive* situation for the regulars (Rothstein, 1972). Medical sectarianism, heroic therapies, and ineffective treatment con-

tributed to the low status and lack of prestige of early 19th-century medicine. At this time, medicine was neither a prestigious occupation nor an important economic activity in American society (Starr, 1977).

The regular physicians were concerned about this situation. Large numbers of regularly trained physicians sought to earn a livelihood by practicing medicine (Rothstein, 1972, p. 3). They were troubled by the poor image of medicine and lack of standards in medical training and practice. No doubt they were also concerned about the competition of the irregular sectarian physicians. A group of regular physicians founded the American Medical Association (AMA) in 1847 "to promote the science and art of medicine and the betterment of public health" (quoted in Coe, 1978, p. 204). The AMA also was to set and enforce standards and ethics of "regular" medical practice and strive for exclusive professional and economic rights to the medical turf.

The AMA was the crux of the regulars' attempt to "professionalize" medicine. As Magali Sarfatti Larson (1977) points out, professions organize to create and control *markets*. Organized professions attempt to regulate and limit the competition, usually by controlling professional education and by limiting licensing. Professionalization is, in this view, "the process by which producers of special services sought to constitute and control the market for their expertise" (Larson, 1977, p. xvi). The regular physicians and the AMA set out to consolidate and control the market for medical services. As we shall see in the next two sections, the regulars were successful in professionalization, eliminating competition and creating a medical monopoly.

Crusading, deviance, and medical monopoly: the case of abortion

The medical profession after the middle of the 19th century was frequently involved in various activities that could be termed social reform. Some of these reforms were directly related to health and illness and medical work; others were peripheral to the manifest medical calling of preventing illness and healing the sick. In these reform movements, physicians

became medical crusaders, attempting to influence public morality and behavior. This medical crusading often led physicians squarely into the moral sphere, making them advocates for moral positions that had only peripheral relations to medical practice. Not infrequently these reformers sought to change people's values or to impose a set of particular values on others or, as we shall soon see, to create new categories of social deviance. Throughout this book we will often encounter medical crusaders. We now examine one of the more revealing examples of medical crusading: the criminalization of abortion in American society.*

Most people are under the impression that abortion was always defined as deviant and illegal in America prior to the Supreme Court's landmark decision in 1973. This, however, is not the case. American abortion policy, and the attendant defining of abortion as deviant, were specific products of medical crusading. Prior to the Civil War, abortion was a common and largely legal medical procedure performed by various types of physicians and midwives. A pregnancy was not considered confirmed until the occurrence of a phenomenon called "quickening," the first perception of fetal movement. Common law did not recognize the fetus before quickening in criminal cases, and an unquickened fetus was deemed to have no living soul. Thus most people did not consider termination of pregnancy before quickening to be an especially serious matter, much less murder. Abortion before quickening created no moral or medical problems. Public opinion was indifferent, and for the time it was probably a relatively safe medical procedure. Thus, for all intents and purposes, American women were free to terminate their pregnancies before quickening in the early 19th century. Moreover, it was a procedure relatively free of the moral stigma that was attached to abortion in this century.

After 1840 abortion came increasingly into public view. Abortion clinics were vigorously and openly advertised in newspapers and mag-

azines. The advertisements offered euphemistically couched services for "women's complaints," "menstrual blockage," and "obstructed menses." Most contemporary observers suggested that more and more women were using these services. Prior to 1840 most abortions were performed on the unmarried and desperate of the "poor and unfortunate classes." However, beginning about this time, significantly increasing numbers of middle- and upper-class white, Protestant, native-born women began to use these services. It is likely they either wished to delay childbearing or thought they already had all the children they wanted (Mohr, 1978, pp. 46-47). By 1870 approximately one abortion was performed for every five live births (Mohr, 1978, pp. 79-80).

Beginning in the 1850s, a number of physicians, especially moral crusader Dr. Horatio Robinson Storer, began writing in medical and popular journals and lobbying in state legislatures about the danger and immorality of abortion. They opposed abortion before and after quickening and under Dr. Storer's leadership organized an aggressive national campaign. In 1859 these crusaders convinced the AMA to pass a resolution condemning abortion. Some newspapers, particularly the *New York Times*, joined the antiabortion crusade. Feminists supported the crusade, since they saw abortion as a threat to women's health and part of the oppression of women. Religious leaders, however, by and large avoided the issue of abortion; either they didn't consider it in their province or found it too sticky an issue to discuss. It was the physicians who were the guiding force in the anti-abortion crusade. They were instrumental in convincing legislatures to pass state laws, especially between 1866 and 1877, that made abortion a criminal offense.

Why did physicians take the lead in the anti-abortion crusade and work so directly to have abortion defined as deviant and illegal? Undoubtedly they believed in the moral "rightness" of their cause. But social historian James Mohr (1978) presents two more subtle and important reasons for the physicians' anti-abortion crusading. First, concern was growing among medical people and even among some legislators about the significant drop in birth-

* We rely on James C. Mohr's (1978) fine historical account of the origins and evolution of American abortion policy for data and much of the interpretation in this section.

rates. Many claimed that abortion among married women of the "better classes" was a major contributor to the declining birthrate. These middle- and upper-class men (the physicians and legislators) were aware of the waves of immigrants arriving with large families and were anxious about the decline in production of native American babies. They were deeply afraid they were being betrayed by their own women (Mohr, 1978, p. 169). Implicitly the antiabortion stance was classist and racist; the anxiety was simply that there would not be enough strong, native-born, Protestant stock to save America. This was a persuasive argument in convincing legislators of the need of antiabortion laws.

The second and more direct reason spurring the physicians in the antiabortion crusade was to aid their own nascent professionalization and create a monopoly for regular physicians. As mentioned earlier, the regulars had formed the AMA in 1847 to promote scientific and ethical medicine and combat what they saw as medical quackery. There were, however, no licensing laws to speak of, and many claimed the title "doctor" (e.g., homeopaths, botanical doctors, eclectic physicians). The regular physicians adopted the Hippocratic oath and code of ethics as their standard. Among other things, this oath forbids abortion. Regulars usually did not perform abortions; however, many practitioners of medical sects performed abortions regularly, and some had lucrative practices. Thus for the regular AMA physicians the limitation of abortion became one way of asserting their own professional domination over other medical practitioners. In their crusading these physicians had translated the social goals of cultural and professional dominance into moral and medical language. They lobbied long and hard to convince legislators of the danger and immorality of abortion. By passage of laws making abortion criminal any time during gestation, regular physicians were able to legislate their code of ethics and get the state to employ sanctions against their competitors. This limited these competitors' markets and was a major step toward the regulars' achieving a monopolization of medical practice.

In a relatively short period the antiabortion crusade succeeded in passing legislation that

made abortion criminal in every state. A by-product of this was a shift in American public opinion from an indifference to and tolerance of abortion to a hardening of attitudes against what had until then been a fairly common practice. The irony was that abortion as a medical procedure probably was safer at the turn of the 20th century than a century before, but it was defined and seen as more dangerous. By 1900 abortion was not only illegal but deviant and immoral. The physicians' moral crusade had successfully defined abortion as a deviant activity. This definition remained largely unchanged until the 1973 Supreme Court decision, which essentially returned the abortion situation to its pre-1850 condition.

This was not the first nor the last medical venture into the moral world of norm creation and deviance. German physicians in the 18th century proposed development of a "medical police" who would supervise the health and hygiene of the population as well as control activities such as prostitution (Rosen, 1974). Physicians were actively involved in the Temperance and "eugenics" movements of the 19th century. The first legal and involuntary medical sterilizations performed in the United States were on "criminals" by crusading physicians seeking both to curb crime and protect the racial stock (Fink, 1938). The following impassioned defense of such selective and "reformist" sterilization appeared in the *New York Medical Journal* in 1902, written by a surgeon at the Indiana Reformatory:

It is my judgment, founded on research and observation, that this is the rational means of eradicating from our midst a most dangerous and hurtful class. Too much stress cannot be placed upon the present danger to the race. The public must be made to see that radical methods are necessary. Even radical methods may be made to seem just if they are shown to be rational. In this we have a means which is both rational and sufficient. It remains with you—men of science and skill—to perpetuate a known relief to a weakening race by prevailing upon your legislatures to enact such laws as will restrict marriage and give those in charge of State institutions the authority to render every male sterile who passes its portals, whether it be almshouse, insane asylum, institute for the feeble-minded, reformatory, or prison. The medical profession has never failed in an attempt,

and it will not fail in this. (Sharp, 1902, pp. 413-414).

In the 20th century, physicians were central figures in crusades for social hygiene (Burnham, 1972) and birth control (Gordon, 1975). Physicians often saw their scientific and professional values as the values that ought to guide the behavior of others. Frequently they argued for certain positions in the name of science when the issues were actually moral. As John C. Burnham (1972) observes, "Repeatedly the leaders of American medicine sought to impose such values upon others, that is, to exercise social control" (p. 19).

American medicine and physicians have had a long-lived, historic involvement with deviance and social control. Some diseases were considered indistinguishable from deviant behavior; sufferers were treated as both deviant and sick. Physicians perhaps always have had a significant role in the control and treatment of conditions such as leprosy and epilepsy. Leprosy, a long-term degenerative disease that severely and horribly mutilates its victims, was widespread in the 12th and 13th centuries. It was a highly feared disease (although it is *not* very contagious), and its sufferers were stigmatized and treated as deviants because of their frightful appearance. Since no physical cure was known, the only means of dealing with the disease was social. Physicians were the diagnosticians. If the diagnosis was firmly established, the leper was segregated for life.

He was expelled from human society and deprived of his civil rights; in some places a Requiem was held for him, and thus he was declared dead as far as society was concerned. He lived in a *leprosarium* outside the city walls in the company of other lepers, all of whom were dependent on charity for their sustenance. (Sigerist, 1943, p. 73)

Epilepsy was considered both a disease and a sign of supernatural demonic possession (i.e., deviance) until the 20th century. Surely uncontrolled seizures were a frightening form of deviant behavior, and epileptics were severely stigmatized and frequently segregated (Temkin, 1971). Thus the lines between sickness and deviance sometimes were not clearly drawn: some diseases were considered deviance, and, as we shall demonstrate in upcoming chapters,

some deviance became defined as disease. The medical profession would have an increasing role in defining and controlling deviance. This "power" rested at least in part on the growth of medical expertise and professional dominance.

Growth of medical expertise and professional dominance

Although the general public's dissatisfaction with heroic medicine remained, the image of medicine and what it could accomplish was improving by the middle of the 19th century. There had been a considerable reduction in the incidence and mortality of certain dread diseases. The plague and leprosy had nearly disappeared. Smallpox, malaria, and cholera were less devastating than ever before. These improvements in health engendered optimism and increased people's faith in medical practice. Yet these dramatic "conquests of disease" were by and large *not* the result of new medical knowledge or improved clinical medical practice. Rather, they resulted from changes in social conditions: a rising standard of living, better nutrition and housing, and public health innovations like sanitation. With the lone exception of vaccination for smallpox, the decline of these diseases had nearly nothing to do with clinical medicine (Dubos, 1959; McKeown, 1971). But despite lack of effective treatments, medicine was the beneficiary of much popular credit for improved health.

The regular physicians' image was improved well before they demonstrated any unique effectiveness of practice. The AMA's attacks on irregular medical practice continued. In the 1870s the regulars convinced legislatures to outlaw abortion and in some states to restore licensing laws to restrict medical practice. The AMA was becoming an increasingly powerful and authoritative voice representing regular medical practice.

But the last three decades of the century saw significant "breakthroughs" in medical knowledge and treatment. The scientific medicine of the regular physicians was making new medical advances. Anesthesia and antiseptics made possible great strides in surgical medicine and improvements in hospital care. The bacteriological research of Koch and Pasteur developed the

"germ theory of disease," which had important applications in medical practice. It was the accomplishments of surgery and bacteriology that put medicine on a scientific basis (Freidson, 1970a, p. 16). The rise of scientific medicine marked a death knell for medical sectarianism (e.g., the homeopathic physicians eventually joined the regulars). The new laboratory sciences provided a way of testing the theories and practices of various sects, which ultimately led to a single model of medical practice. The well-organized regulars were able to legitimate their form of medical practice and support it with "scientific" evidence.

With the emergence of scientific medicine, a unified paradigm, or model, of medical practice developed. It was based, most fundamentally, on viewing the body as a machine (e.g., organ malfunctioning) and on the germ theory of disease (Kelman, 1977). The "doctrine of specific etiology" became predominant: each disease was caused by a specific germ or agent. Medicine focused solely on the internal environment (the body), largely ignoring the external environment (society) (Dubos, 1959). This paradigm proved fruitful in ensuing years. It is the essence of the "medical model" we discuss in Chapter 2.

The development of scientific medicine accorded regular medicine a convincing advantage in medical practice. It set the stage for the achievement of a medical monopoly by the AMA regulars. As Larson (1977) notes, "Once scientific medicine offered sufficient guarantees of its superior effectiveness in dealing with disease, the state willingly contributed to the creation of a monopoly by means of registration and licensing" (p. 23). The new licensing laws created regular medicine as a *legally enforced monopoly of practice* (Freidson, 1970b, p. 83). They virtually eliminated medical competition.

The medical monopoly was enhanced further by the Flexner Report on medical education in 1910. Under the auspices of the Carnegie Foundation, medical educator Abraham Flexner visited nearly all 160 existing medical schools in the United States. He found the level of medical education poor and recommended the closing of most schools. Flexner urged stricter state laws, rigid standards for medical educa-

tion, and more rigorous examinations for certification to practice. The enactment of Flexner's recommendations effectively made all nonscientific types of medicine illegal. It created a near total AMA monopoly of medical education in America.

In securing a monopoly, the AMA regulars achieved a unique professional state. Medicine not only monopolized the market for medical services and the training of physicians, it developed an unparalleled "professional dominance." The medical profession was *functionally autonomous* (Freidson, 1970b). Physicians were insulated from external evaluation and were by and large free to regulate their own performance. Medicine could define its own territory and set its own standards. Thus, Eliot Freidson (1970b) notes, "while the profession may not everywhere be free to control the *terms* of its work, it is free to control the *content* of its work" (p. 84).

The domain of medicine has expanded in the past century. This is due partially to the prestige medicine has accrued and its place as the steward of the "sacred" value of life. Medicine has sometimes been called on to repeat its "miracles" and successful treatments on problems that are not biomedical in nature. Yet in other instances the expansion is due to explicit medical crusading or entrepreneurship. This expansion of medicine, especially into the realm of social problems and human behavior, frequently has taken medicine beyond its proven technical competence (Freidson, 1970b). In this book we examine a variety of cases in which personal problems or deviant behaviors become defined as illness and therefore within medical jurisdiction.

The organization of medicine has also expanded and become more complex in this century. In the next section we briefly describe the structure of medical practice in the United States.

Structure of medical practice

Before we leave our discussion of the medical profession, it is worthwhile to outline some general features of the structure of medical practice that have contributed to the expansion of medical jurisdiction.

The medical sector of society has grown

enormously in the 20th century. It has become the second largest industry in America. There are about 350,000 physicians and over 5 million people employed in the medical field. The "medical industries," including the pharmaceutical, medical technology, and health insurance industries, are among the most profitable in our economy. Yearly drug sales alone are over \$4.5 billion. There are more than 7000 hospitals in the United States with 1.5 million beds and 33 million inpatient and 200 million outpatient visits a year (McKinlay, 1976).

The organization of medical practice has changed. Whereas the single physician in "solo practice" was typical in 1900, today physicians are engaged increasingly in large corporate practices or employed by hospitals or other bureaucratic organizations. Medicine in modern society is becoming bureaucratized (Mechanic, 1976). The power in medicine has become diffused, especially since World War II, from the AMA, which represented the individual physician, to include the organizations that represent bureaucratic medicine: the health insurance industry, the medical schools, and the American Hospital Association (Ehrenreich & Ehrenreich, 1970). Using Robert Alford's (1972) conceptualizations, corporate rationalizers have taken much of the power in medicine from the professional monopolists.

Medicine has become both more specialized and more dependent on technology. In 1929 only 25% of American physicians were full-time specialists; by 1969 the proportion had grown to 75% (Reiser, 1978). Great advances were made in medicine, and many were directly related to technology: miracle medicines like penicillin, a myriad of psychoactive drugs, heart and brain surgery, the electrocardiograph, CAT scanners, fetal monitors, kidney dialysis machines, artificial organs, and transplant surgery, to name but a few. The hospital has become the primary medical workshop, a center for technological medicine.

Medicine has made a significant economic expansion. In 1940, medicine claimed about 4% of the American gross national product (GNP); today it claims about 9%, which amounts to more than \$150 billion. The causes for this growth are too complex to describe here, but a few factors should be noted. Ameri-

can medicine has always operated on a "fee-for-service" basis, that is, each service rendered is charged and paid for separately. Simply put, in a capitalist medical system, the more services provided, the more fees collected. This not only creates an incentive to provide more services but also to expand these medical services to new markets. The fee-for-service system may encourage unnecessary medical care. There is some evidence, for example, that American medicine performs a considerable amount of "excess" surgery (McCleery et al., 1971); this may also be true for other services. Medicine is one of the few occupations that can create its own demand. Patients may come to physicians, but physicians tell them what procedures they need. The availability of medical technique may also create a demand for itself.

The method by which medical care is paid for has changed greatly in the past half-century. In 1920 nearly all health care was paid for directly by the patient-consumer. Since the 1930s an increasing amount of medical care has been paid for through "third-party" payments, mainly through health insurance and the government. About 75% of the American population is covered by some form of medical insurance (often only for hospital care). Since 1966 the government has been involved directly in financing medical care through Medicare and Medicaid. The availability of a large amount of federal money, with nearly no cost controls or regulation of medical practice, has been a major factor fueling our current medical "cost crisis." But the ascendancy of third-party payments has effected the expansion of medicine in another way: more and more human problems become defined as "medical problems" (sickness) because that is the only way insurance programs will "cover" the costs of services. We will say more about this in Chapter 9.

In sum, the regular physicians developed control of medical practice and a professional dominance with nearly total functional autonomy. Through professionalization and persuasion concerning the superiority of their form of medicine, the medical profession (represented by the AMA) achieved a legally supported monopoly of practice. In short, it cornered the medical market. The medical profession has succeeded in both therapeutic and economic ex-

pansion. It has won the almost exclusive right to reign over the kingdom of health and sickness, no matter where it may extend.

OVERVIEW OF THE BOOK

In this chapter we introduced the sociological study of deviance and social control and offered a brief analysis of the development of the medical profession and practice. We locate our study in the labeling-interactionist sociology of deviance that has emerged in the past two decades. Our emphasis differs from most interactionist work in that we focus on historical construction and change of deviance definitions.

Chapter 2 presents the analytic perspective used for the remainder of the book: the politics of deviance definitions and designations. We also present some introductory thoughts about the medicalization of deviance. Chapters 3 through 8 consist of substantive sociohistorical analyses of the changing definitions of various categories of deviance. Throughout we attempt to focus on people, groups, and organizations as they contend about particular definitions of deviance. Chapter 3 examines the oldest and most widely accepted example of medicalization, the medical model of madness. It traces the events, discoveries, and people involved with the promotion and diffusion of the concept of mental illness. Chapter 4 focuses on the development of the disease concept of alcoholism, highlighting how nonmedical groups can use medical means to their own ends. Chapter 5 examines the fall and rise of opiate addiction as a medical problem, illuminating with particular clarity the political struggles between supporters of criminal and medical definitions of addiction. Chapter 6 reviews the development and legitimation of the designations of juvenile delinquency, hyperkinesis, and child abuse and suggests that children, because of their position in society, are a population at risk for medicalization. Chapter 7 traces the definitions of homosexuality from sin to sickness to life-style, noting the profound moral continuity in definition and social response. The recent demedicalization by the American Psychiatric Association is examined and found more symbolic than real. Chapter 9 (written by Richard Moran) outlines the long search for the "born

criminal" and the medical treatments used to "cure" and control criminals.

The final two chapters present a general analysis and conceptual understanding of the medicalization of deviance. Chapter 10 describes and analyzes three types of medical social control, elaborates on the important social consequences of medicalizing deviance, and examines implications of recent and future social policy on medicalization. Chapter 11 endeavors to present a theoretical statement on the medicalization of deviance, serving both as a summary of what we understand about the process of medicalizing deviance and suggestions about issues those who study the problem need to pursue.

SUGGESTED READINGS

Erikson, K. T. *Wayward puritans*. New York: John Wiley & Sons, Inc., 1966.

An excellent and highly readable account of deviance among the 17th-century Puritans. Erikson explores the Antinomian controversy, the Quaker invasion, and Salem witchcraft as "crime waves" and develops a theory of deviance as boundary marking.

Freidson, E. *Professional dominance*. Chicago: Atherton Press, 1970.

A critical analysis of the social structure of medical practice. Freidson outlines the perquisites and consequences of professional dominance from a sociology-of-work perspective.

Goode, E. *Deviant behavior: an interactionist approach*. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1978.

A thoughtful and intelligent introduction to the relativist-interactionist approach to the study of deviance. The first eight chapters are especially useful.

Rubington, E., & Weinberg, M. S. *Deviance: the interactionist perspective* (3rd ed.). New York: Macmillan Publishing Co., Inc., 1978.

A well-integrated collection of articles that includes some of the best examples of the interactionist approach to deviance. Either this book or Goode's could profitably be read as a companion to *Deviance and Medicalization*.

Wertz, R. W. & Wertz, D. C. *Lying in: a history of childbirth in America*. New York: The Free Press, 1977.

Traces the definition and treatment of childbirth from a family event to a medical event. This is a well-presented case of the medicalization of a non-deviant activity.