Class 4: Medicalization

Sociology of Mental Illness

I've got copies of the lecture guide!

Extra Credit

Anyone bring any?

From the syllabus:

"You can earn up to five points in extra credit for the final course grade if you bring in examples from the news, television entertainment, or movies that relate to the main themes in the class or specific readings or lectures we have discussed (one point per submission). To do this, bring in a copy (or some documentation of your example - like a TV schedule guide) and be prepared to share with the class what you heard, read, or saw and how it relates to something we've read or discussed in class. We will take time at the beginning of class and right after the mid-class break for you to share."

MAKE SURE TO PUT YOUR NAME ON YOUR ITEM.

The Plan

- Quiz from last week
- Open questions
  - Accuracy/Precision
  - Grading Scale
- Medicalization
- Sick Role
- Review for exam (last 30 minutes)

Grading Scale

Minimum score that must be earned for your final course grade:

A+	97.0
A	93.0
A-	90.0
B+	87.0
B	83.0
B-	80.0
C+	77.0
C	73.0
C-	70.0
D+	67.0
D	63.0
D-	60.0
F	0.0

You can technically earn up to 105% with the extra credit options. Anything above 97% would be counted as an "A+".

If you receive a letter grade on an assignment, your percent grade that is used in calculating your final course grade will be in the mid-range of the grade and the one above. So, an “A” paper will get a 95%, a “B+” paper will get an 88.5% and so on.

The weight given to each category of graded items (participation, quizzes, exams, paper) is spelled out in the syllabus.

Medicalization

- Medicalization: "defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it" (Conrad, 1992, pg 211)
- Big thinker in the field here is Peter Conrad, who along with Joseph Schneider wrote a book, Deviance and Medicalization: From Badness to Sickness (1980)
  - Didn't start or end with him, still an active area of research

Medicalization

- Involves
  - framing a problem as a medical one and/or
  - treating it as one.
- Usually treatment would fall under the venue of medical doctors (such as with the increasing medicalization of childbirth), but can also fall under other types of treatment (such as alcoholism and psychological therapy, coupled with medication)

Medicalization Consequences

- Benefits:
  - Can make deviant person been seen as more socially acceptable and less culpable
    - The approach is therapeutic instead of punitive
  - Can allow people a way to get "help" for their deviance
- Complications:
  - Can sometimes make the problem more stigmatizing
  - Can label social ills as individualistic ones
  - Because medical definitions and treatment take on the mantle of science, they are seen as morally neutral, when they are actually not

Conflict Theory Perspective

- Medicalization of problems can be a powerful social tool to force conformity and to oppress people who are different and less powerful
- Medicine as an institution has a lot to gain in terms of social power to continue to medicalize problems
- Sometimes these "treatments" can actually harm recovery or improvement
- **Sees medicalization as a social and political acheivement, not a scientific one.**

Symbolic Interactionist Perspective

- Medicalization often changes the way people see problems - both their own and that of others
  - It can lessen "blame" for deviance
  - It can allow people to rewrite the history of a problem.
- Seeing someone as "sick" instead of "bad" or just "wrong or different" can change the way people are inclined to interact with that person.
- Focuses on medicalization as a way in which people are labeled and what the societal reaction is to that.

TRA on Hoarders: Can you think of an interaction that exemplifies this?

Social Constructionist Perspective

- Reality is socially constructed and so are medicalized problems.
- Deviance has to be defined as such, and then further categorized as medical in nature.
- Both diagnosis and treatments are founded on social judgments about deviance
- It stands to reason that the "deviance" of behaving oddly is subject to more ambiguity and interpretation than having a broken hand or having the flu.
- It is important to understand how problems are socially constructed and treated

Medicalization has degrees and levels

Can be minimally, partially or fully medicalized. Problems can also be "demedicalized."

Levels:

- Conceptual - a medical vocabulary (or model) is used to "order" or define the problem at hand
- Institutional - organizations may adopt a medical approach to treating a particular problem
- Interactional - doctor-patient interaction, when a physician defines a problem as medical or treats a perhaps otherwise socially understood problem with a medical form of treatment

Examples of Medicalized Deviance

- Drug or alcohol abuse
- Spousal abuse
- Child abuse
- Social welfare "dependence"
- Homelessness
- Obesity
- Childbirth
- Childrearing
- Death
- Compulsive Shopping
- Compulsive Gambling
- Homosexuality
- Anger
- Menopause

The New York Times

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Push to Market Pill Stirs Debate on Sexual Desire

By DUFF WILSON
Published: June 16, 2010

Ever since Viagra met blockbuster success in 1998, the drug industry has sought a similar pill for women.

Enlarge This Image

Fred R. Conrad/The New York Times

Now, a German drug giant says it has stumbled upon such a pill and is trying to persuade the Food and Drug Administration that its drug can help restore a depressed female sex drive. The effort has set off a debate over what constitutes a normal range of sexual desire among women, with

The Washington Post

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Katrina vanden Heuvel
Opinion Writer

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For pink Viagra, a double standard

By Katrina vanden Heuvel
Wednesday, June 9, 2010

Let's get one thing straight. The discovery and development of flibanserin -- the so-called pink Viagra -- by a German pharmaceutical company is not "disease mongering."

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WHO Calling for an End to Genital Mutilation

Friday, June 02, 2006
Associated Press

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GENEVA — The World Health Organization said Friday that female genital cutting is a form of torture that must be stamped out, even if it is done by trained medical personnel.

The "medicalization" of ritual genital cutting fails to prevent girls from being permanently scarred, threatening their lives when they give birth later and endangering their babies, WHO said in a report.

Genital cutting "is the worst thing that a medical doctor could possibly do," said Joy Phumaphi, WHO assistant director-general and a former health minister from Botswana. "It is even worse than turning a blind eye, because you are legitimizing violation of a basic human right and violence against an innocent victim."

There can be no justification for doctors and nurses "to come and supervise the torture," Phumaphi said.

The practice — called genital mutilation by opponents — is done primarily in parts of sub-Saharan Africa and the **Middle East**. It is usually done on girls under 10. More than 100 million women and girls worldwide are believed to have undergone genital cutting, the U.N. health agency said.

Genital cutting usually involves removal of the clitoris. Those who practice it believe the cutting tames sexual desire and increases a girl's marriageability. Genital cutting is done by both Muslims and Christians.

An estimated 3 million women and girls undergo genital cutting each year, according to UNICEF.

"When the world is trying to save animals, when the world is trying to save plants, women in Africa are subjected to unnecessary torture in the name of tradition," said Berhane Ras-Work, president of the non-governmental group IAC, which campaigns against genital cutting. "It is a horrendous practice, it should not be allowed, it should be condemned, it should be stopped."

Los Angeles Times | HEALTH

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Booster Shots

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Smokers can quit without nicotine-replacement products. Really.

February 9, 2010 | 6:00 am

Contrary to the TV commercials and magazine advertisements, you don't have to use a nicotine-replacement product to quit smoking, say two doctors writing in the new issue of PLoS Medicine.

Many smokers are able to quit unassisted, say Simon Chapman and Ross MacKenzie of the School of Public Health in Sydney, Australia. They criticize what they call the "medicalization of smoking cessation," because it's not backed by evidence. Indeed, an analysis of 511 studies published in 2007 and 2008 show that two-thirds to three-quarters of smokers stop unaided and most ex-smokers report that cessation was less difficult than expected.

The pharmaceutical industry has promoted the "medicalization of smoking cessation," in part by funding smoking cessation studies that use the various nicotine aids or medications. What's really needed, the authors of the essay say, is some balance in the messages smokers receive about quitting. That is: You can do it, and it may not cost you a dime.

-- Shari Roan

Los Angeles Times | HEALTH

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IN THE NEWS: LARRY KING | HOME PRICES | ALLEGED RUSSIAN SPIES | GULF OIL SPILL | ELENA K

Is binge eating a psychiatric disorder?

As the American Psychiatrics Assn. considers including it in its diagnotic manual, skeptics object and possible treatments are debated.

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By Melissa Healy >>>

November 23, 2009

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Rina Silverman's refrigerator is almost always empty. She keeps it that way to avert episodes of frantic food consumption, often at night after a full meal, in which she tastes nothing and feels nothing but can polish off a party-sized bag of chips or a container of ice cream, maybe a whole box of cereal. The food she's eating at these moments hardly matters.

In short order, the nothing that Silverman feels and tastes will give way to nauseating fullness, and a bitter backwash of guilt, shame and self-reproach.

The fullness, in time, passes. But the corrosive shame and self-reproach are always there.

Sociology Lens

What does calling something a disorder do? the case of Chronic Fatigue Syndrome.

by Dena T. Smith, Oct 20, 2009, at 02:34 am

By Dena T. Smith

This week's Science Times reported that Chronic Fatigue Syndrome, (which causes the symptoms one might imagine, given the name of the condition) a set of symptoms with unidentified etiology, has been linked to a virus. This possible cause may potentially shed some light on the mysterious derivations of the syndrome, which many sufferers would like to see conceptualized as an illness or disease. While the story of Chronic Fatigue Syndrome is a fascinating and sometimes disturbing one, for sociologists, is is important to step back and take note of these moments in which new illnesses make their way into our medical vocabulary. These instances shed light not only on the process by which things become medicalized, but also on the consequences of medicalizing conditions for those who suffer their effects, often for long periods of time – and it is often only after the medical word claims a condition as a legitimate "disease" that suffers finally feel as though they are being taken seriously.

In order to be considered a legitimate illness, something must be a medical condition or disorder – a disease. This alone should make us pause and ask ourselves "why?" Given that the symptoms have not changed and people are not suddenly suffering more intensely or in greater quantities, the only reason people who have Chronic Fatigue can breathe a sigh of relief this week is because the medical community may, for the first time, begin to take their symptoms

From: contexts.org

Examples from Conrad and Figert readings and from Tra on Hoarding

- How were these problems medicalized?

- To what degree are these problems medicalized? At what levels?

So what happens to a person when their problem has been medicalized?

- While the different intellectual traditions might disagree on what to focus on, most would agree that individuals whose problems have been medicalized will be expected to take on "the sick role."
- This idea emerges from another, older social theoretical tradition called "structural-functionalist theory," which focuses on how society maintains the status quo

Talcott Parsons (1950s)

- Illness is a deviation from expected behavior and prevents individuals from fulfilling their normal role responsibilities
  - Being a worker, a mother, a productive member of society
- As illness is a social experience and it may limit our role functioning in our "normal" life
  - The sick role: society's response

The Sick Role

- A temporary role, while sick
- Responsibility for normal social role functioning is suspended (a privilege) provided we accept responsibility (obligations).

For the next portion, I would like you to imagine you have fallen ill with the flu and you can't make it to class or work. Here is what the "sick role" offers you.

Privileges of the Sick Role

- You become temporarily exempt from your "normal" social roles
  - How much depends on how serious your problems are
- You are not responsible for your condition
  - You didn't want to be sick.
  - Your illness is beyond your control (but hey, did you get your flu shot like we told you to?)

Obligations/Responsibilities

- Must try to get well.
  - Being sick isn't something you should "milk" for all it's worth. (Don't be a bum, or a "malingerer")
- Must seek competent medical treatment
  - Going to a doctor (according to Parsons, just a doctor)
- Must be compliant with that treatment
  - Take your pills, get your rest, don't make it worse and get pneumonia.

Problems with the Sick Role

- Does a good job explaining acute, short-term problems
  - But what about chronic problems or mental health problems?
- Some problems still are understood to have personal culpability
  - Substance abuse, obesity, even the flu (if you didn't get a shot)
- What happens when people have a problem, won't submit to medical authority, but are still "clearly sick?"

Office hours are online and by phone

I will be available online and by phone at the following times:

- Monday, July 5: 6-7:30 p.m.
- Wednesday, July 7: 9-10:30 a.m.
- Wednesday, July 7: 4-8 p.m.
  - (during the exam period)

You may contact me in the following ways:

- Through Oncourse Chat (visible to everyone)
- Through Oncourse Messages (private)
- At amccrani@indiana.edu
- Via phone 812-322-5475
  - If you get a voicemail, I may be on with another student. Send email.

Format of your exam

- Online at Oncourse under "Original Test and Survey"
- The exam will be available from 4 p.m. until 8 p.m on Wednesday, July 7. I will send out an email announcement when the exam goes up, but it is your responsibility to log-in and take it.
- Make-ups are all essay-based.
- DO NOT start multiple sessions or try to take longer than the allotted time. Points will be deducted, and I have a log file, so I can see what you have done and when you submitted it.
- If you have never tried this kind of test before, there will be a practice quiz on Oncourse for you to try out. Give it a shot.
- This is open-book, but your work should be your own. **Do not consult with others during or after your exam until the exam period is over.**

Format of your exam

Open Book, timed for 60 minutes

10-15:

- Multiple Choice
- Matching
- True/False
- Short Answer

3-5:

- Essay

You can and should refer to your themes sheet, your terms list, your three lecture guides, your notes from lecture, the quiz key, the class sides, and the readings for study review material. Don't forget those questions at the end of each chapter!

Policies for office hour questions

Acceptable Questions

I am having difficulty with the concept of validity. I believe it means ... Is that true?

I am confused by Kleinman's "category fallacy." I think it means the following... Can you tell me if I am right?

Where can I read more about the history of psychiatric epidemiology?

Unacceptable Questions

Tell me what validity and reliability mean.

Please explain category fallacy.

What is the difference between incidence and prevalence? What is lifetime prevalence?

Sun	Mon	Tues	Wed	Thur	Fri	Sat
June 20	1: Intro		2: Perspectives			
June 27	3: Social Epidemiology Paper assignments out		4: Medicalization Review for first exam			
July 4	CANCELED - IUB holiday		**ONLINE EXAM 1**			
July 11	5: Stigma		6: Social Roles			
July 18	7: Stress		8: Social Problems			
July 25	9: Treatment		10: Consumers/Users/ Survivors			
August 1	**11: PAPER DUE** OPEN TOPIC LECTURE		12: Family			
August 8	13: Recovery		**IN CLASS FINAL EXAM**			

For Wednesday

Mon, July 12: Stigma & Labeling

Before this class:

- The Role of the Mentally Ill and the Dynamics of Mental Disorder: A Research Framework, Scheff, pg 409
- Societal Reaction as an Explanation of Mental Illness: An Evaluation, Gove, pg 422
- A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment, Link et al., pg 433
- Americans' Views of Mental Illness and Health at Century's End: Continuity and Change, Pescosolido et al., pg 460