



PRESCRIPTIONS FOR HEALTH REFORM:

A PODCAST FROM THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

Transcript of podcast interview with Peter Conrad, author of *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* 10.2.09

Q. My guest for this podcast is Peter Conrad, the Harry Coplan Professor of Social Sciences at Brandeis University, where he has researched and taught medical sociology for 30 years. His latest book is *The Medicalization of Society*. I'd like to welcome you, Dr. Conrad, and start by asking for a very basic definition. What do you mean by "the medicalization of society"?

A. Well, by medicalization, I mean, it's a word much like any other kind of word that signifies a process, like urbanization or secularization. It's the impact of medical, particularly medical definitions, on life events, on human problems, and on various kinds of difficulties that people have. The word medicalization means literally "to make medical." But what it really means and the way I use it is to create certain kinds of diagnoses for particular kinds of human problems that weren't necessarily defined as medical prior to the medicalization. Taking formerly non-medical problems and making them medical, usually in terms of diagnoses, often sometimes called syndromes, sometimes diseases or illnesses.

Q. Can you give us an example?

A. Sure. Alcoholism used to be a sin and was a crime, now it's a disease. Obesity used to be seen as gluttony, now it's seen as an illness. There are literally dozens and dozens of examples of this. We can see the rise of many kinds of diagnoses—ADHD, anorexia, various kinds of addictions, all the way from addictions that we might all agree with, such as drug addictions, to things like Internet addiction, which is, you know, basically just vaguely medicalized. There are degrees of medicalization. We have some things that are fully medicalized and we have some things that are partly medicalized. So medicalization is a process. It's not just this is medicalized. This is not medicalized.

1

2

Q. How do you separate the progress of science and our ability to just treat a wider range of medical conditions from changes that simply place some of these vague conditions under a medical umbrella?

A. In a few cases, there may actually be scientific evidence that this is a new kind of problem that has many of the characteristics of what we would see as other diseases, what you might call more settled diseases, such as cancer or heart disease, or epilepsy, or diabetes, and so forth. But most of the time, there are at best ambiguous biological and scientific kinds of explanations for this.

Sometimes we have actually biological conditions that are normal conditions that we would all agree are normal conditions, that become medicalized. For example, menopause. Menopause is something that happens to all women, as long as they live old enough to reach a time when they cease having menses. However, in the past 30 years or so, increasingly menopause has been defined and treated as an illness, or certainly something that needs to be treated by medical interventions, when in fact, it's quite a normal condition. So that's an example of where there's probably some biological evidence that says the condition exists, but the notion isn't necessarily ipso facto an illness.

Q. You mentioned the change in the past 30 years that created this shift. What are some of the trends, whether social, or scientific, or political, that have driven this increase in medicalization, and has there been a particular rise in the past 30 or even 10 years?

A. There definitely has been a rise in the past 30 years. When I first started being interested in medicalization in the 1970s, it seemed to me that a lot of medicalization was driven by different parts of the medical profession attempting to expand the medical jurisdiction. It wasn't always this kind of professional expansion that drove medicalization, but it was certainly one of the major features of it. As we look at medicalization, coming into the 21st century, the medical profession is still somewhat involved, but much less so as this kind of expansionary professional organization. In the past 20 to 30 years, we see increasingly biotechnology, particularly the pharmaceutical industry, we see the increase in consumers and consumer demand, and the role of the insurance industry. All have been involved in developing and being what I call the engines behind medicalization.

Let me just give you one example of this in biotechnology, being the pharmaceutical industry. In the past 30, 20 years or so, we've seen the rise of SSRI's, major antidepressants, particularly Prozac, but all sorts of other drugs like Zoloft and

3

4

Effexor and other kinds of drugs. In the late 90s, a new drug came on board named Paxil. Paxil came into a very crowded SSRI market, so the manufacturers of Paxil decided they weren't necessarily just going to compete in the antidepressant market, but they were going to go for the anxiety market. Their first way of promoting Paxil was promoting it for what was then a relatively unknown disorder, which was in the DSM, the Diagnostic Statistical Manual, but was a very relatively rarely used diagnosis called Social Anxiety Disorder. The company promoted the drug, this new drug Paxil, for Social Anxiety disorder.

To do this, they had to first promote Social Anxiety Disorder. So what they did was they had an early campaign that said "Imagine being allergic to people," and then you may have Social Anxiety Disorder. And then after that, the second part of the campaign was: now we have a treatment for Social Anxiety Disorder, and then they advertised such things as "Do you feel like, do you have trouble public speaking?" "Do you get anxious meeting new people?" "Do you have trouble making small talk at cocktail parties? You may be suffering from Social Anxiety Disorder. Ask your doctor if Paxil is right for you." And so they created this whole new disorder, or at least brought it to light, this whole new disorder. Some people would call it social phobia or even just forms of shyness, and they medicalized this so that they could promote a treatment for it. So that's an example of how the drug companies, the biotechnology has become much more of a major driver in the medicalization of what might be a normal life temperament, shyness.

Q. Do you think that the pharmaceutical industry is more of a driver or has become more of a driver than, say, the insurance industry?

A. Oh yeah, I do. The insurance industry has a very complicated relationship to medicalization. In some places, they promote medicalization. In some places, they're resistant to it. I mean, medicalization costs the insurance companies money. But in some cases, the insurance companies have actually been also involved in medicalization. Let me give you two examples of that.

One is with obesity. I used to say, when I gave talks on this 10 years ago, 15 years ago, I said that one of the limits of obesity, the medicalization of obesity, is that whatever insurance company you want to talk about, won't pay for intestinal bypass operations. Well, they will now. Because obesity has in fact been increasingly medicalized and now under certain conditions, the insurance companies will in fact pay for intestinal bypass operations which of course is something that promotes the medicalization of obesity. So in one sense, that's how insurance companies have been involved.

5



Another way insurance companies have been involved—and here I would say with in general with psychiatric problems, mainly depression, but it would also be other psychiatric problems—25 years ago, when people had psychiatric problems, and they would go to a psychiatrist, it would often be the case, well, do we treat this person with psychotherapy or long-term psychotherapy, or do we treat them with psychoactive medications, or some combination of both? But there used to be a decision point there, a choice, the drugs being the more medicalized way of treating it and the psychotherapy being the more social-psychological way of treating it.

Now, if a person comes to a doctor or a psychiatrist with a mental health problem, the question isn't whether they get psychotherapy or whether they'll get drugs, it's just which drug they'll get, because insurance companies won't pay for psychotherapy anymore, at least not any length of time. Maybe short-term interventions, not any length of time. In both of those cases, I would argue that insurance companies have been involved in the increasing medicalization, in the one case, obesity, and in the other case, mental health problems.

There are other cases of course where the insurance companies won't pay, or don't cover it. Infertility is an example of that. Infertility used to be a problem where you'd go get—I'm talking here maybe hundreds of years ago—but you'd go to get some kind of votive object, some kind of fertility object, and maybe pray to it and hope that one would become fertile. Now it's increasingly medicalized, with IVF and all sorts of other kinds of interventions. But infertility in general—I don't think it's 100 percent, but in general—is not covered by health insurance. So therefore the insurance companies have been at least somewhat of a limit on how much involuntary childlessness might become medicalized as infertility problems, because people have to pay out of their own pocket.

Q. Let me ask one more question about the causes of medicalization, and that is what do you think the role of the media has been?

A. Well, it depends what you mean [by] the media. If you mean the public media like newspapers, television, and those kinds of media, I would say that they've certainly been involved in spreading the word about medicalized solutions to problems, again, be they things like depression or ADHD—and here I mean minor depression. Major depression has been medicalized for a long time. Here I'm talking about minor kinds of depression, or ADHD or obesity or anorexia.

6

I think the media's been important in disseminating information and understandings about medicalized solutions to problems. I don't think the media's been a major factor in being an engine behind medicalization, but they certainly are a secondary force. You can see many examples of medicalized solutions to problems in everyday TV shows, I'm sure, although I must confess to you I don't watch them very much.

Q. Let me ask then about some of the consequences of medicalization, and particularly some of the economic consequences, as we stand here with the current federal administration looking at major healthcare reform.

A. Well, let me tell you what I think, before I get into the healthcare reform, and economic consequences, I think one of the major consequences, and one of my major concerns about medicalization is the pathologization of everything. And that's turning all human differences into medical problems. I think that's a very serious issue.

A second serious issue related to that is the individualization of these problems, turning the focus of the problems onto the individual with clinical individual solutions instead of social solutions. I mean, obesity is a good example of that. We all know that the rise of obesity in the past 35 years in the United States has been absolutely enormous, and there's not a medical cause for that. The cause is completely social, in terms of the food available, in terms of dietary and cultural kinds of things that we've changed, in terms of promotion of the kinds of foods that we eat, in terms of fats, all those, portion size, and yet we look on the individual as ways of dealing with so-called obesity epidemic by intervening on an individual medical level, rather than on a societal level. Sure, we've done some on a societal level, by at least making the amount of fat, for instance, available on labels on food and so forth, and reducing the amount in some cases [of] the kinds of foods we offer to kids in school, although that's been very limited in its application. I think those are certainly two major issues, the individualization of problems and the pathologization of everything.

Thirdly, I think there's a question of, and this is a question, of how much we're spending on these kind of, what I would say, minor problems, as opposed to major problems as part of our healthcare costs. We have the highest healthcare costs in the world, 16 percent of our GNP. How much of that goes to medicalized problems that might be able to be dealt with other ways is certainly an empirical question. It's probably not overwhelming, but at the same time, it's probably, when you're talking about healthcare, it's probably significant how much of this is paid.

7

And partly, that goes to the kind of social system we have. The only way to get human problems, the care for human problems, reimbursed, is to medicalize it. For example, if a couple is having a difficult time and needs couples' therapy, let's say, to try to get through a rough patch in their relationship, and they wanted some kind of reimbursement for their psychiatric or psychosocial intervention, one of the people in that couple would have to get a diagnosis, even if it was something as vague as "social adjustment disorder of adulthood" for insurance companies to pay for it. And so the way we pay for our social services in some way, particularly our individual social services is another thing that promotes medicalization.

As we stand on the brink, hopefully, of some kind of health reform, it's an interesting question. I think medicalization will be in some ways increased by the development of large-scale universal health insurance, but it may also be limited in certain ways because it would be limited that certain kinds of problems would be excluded from healthcare. I hope it's not serious mental health problems, because they need to be covered, but a lot of the kind of minor things that people often get medicalized might in fact be not included in a basic plan. I don't know the answer to that, but it's certainly possible that the development of universal health insurance could increase medicalization. But as with the insurance companies, it could also act as a constraint.

Q. Do you see any differences in the impact on medicalization of the two polar ideas in healthcare reform, one being a single-payer system, which could include the government paying for healthcare costs, versus a consumer-driven healthcare system where everyone has high-deductible insurance and a health savings account. Do you think either of those solutions would affect medicalization differently?

A. That's a good question, and I'm not sure I know the answer to that. I will say that I'm a supporter of a single-payer system, although it doesn't have to be a government single-payer system. I think there's a possibility to create a single-payer system that would in fact include and subsume our existing private healthcare insurance system, but it would still be a single-payer system. I'm not a big one on the more extreme private approaches like health savings accounts and things like that. I actually don't know, I've never looked at whether either one of those would be more likely to promote medicalization or not. It would depend how they were organized.

8



Q. Let me ask a similar question then. Do you think the recent healthcare reforms in Massachusetts—mainly the mandate that everyone have insurance—has that had an impact on medicalization with everyone having to be part of the system?

A. That's a good question also, and again, an empirical question. I don't know the answer to that. I think that it clearly makes medical care more available to people—I think it's now 94 percent of people in Massachusetts have some kind of health insurance—but how much this deals with the kind of medicalized problems that we're talking about, things like ADHD, anorexia, minor depression, and obesity, menopause, or things that we haven't even mentioned, like PTSD, or so forth, I don't know the answer to that. And substance abuse of various kinds, all of these are medicalized problems. I don't know how many of them are dealt with in greater numbers under the Massachusetts system now than would have been 10 years ago, before we had this. I just don't have the data for you.

Q. Now you've mentioned some of the problems generated by medicalization. Do you see medicalization continuing to increase?

A. Let me say one thing that I didn't say before that I should say at least clearly, that medicalization is not just the drug companies or the medical profession doing it to us. It's consumers as well, consumers want many of their problems to be increasingly medicalized. One thing we didn't talk about for instance, is the medicalization of bodies that the whole cosmetic surgery industry has been into. And that is hugely consumer driven, whether it be liposuction or breast implants or eyelid surgery, that's a kind of medicalization that's almost totally, not 100 percent, but almost totally consumer driven. That's a good example for us to see how consumers are involved in this.

One of the interesting examples that I've actually written about is adult ADHD. ADHD in children's been around since the 70s. It had different names, but it's been around, at least as a viable diagnosis, since the 70s. I argue it's a classic example of medicalization. But in the 1990s, we began to see something called adult ADHD. But adult ADHD was not promoted by the drug industry, nor really by the medical profession, with a few exceptions, but was something that consumers, people on their own would go to physicians and say, well, I can't keep my desk clean, I can't keep a job, I'm having difficulty focusing or concentrating. I think I have ADHD. These are people who had never defined before, went to their physicians and the physicians would ask, "Well, how do you know that you have ADHD?" and they would say something like, "Oh, I read it in a book," or "My kid was diagnosed, and I was just like him."

This was, and I give this one example, almost a consumer-driven diagnosis in the beginning, with some physicians suggesting it also. I don't want to suggest that it was just made up out of thin air. But we have demand from consumers for treatments for various problems, like not being able to have the success you want in life in your job. I actually called it, the adult ADHD, the medicalization of underperformance. I think we have consumer-driven parts also.

You asked me what I thought the future was. I think, as best I can see, the role of consumers, the drug companies, and the insurance companies is not going to change very much in the next few decades, unless there are major changes, not just in the way we reimburse healthcare, but in what the limits are on what we reimburse for healthcare. And if there are such changes, then we may see changes in medicalization. Otherwise, I would suggest that there is a great deal more pushing in this kind of river of medicalization than there are dams set up to slow it down.

Q. So is medicalization something that we should be trying to slow down?

A. Oh, I think it is. I think it is. We just touched on a few of the examples of medicalization that we've seen in the past 30 years, but if we want to think about what the other examples of medicalization are and the ones in the future, we can have much larger accounts of medicalization. And again, we have problems that are completely medicalized like childbirth or that are largely medicalized, like menopause, to ones that are just barely medicalized, like sexual addiction, or those kinds of very marginal problems. So when we talk about medicalization, we talk about a wide range of things.

I had a list here, which was in my book in the beginning, just examples of things that have been medicalized in the last 30 years or so, from ADHD to anorexia to chronic fatigue syndrome to post-traumatic stress disorder, panic disorder, fetal alcohol syndrome, pre-menstrual syndrome, and then of course there's such things that have been around for a while, like alcoholism and menopause and childbirth and obesity and increasingly other things like contraception and so forth have all become medical problems, many of which were not, certainly 50 years ago.

You have to look at it and see, has society benefitted from this, and I would say in individual cases, there's no question the answer is yes, but in some cases the whole trend of medicalization raises the notion much more broadly, is the general notion of medicalization a good thing. I would say it's at least equivocal at best, if not problematic.



Q. Would you say that the main problem from a socioeconomic perspective, is it that it's costing us money, draining the healthcare system or is it that it's focusing on these individual solutions rather than global ones?

A. I think it's several things. Sure, it's costing us money, but I don't know—you know, some of these problems may cost us money in this society in a different way if we dealt with them in a different way, I mean, if we dealt with obesity differently than focusing on bypass operations, for example. We would be still be spending money. So it's not just spending money, it's the way in which we focus on the individual solutions, the way in which we increasingly make normal life events into pathologies, normal life stress into something we need Prozac for, normal shortness [into] something we need and people use human growth hormone for, normal shyness into Social Anxiety Disorder, and so forth. The moving of the thresholds of normal to pathological through medicalization, I think is one of the things that concerns me the most.

And then of course, it makes a much larger pool of people that get caught up in this medicalization net. And again, I don't mean it to mean just that the physicians are doing this by any means. Consumers are often also asking for it as well.

12

