

**SOC 3290 Deviance**  
**Lecture 7: The Pathological Perspective 2:**

Today we will begin to discuss the various social control policies that have historically - and today - characterized the pathological perspective. Essentially, the pathological perspective is associated with the medical model of social control. Since the late 19<sup>th</sup> century, whether administered by doctors or other “helping professionals” such as psychologists, nurses, or social workers, “treatment” is prescribed as the cure for virtually all types of nonconformity (e.g. alcoholism, homosexuality). This proliferation of control in the name of treatment is described by Kittrie as the rise of the “therapeutic state,” where medical solutions are mandated for all human problems, while the state is under a duty to “help those who can’t help themselves” by encouraging, even forcing treatment on nonconformists.

While many people view this as a progressive development relative to what went before, there are several anti-humanitarian features. One is the unwarranted assumption that deviants have no real choice, no real agency in behaving the way they do. Similarly, there is a problem in the neat way therapeutic control agents pretend to separate moral judgements from scientifically informed treatment (e.g. drapetomania; Victorian medical interventions to “cure” masturbation; Soviet diagnosis of dissidents as mentally ill). Medical designations of deviance are significantly influenced by the moral order of society and can’t be neutral.

Yet, pathological theorists have rarely heeded such criticism - and many have lived to see their ideas for creating a “healthy” society” translated into policy. For example, Lombroso’s ideas about atavism (and phrenology, which was associated with it) were well received by an eager public, counseling and advising on public and private concerns. Moreover, phrenology was also used as a control mechanism in public institutions (e.g. between 1831-1904 all inmates in a Philadelphia prison were classified according to bumps on their heads; delinquents in a New York reformatory were classified according to atavistic anomalies).

**Eugenics:**

But there were also more drastic social control practices derived from early theories of heredity and feeble-mindedness: the eugenics movement. This was based on the very popular idea that if you remove deviants from the gene pool, they wouldn’t reproduce and perpetuate themselves. In the long run, there would be fewer deviants and society would be better off. While the Nazi’s took such ideas to their farthest extreme (by actually killing people considered “defective”), in most areas such ideas were manifested in involuntary sterilization laws (permitting the involuntary sterilization or castration of deviants such as the mentally ill, mentally retarded, epileptics, hereditary criminals, sex offenders, degenerates, etc.). Between 1907-37 thirty one American states passed such laws, and as late as 1976 26 states still allowed this for the mentally ill. Canada had many such laws as well.

All such laws were based on the unproven assumptions of pathological theorizing. They

have sanctioned over 70,000 involuntary sterilizations in the U.S. alone. Over time, these laws have been challenged, and may likely be unconstitutional. Yet they also may be creeping into new areas (e.g. welfare mothers).

### **The Mental Hospital:**

An alternative control strategy involves attempts to rehabilitate or change the behaviors of existing deviants. Perhaps the most important of these has been the use of hospitalization as a mode of curative control for those suffering from a mental disorder. Starting with the “great confinement” of the 17th-18th centuries, large numbers of psychologically disturbed people have been treated behind the locked doors of the mental hospital/asylum. For many years, supposed hopeful treatments were alternatively proposed, applied and discredited (e.g. bloodletting, enforced orderliness, always enforced restraint). Progressive reformers balked at the harsh custodial control, but little had changed by the mid twentieth century. Mental hospitals were then essentially warehouses for the mentally disordered. Physical terror at the hands of an overworked, undertrained and poorly paid staff was common. Some new technologies, such as electroshock therapy and psychosurgery emerged, but talk therapy was seldom used (this was for rich neurotics in private, outpatient care). Basically, “treatment” was not successful, but the public wanted to believe that it was.

Then, in 1952, the mental hospital entered a new phase of optimism when French researchers synthesized Thorazine- the first of the so-called antipsychotic drugs. This was heavily marketed shortly thereafter to doctors and others - revolutionizing the treatment of mental illness. It could be used to reduce severe symptoms, restore order to unruly hospital wards, and enable medical personnel to get on with the business of serious psychotherapy. Doctors and the pharmaceutical industry couldn't speak highly enough of the benefits of this, and many other new medications. Many pointed to the day when chemotherapy would permit outpatient care for severely disturbed patients. Critics pointed out that these drugs were used more to control patients than to cure or otherwise deal with the causes of their problems. Not only that, heavy use of such drugs caused *tarditive dyskenesia*, a disfiguring and disabling condition of the central nervous system. This was - and still is - a big price to pay, and the optimism surrounding the pharmaceutical revolution was short lived. Rather than preparing patients for treatment, the widespread use of psychotropic drugs soon became a form of treatment: chemotherapy became a substitute for psychotherapy. Within a decade medication was the only demonstrable treatment offered to the vast majority of institutionalized mental patients.

### **Depopulating Mental Hospitals:**

Peaking in 1955, the number of people institutionalized in mental hospitals steadily declined thereafter. There were several reasons for this. One is the widespread use of psychotropic drugs enabling mentally disturbed individuals to function in a more “controlled” fashion in society. Yet, two other factors were probably more important. One involves legal rulings that involuntarily confined mental patients have a right to be adequately treated in the least restrictive environment or be released. These were buttressed by similar rulings tightening up the conditions under which a person could be put away in the first place. All such rulings were

the result of years of hard-fought legal battles by those confined against their will, buttressed by journalistic exposes, critical sociological research, and the right to treatment movement. The other factor involves the incredible cost involved in maintaining large, publicly funded mental institutions. Indeed, some provide evidence that the timing of depopulation coincides with government fiscal crises, and maintaining/upgrading these old buildings, with union staff and inflationary pressures. Essentially, then, what we see is a coincidence of interests between the pharmaceutical industry, liberal humanitarian reformers and fiscal conservatives in a particular historical context driving the deinstitutionalization of mental patients.

### **Mental Hospitals Today: An Uncertain Future:**

Such changes present uncertainties for the continued reliance on mental institutions for control and treatment. Some jurisdictions are seriously considering getting out of the mental hospital business altogether (e.g. the "N.S."). Proposals exist to contract for beds in private hospitals for the most seriously disturbed, while others would have to seek outpatient assistance through community mental health centres. This, in effect, involves "dumping" deinstitutionalized patients into communities ill prepared to receive them.

Where do such patients go? They generally don't access the community health facilities opened since the 1960's for this purpose - others do (e.g. seeking help for family problems). Such centres greatly expanded the reach of medical control over others without significantly affecting the care of patients who had already been institutionalized.

So where do they go? Generally nowhere. Many are unable to care for themselves - whether due to their condition or their many years of being taken care of by others. Unless they are among the lucky few who have family willing to care for them and put up with their behavior, or are able to get into a well-managed group home, they often end up either on the street, or as welfare tenants in seedy, run down rooming houses. Many are on medication, but often stop taking it. Considering this situation, some advocates have suggested that there should be a right to proper post-hospital care for mentally disturbed ex-patients.

### **The Pathological Perspective Today:**

Despite its long history of failure, the pathological perspective is still alive and kicking today. Indeed, born-again pathological theorizing often commands the favor of governmental agencies committed to fighting crime and nonconformity - particularly since the late 1970's. This has been fueled by economic turmoil, international instability, neo-conservatism, the failure of earlier, poorly administered social reforms, and new interest in - and funding for - sociobiological research on "the black box" of deviance. Some previously sociological researchers have turned away from environmental factors to consider the "hard science" view that deviance somehow "lies within" individual deviants (e.g. Jeffery: protein deficiencies and low intelligence; Cressey: chemical imbalances in maternal blood during pregnancy). Others advocate a synthesis of pathological and social factors (e.g. Mednick and Christiansen: lower class crime largely

economically driven; middle-class genetic; Kelly: hypoglycemia and cerebral allergies may aggravate and perpetuate deviance/perceptual distortions).

Significantly, despite methodological flaws, such ideas are already being put into practice. Some probation departments screen clients for hypoglycemia, and drugs are commonly used in prisons to control (and research) difficult inmates.

Given this quick implementation, it's important to recognize the relatively uncritical quality of the most recent celebrations of this perspective. None have received more attention than James Q. Wilson and Richard J. Herrnstein's book Crime and Human Nature. Uncritically reviewing many of the studies we have discussed in this vein, and avoiding any direct engagement with their critics, they merely assert that "many criminologists, most often trained as sociologists, are simply uneasy with biological and psychological explanations" (they are not). They then assert that "the average offender tends to be constitutionally distinctive though not extremely or abnormally so." Without denying environmental influences outright, the authors skillfully underscore the roles of "constitutional dispositions," "biological factors," and "psychopathologies of various sorts," contending that "it is the clear consensus of those most intimately acquainted with the data that crime and delinquency are, in large measure, shaped by inherited pathologies."

More problematic still are "gene based evolutionary theories." Lee Ellis, for example, evokes the principle of natural selection to explain deviant acts ranging from rape to child abuse. Arguing that females tend to discriminate against mating with males who are "only minimally capable of resource procurement," Ellis argues that "there is considerable evidence that forcible copulatory tactics could have evolved as part of male efforts to mate with large numbers of females, and female tendencies to resist any encounters that effectively usurp control over their choice of genetically resourceful sex partners." Obviously, this biological explanation of rape completely discounts the explanation that, in a patriarchal culture, some men attempt to assert power over women by violence. This ignores cross cultural research that shows sexual violence has much more to do with culturally specific gender roles than with alleged human instincts for human mating. Ellis' work is hardly different than the speculations of early pathologists, reminding us again that the "cyclical optimism" of pathological thinking continues to this day.

Let's now consider two of pathological thought's more prominent contemporary applications: (1) hyperkinesis (a.k.a. hyperactivity or ADHD); and (2) the use of psychosurgery.

### **Hyperkinesis:**

Hyperkinesis is today considered perhaps the number one childhood problem. There are many well-funded institutes, clinics, and school programs. Once a child is diagnosed, the treatment of choice is pharmaceutical intervention (Ritalin). Yet, though classed as a disease, hyperactivity is primarily a form of social deviance - and one recognized by the unruly behavior of children (e.g. restlessness, short attention span, fidgeting, impulsive or aggressive behavior,

etc.). Such behaviors present control problems for teachers and parents, but were once considered merely evidence of a bad child. Why now are they seen as a disease and treated with drugs?

Peter Conrad looked into this and discovered that medical researchers never did discover an organic defect that causes hyperactive behavior. What was discovered was that certain drugs could change or reduce unruly behavior. Inferences regarding organic deficiency as the cause of unruliness were arrived at retrospectively (i.e. since chemicals could change unruly behavior, chemical deficiencies must have caused the behavior in the first place). This was illogical (e.g. cocaine may enhance exhilarated action, but few would argue that the lack of exhilaration is the result of a pathological deficiency of the chemicals in cocaine), but, as it was accepted as an explanation by many, successfully converted what otherwise be a social problem into a problem for medical control.

But what of the context that produced this view (in the 1950's, such a diagnosis was unknown). Between the mid-1950's to the early 1970's there emerged in medicine an interest in child mental health, and the pediatric specialties were looking for new childhood diseases to combat (now that old ones like smallpox, polio and diphtheria had been successfully been brought under medical control). While they had been successful in the past, pediatric specialists were aware that prestige in the medical profession was awarded based on the dangerousness of the diseases being fought. Thus, they were now on the lookout for new dangerous diseases.

Then, related to an earlier discovery by Bradley that amphetamines improved the behavior of some children with behavior or learning problems, ritalen was synthesized in the late 1950's - having the same effect with fewer side effects. It was approved by the FDA in 1961, and its use largely legitimized by the pharmaceutical revolution then going on in the mental health field generally (e.g. many seriously disturbed patients' behaviors and symptoms were being altered, bringing them under more control - cited as evidence by many that mental disorders may be physiological in origin). Since pediatric specialists were looking at the psychiatric problems of children for new diseases to combat, the fact that drugs had become available which controlled unruly behavior reinforced the shaky logic seeing non-acute childhood behavior problems as a disease. This quickly lead to them labeling such problems hyperkinesis.

But there were political factors involved as well. There was lobbying by influential groups such as the Association for Children with Learning Disabilities, the dominance of medical interests on the government investigating committee, and, most importantly, the massive advertising campaigns by drug companies aimed at convincing doctors that hyperkinesis was a real disease treatable by drugs. Hey were well-rewarded for their efforts: one company alone reported \$13 million in profits for the year 1971 alone - and that's just 1 company 31 years ago. While drug companies lined their pockets, medical professionals expanded their interests in the domain of social controls. Hyperkinesis emerged as yet another speculative category of pathological deviance.

### **The Surgical Control of Human Behavior:**

Psychosurgery is brain surgery aimed at changing human behavior. This began in 1890 with the work of Buckhardt, who removed small parts of the brains of 6 “dangerous and psychotic” individuals, rendering them “harmless.” While soon stopped by the ethical objections of others, psychosurgery was reborn in 1935 when Moniz performed the first prefrontal lobotomy (and was later awarded the Nobel Prize). His procedure was later carried to America, and by the early 1950's 50,000 lobotomies had been performed in the U.S. alone.

Advocates of psychosurgery made strong claims about the desirability of the operation for patients and society, downplaying negative outcomes as the exception. But many lobotomized individuals became vegetable-like, and other patients were characterized by a dramatic reduction in their ability to fantasize, abstract or think creatively - losing some of the more distinctive features of human cognition.

During the 1950's a number of journalistic expose's revealed something of this darker side of psychosurgery, and questions were raised about the kinds of people selected for the operation. The official line became that it was reserved for the most serious cases only, and the use of lobotomies dropped drastically. Some say this was because the newer psychotropic drugs made them less necessary. Other suggest that this may have more to do with newer psychosurgical techniques introduced in the 1960's and '70's (i.e. using “safer,” “more effective” and “more precise” ultrasonic beams and electrodes).

These newer psychosurgical techniques tend to be directed at several subcortical structures of the “old” paleomammalian brain or the limbic system. Particular focus has been placed on the hypothalamus, the amygdala, and the thalamus. Based on experiments with animals, abnormal functioning in these structures is believed to have a role in poor emotional regulation, aggression and sexual behavior). Thus, things are done like drilling holes in both sides of people's heads and burning away about a forefinger of tissue on either side of these structures (a “cingulotomy”). Advocates of such procedures suggest that they are relatively safe and sure ways of normalizing some of society's most difficult deviants. Critics, including some prominent physicians, have strong reservations - suggesting that this is nothing short of conducting experiments on human beings. They question whether the behavior problems originate in these areas, as well as whether the procedure is dangerous or mutilative of the individual.

Many proponents of psychosurgery point to animal research as backing up their claims (e.g. Delgado's “remote control” studies where implanted radio receivers caused variations on aggressive behaviors - but not always, as rhesus monkeys wouldn't always perform as suggested and attack across social hierarchies of deference). What can one reasonably conclude about human behavior from such animal studies? There is no doubt that altering the electrical chemistry of the nonhuman brain is associated with changes in aggressive behavior. Yet, this does not *necessarily* mean that aggressive behavior is *always* caused by electrical or chemical changes per se. Even if aggression is caused by physiological change, what causes the physiological change itself? It is reasonable to conclude that environmental cues usually trigger these. Yet, even though the animals in these experiments were essentially normal before

undergoing the experiment, pathological researchers made reference to such things as “yet undetected lesions” or “present, but not yet observed pathologies.” This is strange, speculative language for supposedly hard-nosed scientists. It seems as though researchers are convinced that pathology must be present if aggression is observed. Using similar logic, psychosurgeons make giant leaps from data derived in animal studies to arguments about the physiological basis of human violence, or exaggerate rare human examples where lesions have been shown to be tied to aggressive behavior (popular mythology aside, there’s no evidence that epileptics are more violence prone than others). Some such writers go so far as to develop a “profile of potentially violent people,” characterized by a “damaged limbic system” and representing excellent candidates for neurological social control (e.g. people with a history of physical assaults, intoxication, impulsive sexual behavior, and/or a history of accidents).

A further problem with such reasoning (and the associated “profile”) is that the pathological image it evokes also brings to mind an image of an angry, frustrated, lower class male. Studies show that such individuals are bombarded with the goal of success and power but constantly denied it. They frequently divert this goal to the private spheres of their lives, acting out their own “power game” in physical aggressiveness, drinking, and sexual aggression. Others with more social power may play their game in a more subtle fashion at the office or other social circles, and not fall prey to the same types of “illegitimate aggression” seen above. This, then, suggests a link between violence and social power - which may be a reasonable non-pathological explanation of the behaviors noted in this profile. Why leap to ambiguous inferences of brain pathology based upon “as yet unobserved” abnormalities?

Of course, pathological theorists have a retort for such objections, translating the critiques into “hypotheses for neurological investigation.” Noting, for example, that most slum dwellers don’t riot or engage in violent behavior, Mark and Ervin ask what is different about the brains of those that do. They view violence as essentially a public health problem, proposing “early warning tests” to detect people with low thresholds for impulsive violence.

But regardless of the scary implications of such a proposal, how effective is their program of surgical control? While pointing to a number of “successful cases,” sometimes in the long run things go awry (e.g. one man became more and more violent, vegetable-like, lost his memory, and suffered repeated hospitalizations and delusions, and was sued - unsuccessfully - because the patient had given prior consent). Yet, not all psychosurgery cases end badly. One study reports that many do not suffer such a record of long-term impairment, and that their mental abilities eventually recover. Yet, when patients with physical problems vs. behavioral problems are removed from the study, surgical patients show no more improvement than controls. This is not convincing enough evidence to suggest that surgery is an effective therapeutic tool.

In the long run, the future of psychosurgery is uncertain. Its controversial and often dangerous record has created a climate of relative caution among government officials charged with its regulation. Indeed, national research ethics commissions have proposed standards

permitting such procedures only: (1) when effective; (2) serving the advancement of science; (3) if chosen by the patient for his/her own good; and (4) if there is informed consent. Needless to say, several of these criteria are themselves quite controversial (e.g. how to determine effectiveness? Informed consent?)

But while such legal restrictions have limited the spread of psychosurgery, they haven't limited the fertile imaginations of pathological theorists - some of whom propose bold new biotechnical controls going far beyond the frontiers of current surgical practice (e.g. Jose Delgado suggests implanting two-way radio transmitters into the brains of deviants to monitor and control their neurological activity. "Neuronal activity related to behavioral disturbances ...could be recognized in order to trigger stimulation of specific inhibitory structures." The possibilities here are both limitless and horrifying - and who makes these decisions? At such far extremes of the pathological perspective we are confronted with the total control potential of positivist science - something that is not far from being recognized.

### **Assessment of the Pathological Perspective:**

Pfohl begins by noting that much of what he's said thus far about the pathological perspective hasn't been positive. It promises much but delivers little; claims to be rigorously scientific but has been plagued by methodological problems; hails humanitarian, curative treatment but practices the politics of repressive intervention. That isn't to say that there aren't some advantages to this perspective. In what follows, we will review the advantages and disadvantages of this viewpoint on deviance and social control from Pfohl's perspective, largely based on the work of Peter Conrad and Joseph Schneider.

Starting with advantages, Pfohl notes that perhaps the strongest feature of the pathological perspective is its emphasis on naturalistic causation. By locating deviance in the body and mind, it introduces complexities ignored by the earlier viewpoints. Other positive aspects include its humanitarian intent, its seemingly eternal optimism, and its flexibility. Also important are the benefit of the sick role for deviants who comply with treatment - being able to avoid blame and shun responsibility so long as they behave like good patients, desirous of being "cured."

Turning to the disadvantages, however, it is clear that these aspects of the pathological perspective are more numerous. Of particular concern is the way in which this perspective's highly individualistic and overly deterministic medical imagery denigrate both human choice and its sociohistorical context. Life is rarely a matter of free choice but neither is it usually totally determined. Somewhere in between we find ourselves struggling with history, and pathological theorizing misses this point. It also gives the false impression that the lives of "deviants" are somehow more determined than those of "normal" people. *These labels implicitly remove responsibility for behavior from individuals in favour of their "disorder,"* creating a "dual-class citizenship" where "the not completely responsible sick are placed in a position of dependence on the fully responsible nonsick" (Conrad and Schneider, 1980:249). Thus, others are given official



permission to patronize “deviants,” who are labelled "not responsible for their actions" due to a "mental disorder." Their interactional effectiveness is thereby diminished.

Then there is the problem of false neutrality. There is nothing neutral about viewing deviants as sick. Prior to studying the individual, pathological researchers have made a moral judgement that the deviant subject acted wrongly. While dressing these up with neutral sounding terms like “syndromes” or “disease types,” in practice these are little more than code words for moral judgements about the undesirability of certain forms of behavior. Since our society assumes the moral neutrality of medicine, then "*defining deviance as disease allows behavior to keep its negative judgement, but medical language veils the political and moral nature of this decision in the guise of scientific fact*" (1980:249). Such a characterization gives others further permission to hide their negative feelings, and even to rationalize avoidance or dismissal of “deviants.”

Next, there is the problem of *expert control*. As Conrad and Schneider write: When a problem is defined as medical, it is removed from the public realm, where there can be discussion by ordinary people, and put on a plane where only medical people can discuss it. The language of medical experts increases mystification and decreases the accessibility of public debate (1980:249). Of course, these people’s careers are staked on the premise that deviance is a problem of abnormal individuals. No wonder the game of pursuing pathological traces is played from one losing season to another. The expert control of deviance is a multi-billion dollar business. The experts who have cornered the medical control market have little interest in demysticising this game.

This isn’t to suggest that those who profit thereby always do so in ways that are intentionally self-serving. It is more likely that they are caught up in institutionally supported ways of thinking and thus become blinded to the insights of other perspectives. In many cases they reduce the complexities and contradictions in their patients’ lives to nothing but the narrowest categories of individualized pathology (e.g. when questioned about what he would do if called an obscene name, and a patient replied it would depend whether it was a man or a woman, the doctor characterized this as an “ambivalence towards women.” It’s more complicated than that - it could be a class-based mode of thinking). Mention Rosenhan study? All of this becomes even more complicated when medical experts are bombarded by advertizing campaigns, such as those conducted by the big drug companies, attempting to persuade them that personal problems are truly biochemical problems and that drug therapy is the only reliable way to control deviance. These further add to the institutional and perspectival “tunnel vision” of experts - not experienced by others (e.g. college students).

Fourth, there is the problem that the pathological perspective individualizes social problems. By medicalizing the behaviour of deviants, we buy into this dominant societal ethic, and tend to search for causes and solutions to complex social problems within the *individual* instead of the social system. By seeing the causes of the problem in the individual instead of society, we "blame the victim" when we try to change him/her instead of society. We also, in

providing treatments, tacitly support existing social and political arrangements. Individual behavior becomes a "symptom" of an individual disease instead of a possible statement on the nature of the current social and legal situation. Indeed, this is making such *unwarranted attributions* regarding the *locus* of the person's problems (Batson et. Al, 1982; Pelton, 1982), often inferring that the problem lies with the client when it may actually be due to some aspect of the client's social situation

The fact is, nothing would be deviant if nobody was bothered by certain types of nonconformity. This obvious fact is usually ignored by the pathological perspective. It sidesteps the complex network of social forces, the rich and troubling complexity of life to biochemical or psychological formulations. While we may certainly be biochemical and psychological beings, we are never just that. We are also always in interaction with each other. By reducing theoretical explanations to these levels alone, the pathological perspective is untrue to the complexities of human life itself (e.g. homelessness being seen as the result of mental illness, as opposed to unequal access to the distribution of wealth. Snow finding the incidence of mental illness at 15% among the homeless, and much of that may be due to the stress of the "insane contexts" in which such people live).

Fifth, and relatedly, pathological theorizing ignores the politics of deviance. Questions of deviance and social control are generally political - involving matters of power and its exercise. But, blinded by its commitment to positivist rationality, pathological thinking depoliticizes deviance. Dissidents are chemically controlled, not because they are politically troublesome, but because they are "believed" to be "mentally disturbed." Drug users are forced into treatment not because their escapism threatens the values of an instrumental, achievement oriented society, but because they are thought of as "sick." And so on. This isn't to romanticize *all* deviants as self-conscious rebels. Still, the story of deviance is always a story of resistance to power, regardless of whether it is an alcoholic struggling with failure, an angry teenager in a gang, or a terrorist trying to change the world. To effectively address deviance, we have to pay attention to its political dimensions. The pathological perspective fails miserably in this regard, denying that deviance is shaped by anything but an abnormal body or mind.

Going hand in hand with depoliticization, there is *the possibility of medical social control* of "victims" of crime. As Conrad and Schneider state: "Defining deviant behaviour as a medical problem allows certain things to be done that could not otherwise be considered; for example, the body may be cut open or psychoactive medications given...This treatment can be a form of social control" (1980:249-50). Notably, such potential in the medical label may lead to victimization of deviants" by mental health officials who are supposed to help them, and this may be rationalized as being "for their own good." For example, it has already been noted by several authors that the practice of prescribing tranquilizers, sometimes for extended periods, may ultimately delay individuals coming to terms with traumatic experiences (Knapp 1986:137; Rando 1986:363; Wolfelt 1987).

Other examples include the medicalized "treatment" of various so-called "female

maladies” such as hysteria, panic or anxiety disorders, and eating disorders. Why are these behaviors viewed as diseases rather than symptomatic of the patriarchal violence surrounding women? Charcot’s work on hysteria, for example, was formulated in a patriarchal culture that pathologized the behavior of women (that, in earlier, pagan cultures, may have been revered). It suggested that hysteria was hereditary and concentrated in sexual zones of the female body. Freud was so impressed he went even further, calling the extemporaneous verbalizations of intelligent, bored Victorian women, who were highly restricted in their roles, a disease (but couldn’t it be a political protest?). This was even more problematic when he blamed some women’s hysteria on repressed childhood memories, masturbatory fantasies, incestuous desires, and lesbian or bisexual longings (when, in fact, there was sexual impropriety going on with the father/father’s friend).

Relatedly, Jackie Orr focuses on the psychiatric control of panic or anxiety disorders in the 1980’s-1990’s. First named in the 1980 version of the DSM, this “disorder” resembles hysteria. Pharmaceutical companies were heavily involved in the research on panic, and sometimes this involved selling the pathological perspective itself. Upjohn produces and promotes the drug xanax, an effective but highly addictive product. As a means of marketing both panic disorder and its drugs, in the early 1990’s Upjohn began sending free video news releases to local TV stations. While resembling documentaries, these were really carefully packaged corporate promotions. TV stations were encouraged to broadcast clips on their news. When watching these remixed clips, viewers may have thought they were seeing reports on the latest mental health research rather than promotional material for pharmaceutical solutions to panicky social and political problems.

Current estimates of “panic disorder” suggest that about 80% of sufferers are women. Why? If you move beyond the depoliticized medical imagery and look at the social and gender dynamics characterizing women’s lives in a high-tech society ruled by male-centered values, patriarchal economic processes and the frequent depiction of women’s bodies as commodities, then “panic disorder” may be less a symptom of individual illness than a social sickness engendered by heterosexist power structures. Pathological interpretations of eating disorders are similar. Maybe, just maybe, they are sicknesses caused by a society that literally feeds off women’s bodies, just as it feeds us all with images of unrealistically thin and picture perfect female models. Anorexia and bulimia are not simple pathologies of the diseased individual, but more likely symptomatic of the socio-political structures faced by women in today’s patriarchal society.

Finally, the pathological perspective is problematic in that it tends to divert questions about good and evil. Issues of accountability are blurred within a technocratic framework devoid of any reference to right or wrong. This only hinders us from comprehending the human element in the decisions we make, the social structures we create, and the actions we take (e.g. was Hitler psychologically disturbed or evil? What about Paul Bernardo?) Clearly medicalization is not the sole cause of the exclusion of evil, but it shrouds conditions, events, and people and prevents them being confronted as evil... “Sickness gives us a vocabulary of motive that obliterates evil

intent. And although it does not automatically render evil consequences good, the allegation that they were products of a 'sick' mind or body relegates them to a status similar to that of 'accidents'....it prevents us from seeing and confronting man's inhumanity to man" (1980:251-2).

In the end, pathological theorizing has multiple weaknesses. It hasn't proved itself by the standards of rigorous positivistic science, nor does it adequately address matters of human responsibility. Moreover, while cloaking itself in the false neutrality of expert medical control, it reduces complex social and political problems to a simplistic pursuit of technocratic solutions. Indeed, insofar as it impairs society's ability to confront questions of good and evil, one wonders whether there is something evil about this perspective itself.

Yet, the pathological perspective remains perhaps the single most socially accepted theory of deviance. So long as our image of deviance remains hospitalized within the positivist asylum of medicalized theorizing, we will be denied a full vision of deviance and social control as aspects of the practical struggle of people together in history.