

Towards a rhizomatic perspective of the medicalized Body?

A Review on Medicalization and Gender

¿Hacia una perspectiva rizomática del cuerpo medicalizado?

Una revisión sobre la medicalización y el género

Adriane Roso

 <https://orcid.org/0000-0001-7471-133X>

Universidad de Harvard, Estados Unidos.

adrianerubioroso@fas.harvard.edu

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Abstract

Medicalization has been one of the most important topics for feminist agenda and gender studies. During the second wave of feminism, when sexual and reproductive rights were the top concerns for women, is exactly when the studies of medicalization started to grow. The goal of this research is to present some characteristics of the studies that are concerned with the gendered medicalized body by indicating how the medicalization process has been explained, understood and interlaced with different institutions and people. One main concern in this review is to pay attention to how gender is expressed in medicalization studies. Within a qualitative design, and the support of SPSS™, we constructed a mapping review on the literature published in books, and thereafter we developed a content analysis of the chapters on medicalization. An overview of the characteristics of the studies are presented, and after two categories are discussed: (a) meanings of medicalization and (b) medicalizing bodies and its entrepreneurs: a rhizomatic expression. It was concluded the medicalization thesis should be considered as one line of a "rhizome" that connects to different actors, corporations and organizations. In deconstructing the rhizome, the analytical category gender should be understood as a socio-historical construction related to relations of domination and to resistance as well. Also, the medicalization authors should be sensitive to the epistemologies of the Global South.

Key words: health, mapping review, medicalizing bodies, social medicine, sociology of health.

Resumen

La medicalización ha sido uno de los temas más importantes para la agenda feminista y para los estudios de género. Durante la segunda ola del feminismo, cuando los derechos sexuales y reproductivos eran las principales preocupaciones para las mujeres, es el momento exacto en cual los estudios sobre la medicalización comenzaron a aumentar. El objetivo de esta investigación es presentar algunas características de los estudios relacionados con el cuerpo medicalizado y generizado, indicando cómo se ha explicado, entendido y entrelazado el proceso de medicalización con diferentes instituciones y personas. Una preocupación principal en esta revisión es prestar atención a cómo se expresa el género en los estudios de medicalización. Dentro de un diseño cualitativo, y con el apoyo de SPSS™, construimos una revisión preliminar sobre la literatura publicada en libros, y luego desarrollamos un análisis de contenido de los capítulos sobre medicalización. Se presenta una descripción general de las características de los estudios, y después se discuten dos categorías: (a) los significados de la medicalización y (b) los cuerpos medicalizados y sus emprendedores: una expresión rizomática. Se concluyó que la tesis de medicalización debería considerarse como la línea de un "rizoma" que se conecta con diferentes actores, corporaciones y organizaciones. Al deconstruir el rizoma, la categoría analítica del género debe entenderse como una construcción sociohistórica relacionada con las relaciones de dominación y también con las de resistencia. Además, los autores que tratan sobre la medicalización deben ser sensibles a las epistemologías del Sur Global.

Palabras clave: Salud, revisión preliminar, cuerpos medicalizados, medicina social, sociología de la salud.

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1. Introduction¹

Medicalization has been one of the most important topics for feminist agenda and gender studies. During the second wave of feminism, when sexual and reproductive rights were the top concerns for women, is exactly when the studies of medicalization started to grow. According to Maureen C. McHugh and Joan C. Chrisler (2015), medicalization can have a serious impact on women's health and wellbeing because it teaches us to doubt our bodies' wisdom without medical supervision or management.

Considering the importance of the medicalization in women's life, in this article our objective is to identify some characteristics of the studies presented in the literature published in books that are concerned with the gendered medicalized body, indicating how the medicalization process has been explained, understood, and interlaced with different institutions and people.

Medicalization has been understood as a process in which a condition that is regarded as an illness or disease is not a "real" medical problem, but it is defined as one (Conrad, 2007). Medicalization starts to take form when a situation or "a problem is described using medical language, understood through the adoption of a medical framework, or 'treated' with a medical intervention" (Conrad, 2007: 5). It also "includes the identification and treatment of behaviors that would not be defined as medical maladies in adults" (Conrad and Joseph Schneider, 2014: 170), as the Premenstrual dysphoric disorder (PMDD) (For further discussion of this topic, see Browne, 2015; Saddichha, 2010; Fingerson, 2006; McHugh and Chrisler, 2015; Offman and Kleinplatz, 2004).

One specific concern in this review is to pay attention to how gender, as a historic and psychosocial category, is expressed in medicalization studies. Indeed, 'Medicalization is not yet gender equal,' as Conrad (2007: 10) argued, but the way the medicalization process develops in a certain society is directly related to gender politics, power relations and social representations of masculinities and femininities.

A critical literature review in books on medicalization can help to clarify concepts and provide a framing to understand how medicalization are interpreted in the field. To the best of our knowledge, there are few published works (articles and books) that use the method of literature review on the subject of medicalization (some examples are Bell and Figert, 2012b; Kvaalea et al., 2013; Zorzanelli et al., 2014).

The purpose of our review is to sum to the medicalization thesis, by pointing out possible gaps and strengths in the extant literature and offering some insight to guide future research intended to further develop theories and knowledge on gender, health and psychosocial processes.

After defining some essential concepts, we will present an overview of some characteristics of the chapters analyzed, followed by a qualitative discussion of two categories: the meanings of medicalization and the process of medicalizing bodies and its entrepreneurs. Questions that guided our review were: what are the main characteristics of the studies on medicalization? What kind of professionals/institutions are recognized as being involved in the process of medicalization? How do the authors of the reviewed chapters understand the involvement of these professions/institutions in medicalization? Do the authors of the reviewed chapters discuss how the institutions intersect with each other, or oppose one another? How do the authors understand gender?

2. Method

This research draws upon a mapping review of secondary sources (Onwuegbuzie et al., 2016; Jesson et al., 2011) at Harvard University's online library catalog.

Our literature review initially consisted in describing and analyzing quantitatively the content of the chapters (descriptive statistic and multiple responses) with the support of SPSS™ (Version 25). The raw data was reviewed, labeled, sorted, synthesized, and categorized. After this process was done, qualitative content

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analysis was employed in order to analyze the content, capture synthesis, and display ordering and searching within and between cases.

To select the documents used in this review, the first step involved searching for books on medicalization at Hollis™ (Harvard University online library catalog). All books in our sample were published by reputable presses such as the Oxford University Press, Duke University Press, University of California Press and Princeton University Press. Most presses in our sample consult with Editorial Boards that advise and support the editor, and to contribute to the subject area in question.

The search period included coverage of the available books on Hollis™ from their earliest records (1995) until April 2, 2018. The results included 3,246 books. We refined these results to only include medicalization + subject “women”, OR “men” OR “gender”. The search yielded 158 items, which were again refined considering online availability at Hollis™ (whole book or summary), that included the presence of the word “medicalization” on the book section’s title. Fiction, encyclopedias, dictionaries, multiple sources, reports, or conference proceedings were excluded. This screening process yielded 38 chapters (1421 pages, including introductions), within 33 books.

Table 1. The chapters analyzed

Reference	Reference	Reference	Reference	Reference
1. Aderinto (2014)	9. Durazo (2006)	17. Hart, Grand, and Riley (2006)	25. Morsy (1995)	33. Sanders (2017)
2. Asma (2009)	10. Eden (2006)	18. Hickey (2006)	26. Muehlenbeck (2017)	34. Shell-Duncan, Obiero, and Muruli (2005)
3. Barnack-Tavlaris (2015)	11. Ferguson (2002)	19. Kanogo (2005)	27. Nichter (1998)	35. Stoppard and Gammell (2003)
4. Baxi (2013)	12. Fingerson (2006)	20. Kaw (2013)	28. Ratcliff (2002)	36. Tiefer (1999)
5. Bell and Figert (2012a)	13. Georges (2008)	21. Kligman (1998)	29. Riessman (1998)	37. Wolf (2012)
6. Chrisler and Gorman (2015),	14. Greil (2002)	22. Light (2013)	30. Riska (2013)	38. Woliver (2002)
7. Conrad and Schneider (2014)	15. Grossmann (1995)	23. Lopez (1998)	31. Rivera-Garza (2003)	
8. Cosminsky (2016)	16. Handwerker (1998)	24. McClellan (2017)	32. Rivkin-Fish (2005)	

After reading the preface and introduction of each book to get an overall view of the subject discussed by the author(s), every chapter on medicalization was read multiple times, including endnotes. A list of 228 initial numeric variables (227 nominal and one ordinal) were created with the help of independent evaluations by two other experts on the topic. The variables were grouped in sets, and for every set, a string variable identified as “Comment” was created. These variables consisted of a space where additional information regarding the topic could be registered. Lastly, a book report for every chapter and introduction was constructed as well. These procedures were done with the intention of enriching data collection, which would help to conduct a prospective qualitative analysis.

3. An overview of some characteristics of the studies

Four variables were selected to be presented in this article in order to describe the characteristics of the book chapters reviewed: the field of study of the first author, the profile of the target population or context, the conceptualization of medicalization, and the professionals and institutions involved.

3.1. Author's field of study

Regarding the field of study of the author(s) for each chapter, the highest percentage of them were in the field of sociology and political science (37.8%). In second place, comes anthropology (27.0%), followed by history (21.6%), and then psychology (10.8 % each). None of the authors were from the field of medicine (though some of them were medical anthropologists), psychiatry, or nursing. Philosophy and law accounted for 2.7% of the chapters. It was noted that in 84.2% of cases the second and third author of the chapters were from the same field as the first author.

As expected, sociology seems to be *avant garde* in the study of medicalization, considering it was sociologist, Irving Zola (1972), that started this area of study. But our study shows that Psychology entered in this area of study around the same time as sociology, (e.g, Barnack-Tavlaris, 2015; Chrisler and Gorman, 2015; Stoppard and Gammell, 2003; Tiefer, 1999). Worth mentioning that in the APA Dictionary of Psychology (VandenBos, 2007) the word medicalization is not found, only medication, overmedication, and self-medication.

Though we only considered the field of study of the first author of the chapter in our quantitative analyses, we observed that most writings are designed within one-author modality. Only one is interdisciplinary (Shell-Duncan et al., 2005).

Certainly, we cannot infer from our results that the chapters did not adopt an interdisciplinary approach, because interdisciplinarity could have been expressed in the theoretical level and not regarding the author's field. However, this finding indicates that the medicalization theorists could invest more in interdisciplinary work.

3.2. Population profile

3.2.1. Gender and sexual orientation

In our review, we noticed the reference on women and on men in the chapters analyzed most of the time can be read as the biological "sex" (female and male), and the authors do not necessarily take gender as a socio-historical construction related to relations of domination and to resistance as well. But we also found authors that work within this perspective (e.g., Aderinto, 2014; Grossman, 1995; Light, 2013; Riska, 2013) and within a feminist analytical frame (e.g., Barnack-Tavlaris, 2015; Bell and Figert, 2012a; j Eden, 2006; Stoppard and Gammell, 2003).

Interesting to point out that the main target population studied in the chapters analyzed were women (76.3% of the cases). The major interest in targeting women in the studies can be justified by medicalization being one of the most important topics for feminist and gender studies. During the second wave of feminism, when sexual and reproductive rights were the top concerns for women, is exactly when the studies of medicalization started to grow.

Though women were the first target of the medicalization studies, the interest on men's body (13.2 % of the cases in our study) as a target of medicalization has been growing (e.g., McClellan, 2017; Riska, 2013; Bell and Figert, 2012a; Conrad, 2007; Rosenfeld and Faircloth, 2006; Riska, 2003). In our review, we confirm that men are theorized as a "gender-neutral category" (Riska, 2003: 64)², since most authors signal differences between women and men, but don't interpret them from a gender perspective, that means, within a relational, structural and performative framework.

One important aspect observed in the set of studies analyzed was that individuals who identify as being LGBT were rarely examined. Only one study investigated the transgender population (e.g., Bell and Figert 2012a), other chapter started with a lesbian's testimony, but really only discussed violence against women in general (e.g., Durazo, 2006). None of the chapters considered bisexuality. This can become a gap in the studies of medicalization and leads to the misrepresentation of sexual practices.

² For a critical reflection of this construct see Saguy and Williams (2019).

3.2.2. Racial/ethnic populations

For race/ethnicity, most chapters fell under the variable “does not identify or does not have a focus on one particular race/ethnicity” (63.2%). 10.5% of the chapters focus either on White/Caucasian or Black samples and 5.3% of the cases covered Hispanic/Latino, Asian, and Indian/Native (Mayan, Nomadic) populations. If Blacks, Asians, Indians/Natives, and Hispanics/Latinos were clustered under the description “people of color”, their population totals would surpass the studies that deal mainly with white people. It should be noted that only three studies (7.9% of the cases) specified the race/ethnicity of the health personnel.

The presence of the social marker race/ethnicity is an interesting one to observe, especially if we consider medicalization theorists pay insufficient attention to these markers and their consequences for global health and healthcare (Bell and Figert, 2012a). However, it seems one of the strengths of the medicalization thesis, in the set of chapters analyzed here, is challenging this research gap, focusing exactly on the population that is most at risk to be medicalized. On another hand, we noticed that though there is interest in focusing on “people of color”, few chapters discuss directly how medicalization can be employed as a strategy of the racism (exceptions are Aderinto, 2014; Hickey, 2006; Kanogo, 2005; Morsy, 1995).

3.2.3. Population regions

The region most mentioned in the chapters is Anglo-America (57.9%), and more specifically, the greatest concern is within the US population. Latin America (Guatemala, Puerto Rico, Mexico) and Africa (Nigeria, Kenya, Egypt) accounted only for 10.5% of the studies. Asia is the least targeted region (5.3%), having China (Beijing) and India as its most prominent regions.

North America and Europe (particularly the United Kingdom) preponderance in the studies of medicalization was already pointed out by Bell and Figert (2012b). We agree with this idea, but it seems there is a communication issue here, or a situational bias: there are many publications in Latin America, Africa, and Asia that deal with medicalization, but they rarely circulate in the North American and European contexts, and therefore are not part of our sample.

Salient is the fact Europe, notably England and France, were cited in more than one work as the sites from where medical knowledge originated. The relation between colonialism and medicalization as a strong factor that provides ground to medicalization was highlighted by a few authors (e.g., Aderinto, 2014; Rivera-Garza, 2003), but it remains a subject under-explored in most chapters analyzed.

4. The meanings and entrepreneurs of the medicalization

Based on the variables, two major categories were created in order to investigate more carefully their connotations: (a) meanings of medicalization and (b) medicalizing bodies and its entrepreneurs.

4.1. Meanings of medicalization

Our understanding of the different interpretations of medicalization was supported by Zorzanelli, Ortega and, Bezerra-Júnior's four main meanings of medicalization (2014).

Meaning 1 (the major strategies of hygienizing of a population) is specially linked to Foucault's work. The term medicalization is related to (a) the process of collective measures of the State in the containment, control and registration of diseases, and in the formation of practices of health, and (b) to the assumption of the intrinsic interconnectedness of the human body experiences and medical knowledge. The dimension of medicalization incorporates health, well-being, and it has a normative function. In meaning 2 (the transformation of behavior considered deviant into a disorder/disease), the transgressive and deviant behavior of social norms are defined as medical disorders of the current social norms. Authors working within the meaning 3 (control strategies and the medical imperative on population) center their analysis on the authoritarian function of medical power and understand the medicalized patient as passive consumers towards medical decisions. In meaning 4 (irregular processes that involve other people or institutions beyond

those in the medical profession), there is an emphasis on the role of actors outside the medical field. The process is understood as a diffused action and it is carried out through multiple actors.

In our understanding, most chapters (36.8% of cases) in our sample can be classified in the meaning 1 (e.g., Baxi, 2013; Light, 2013; Wolf, 2012; Georges, 2008; Kanogo, 2005). Michel Foucault was the main reference in the chapters classified under this definition, which is not a surprise because he was one of the first authors to call attention to the effects of medicalization (Foucault, 1963; 1978). Other authors were referred to in the construction of this definition, like Arthur Kleiman (in Rivera-Garza, 2003) and Ivan Illich. The authors highlighted how consumers resist to medicalization. Constructs like pleasure, desire, hygiene, biopolitical technology, surveillance, resistance to power, and normalizing knowledge are also included under this definition.

Though the chapters analysis of the first definition are deep and critical, sometimes they lack to recognize the influence of other institutions/organizations besides the government. The meaning 4 seems to fill out this gap (e.g., Conrad and Schneider, 2014; Barnack-Tavlaris, 2015; Greil, 2002; Tiefer, 1999; Morsy, 1995; Grossmann, 1995). Representing 28.9 % of the cases in our study, the authors within this meaning, while not forgetting the role of the government, medical professionals, and the pharmaceutical industry, they also emphasize the positive outcomes of medicalization. Peter Conrad is the reference author here for most studies in this classification.

In both the meaning 2 (15.8% of the cases) and the meaning 3 (13, 2% of the cases), the dominance of the health professional is a central issue, but in the second definition the discussion tends to be focused on the health professional's behaviors and attitudes. The meaning 3 leans more on the criticism of the disease model. Finally, there are two chapters that didn't fit with any of these definitions (Bell and Figert, 2012a; Riska, 2003) which, as we will show later, have rhizomatic characteristics.

We have no intention of disconnecting all these meanings of medicalization. On the contrary, all of these definitions might be integrative. The classification of such a complex process as medicalization is far from simple; sometimes it was possible to identify clearly an author's interpretation of medicalization and affiliation (e.g., Asma, 2009; Durazo, 2006; Fingerson, 2006; Ferguson, 2002; Stoppard and Gammell, 2003).

The meanings of medicalization described by Zorzanelli, Ortega, and Bezerra-Júnior (2014) were very important tool to understand how studies were analyzed in each chapter. However, their list of meanings had to be expanded upon to better fit the ideas of the authors that explore more intensively other processes related to the medicalized body. Therefore, we created a fifth meaning for medicalization, which we call "medicalization as a rhizome-process".

4.2. Towards a rhizomatic perspective of the medicalized body?

Though medicalization is understood as "a nuanced, dynamic process, not a fixed endpoint" (McClellan, 2017: 13) and a capacious concept, it does not fully capture the complexity of the process of the medicalized body, especially when examining issues of gender and sexuality in relation to health and healthcare in the globalized world (Bell and Figert, 2012b). Like a horizontal underground stem, different entrepreneurs and processes altogether construct and reinforce medicalization, configuring a textured terrain, as if they were operating as a rhizome - an expression Gilles Deleuze and Felix Guattari (1987) borrowed from biology to present an alternative understanding of power. From their perspective, in a rhizome, there are only lines, as in a map, that are detachable, connectable, reversible, and modifiable with multiple entryways and exits. Instead of a core system with hierarchical modes of communication and pre-established paths, the rhizome is an a-centered, nonhierarchical, intermezzo system.

Though we considered the "medicalization as a rhizome-process" very fundamental to understand medicalization in the interface with gender, only two chapters analyzed in the sample could be categorized under this meaning (e.g., Bell and Figert, 2012a; Riska, 2003). Working strongly with the notions of pharmaceutization and biomedicalization, they don't neglect the thesis of medicalization; instead, they seem to understand those notions as components that interact with the process of medicalization. While the term pharmaceuticalization calls attention to the global, cultural, and economic power of the international pharmaceutical companies in medicalizing symptoms and in creating a market for new drugs (Bell and Figert, 2012b), biomedicalization is related to the transformation of (non)human through technoscientific biomedicine (Clarke et al., 2010). One difference between pharmaceuticalization and biomedicalization worth

noting, is that in research/academic based settings there is a tendency to de-emphasize gender and emphasize transnational processes using a pharmaceuticalization perspective; however, the biomedicalization perspective tends to highlight gender in their processes as well as focus more on western societies than all types of societies (Bell and Figert, 2012b).

In our mapping review, we identified the use of the constructs like biopower, transnational corporation, masculinization, and gender as indicatives of the meaning of medicalization as a rhizome-process. They are saliences in the map of a medicalized body, and like a rhizome, they form a complex net that medicalize and, at the same time, demedicalize bodies – a tensioned and fluid process permeated by resistance and agency.

4.3. Medicalization and its entrepreneurs: a rhizomatic expresión

In our study, we identify a variety of “moral entrepreneurs”³ cited as influencing and interacting with the medicalization process. Moral entrepreneurs are seen as people or institutions that intend to prolong the life of certain groups of people and diminish the lives of others through technology and implementation of “progressive” and eugenic discourse and knowledge, in a process similar to what Foucault (1978) named as biopolitics. We observed that the moral entrepreneurs make medicalization work in the way that there is no center, no core, in this process; as a rhizome, they spread and sum their knowledge to medicalized bodies. For example, different governmental agents (ministries), unions, universities, international agencies (like the Red Cross), and the media engage in carrying out demographic dictates, through pro-natalist policies and surveillance of women’s bodies (see Kligman, 1998).

Physicians were the most cited entrepreneurs in chapters (76.3% of the cases). Gynecologists/Obstetricians (55.3% of the cases) came second, followed by other health professionals, including midwives (26.3%). It is worth noting that medicalization studies commenced with criticizing the medical professional. This finding confirms Conrad’s argument that “Medical professionals and physicians are still key players” (Conrad, 2007: 156).

In general, most health professionals were cited as collaborating with the medicalization process. In the past, and particularly in texts that focus on the beginning of the 19th and the 20th century, medical professionals were viewed mostly in a negative perspective. Some of the reasons cited for this negativity were they performed experimental procedures on the body (e.g., Hickey, 2006; Ferguson, 2002; Lopez, 1998), medicalized reproduction and labor (e.g., Light, 2013; Hart et al., 2006; Woliver, 2002; Riessman, 1998) without evidence of their safety or effectiveness (Ratcliff, 2002), performed surgery without anesthesia on slaves (e.g., Hickey, 2006), were xenophobic (e.g., Riessman, 1998), were profit oriented (e.g., Barnack-Tavlaris, 2015; Hart et al., 2006; Woliver, 2002), encouraged the use of certain “drugs as routine aid to socialization” (e.g., Hart et al. 2006: 158; Conrad and Schneider, 2014) and created a demand for drugs for patients (e.g., Riessman, 1998), inspected, regulated, and controlled the body to medicalize sexuality (e.g., Hickey, 2006), aggressively superintended a mother’s parenting (e.g., Sanders, 2017; Greil, 2002), allied with manufacturing industries (e.g., Light, 2013; Ferguson, 2002), did not inform patients of other sources of help (e.g., Stoppard and Gammell, 2003), and reinforced negative stereotypes about women (e.g., McClellan, 2017; Wolf, 2012), particularly impoverished women (e.g., Lopez, 1998). One study also shows how medicalization research can be used to reinforce judicialization and influence courts to medicalize violence (e.g., Chrisler and Gorman, 2015).

Medical professionals many times act without realizing their possible role as a moral entrepreneur. Other times, they were “forced” by the government to act as moral entrepreneurs (see Kligman, 1998). And other times, their voices would “remain widely silenced” by the government, as was the situation of health providers in Post-Soviet Russia (Rivkin-Fish, 2005: 209).

The identified roles of the health professionals in the process of medicalization raises some ethical concerns that are directly related to intergroup bias, such as racism, ethnicism, sexism, colonialism, and epistemicism. A few different types of intergroup bias were discussed among the chapters analyzed. Gender discrimination and classism were discussed most among the chapters analyzed (56.3% of the cases each). Colonialism, post colonialism, imperialism, and racism/ethnicism came second (37.5% of the cases) and

³ For further discussion of this term see Becker and Geer (1963) and Conrad and Schneider (2014).

epistemicide third (34.4%). Other intergroup discriminations identified were identified, as ageism homophobia/transphobia, religious intolerance/anti-Semitism, and xenophobia.

Here, we want to call attention to epistemicide, a term developed by the Portuguese sociologist Boaventura de Souza Santos (Santos, 2014; Santos, 2011) to highlight the importance of the recognition of the fundamental importance of the epistemologies of the South. Epistemicide operates through ideological strategies like corporatism and colonialism. It helps to construct and fortify some professions and discredit others, and technology plays an imperative role in this, where western medical doctors use their authority as an advantage over native midwives and native doctors. The researches on midwifery of Sheila Cosminsky (2016), in Guatemala, Georges (2008) in Greece, and Aderinto (2014) regarding colonial medics, in colonial Nigeria are worthy examples of studies that are concerned about epistemicide.

Regarding professionals in the social sciences, sociologists/anthropologists were cited in 44.4% of the cases each. Lawyers/attorneys/judges come second, representing 37.0% of the cases, then the "psych professions" (psychologists, therapists, psychoanalysts, and counselors) appeared in 29.6% of the cases. Other professions were cited in the chapters, like journalists/reporters, social workers and historians.

It was expected sociologists (and anthropologists) would be cited in the chapters, because the thesis of medicalization, as was stated previously, started with sociologists. What is interesting, is the presence of professionals from the legal system, indicating the authors of the chapters analyzed are aware of the judicialization process, even though most authors didn't apply this theoretical construct in their analysis of medicalization.

Another important aspect to point out is related to the "psych professions". If psychiatry is also included in the "psych professions", the percentage for this variable would be higher than the percentage of sociologists/anthropologists or gynecologists/obstetricians mentioned in the chapters analyzed. Researchers of medicalization should beware of this data because the significant proportion of "psych" professions identified in the chapters (58.5%) might indicate the presence of the phenomenon described as psychologization.

Psychologization can be understood as "a widely shared form of cultural representation" (Sapountzis and Vikka 201: 375), that affects particularly minorities. It "has become a process for various arms of the state to use psychology to enhance the harnessing of human potential and to exercise power in new, subtler ways" (Jie Yang, 2013: 50)⁴.

How are these social and humanities professions involved in the studies? Sociologists and anthropologists were cited as bibliographic references (e.g., Rivera-Garza, 2003; Tiefer, 1999), and as therapists (e.g., Nichter, 1998). They are also referenced as denouncing the institution of medicine as an agent of social control (e.g., Ferguson, 2002), pointing out the weaker parts of the medical profession in the medicalization process (e.g., Riska, 2013), overlooking the body as central to everyday experience (e.g., Kaw, 2013), and calling attention to the direct consumer involvement in health issues (e.g., Riska, 2013; Light, 2013). Historians were also cited as bibliographic references (e.g., Sanders, 2017), indicated as documenting the political activities surrounding and relating to medicine (e.g., Riessman, 1998), and not studying the advertisements of medical products of the period 1919-39 (e.g., Light, 2013).

Some professionals were cited as working within democratic governments with reinforcing medicalization, as the case of social workers and psychologists (e.g., Sanders, 2017; Conrad and Schneider, 2014), while some worked against communist governments like psychologists during the Cold War (e.g., Rivkin-Fish, 2005). Others were pictured as trying to make the judicial system work (e.g., Ferguson, 2002). Journalists and reporters were portrayed positively in most articles, as denouncers of un-ethical or blurred procedures related to population health (e.g., Hickey, 2006; Ferguson, 2002).

It is incorrect to make a generalization, affirming all health professionals were represented in the chapters negatively. Psychologists, for example, are seen in positive ways as well. In interviews conducted by Stoppard and Gammell (2003), one of their interviewees said her psychologist was "helpful, because she was able to talk to someone about her feelings, something she was unable to do with family or friends, or even her psychiatrist" (Stoppard and Gammell, 2003: 47).

Because the medicalization process is fluid and also dependent on the demand of the patient, sometimes, in the same text professionals might be described as against medicalization, and other times

⁴ The way child abuse was framed as a legitimate medical is an example of the process of psychologization (see Conrad, 1992).

working through demedicalization, or perceiving medicalization to be for the “good” of the patient/client (e.g., Conrad and Schneider, 2014).

Regarding the many institutions involved in the process of medicalization, the most cited was the Federal/State Bureaucracy (FSB). Health and Social Assistance Department Centers represented 51.7% of the cases. Courtrooms/supreme courts come in second (24.1%). Police, asylums and foster homes, prisons, and the U.S. Food and Drug Administration (FDA) accounted for 20.7% of the cases. Last, but not least important, military institutions/armies were identified as 13.8% of the cases. These institutions overseen by the government (State/Federal Bureaucracies) were pictured as central actors in the medicalization process, independently of whether the author believes the medicalization process as a major strategy of control or not.

In many chapters analyzed, it was observed that many authors provided evidence to show how the government and other entrepreneurs make secret alliances in order to achieve their medical goals (e.g., Durazzo, 2006; Kligman, 1998). Other authors also denounced how the government controls, organizes, and “educates” institutions to use and prioritize medicalization (Conrad and Schneider, 2014; Cosminsky, 2016; Handwerker, 1998; Sanders, 2017). Some authors also understand the government as a site for professional categories and manufactures companies to obtain their personal interests (Conrad and Schneider, 2014; Chrisler and Gorman, 2015; Ferguson, 2002).

On another hand, some State/Federal Bureaucracies were highlighted in positive ways, as the National AIDS Program in Brazil (financed partially by the World Bank), the Brazilian Governmental Program of Maternal Health (e.g., Morsy, 1995), the United States of Commission on Civil Rights, and the Congressional Subcommittee on Privacy, (Conrad and Schneider, 2014).

International institutions were also shown as contributing to medicalization and ignoring cultural contexts, but most of the chapters do not mention them (68.8%). The World Health Organization (WHO) is the entrepreneur that was mentioned the most (26.3% of the cases), World Bank was cited in 5 chapters (13.2 % of the cases), and the UN, USAID, UNESCO, and UNICEF in 4 chapter (10,5% of the cases).

Some authors criticized the way international agencies implement health and maternal policies without taking into consideration cultural norms and structures of local communities (e.g., Sanders, 2017; Chrisler and Gorman, 2015; Cosminsky, 2016; Morsy, 1995; Rivkin-Fish, 2005).

Pharmaceutical industries were the second most cited in the chapters (27.3% of the cases). Insurance industries comes in third place (18.2% of the cases), then drug stores and the food/beverage industry (9.1% of the cases). Lastly, laboratories are cited in 6.1% of the cases. The pharmaceutical industries have been pointed out in some chapters as one, if not the most, influential and interested in promoting medicalization (e.g., Conrad and Schneider, 2014; Conrad, 2007). Some authors in the sample fully discussed the interaction between pharmaceutical industries, health personnel, and patients (e.g., Barnack-Tavlaris, 2015; Riessman, 1998).

It is important to remind here that at the end of the 1980's, researchers started to notice the strong influence of the pharmaceutical industry in the process of medicalization (Nichter and Vuckovic, 1994; Nichter, 1988; Rozemberg and Manderson, 1988). The term pharmaceuticalization gained relevance while also calling attention to the global, cultural, and economic power of the international pharmaceutical companies in medicalizing symptoms and in creating a market for new drugs (Bell and Figert, 2012b).

Other corporations were mentioned by some authors, like the insurance industry, drug stores, laboratories, and the food/beverage, cosmetic, and reconstructive industries. With the exception of the cosmetic and reconstructive industries, these corporations weren't the main concern of the authors; they were more in the background of the discussion (e.g., Kaw, 2013; Ferguson, 2002; Tiefer, 1999; Lopez, 1998).

5. Conclusion

In this article, we observed that the writings analyzed give different meanings to medicalization, but most authors understand this process as a major strategy for the hygienizing of a population. Within this meaning, we noticed that sometimes the authors lack to recognize the influence of other institutions/organizations besides the government. Most authors tend to emphasize the negative effects of medicalization, but there are authors that emphasize the positive outcomes of medicalization, especially within the fourth meaning of

medicalization mentioned (irregular processes that involve other people or institutions beyond those in the medical profession).

The dominance of the health professional, specifically physicians, was pointed out as the most significant in producing and reinforcing medicalization in most chapters, but other entrepreneurs were identified as well such as psychologists, international institutions, like WHO, World Bank and the UN, and the pharmaceutical industry. Worth mentioning that, though, authors were able to identify different entrepreneurs that influence the medicalization process, the majority of the authors didn't explore deeper their interconnectedness in producing medicalized bodies.

From its origins, medicalization was identified as a brutal process for many authors. Some connected it to painful experimental procedures on the body, particularly on slaves and other minorities. Others perceived it as xenophobic and sexist, particularly toward people from the Southern hemisphere and impoverished women. Moral entrepreneurs were identified as engaging in it voluntarily and other times the authors of the chapters recognized they were forced to participate in the process, or times, the moral entrepreneurs' voices were perceived as silenced.

On another hand, we perceived that the actions of professionals, institutions and corporations weren't always portrayed as negative. Psychologists were pictured as helping patients to deal with the effects of medicalization; journalists were represented as "by the side" of the consumer; the National AIDS Program in Brazil and the United States of Commission on Civil Rights were seen as culturally competent institutions.

As we could see, there is no single way to understand medicalization, but we can conclude medicalization was understood for the majority of the authors as an ethical issue, because it was shown as producing and maintaining oppression and discrimination. However, most chapters didn't construct an analytical framework considering the gender as a socio-historical construction related to relations of domination and to resistance as well. Moreover, most authors didn't adopt the analytic tool "intersectionality", in which the different forms of relations of domination and violence, as well as the different forms of racism and sexism, epistemicism and religious intolerance/anti-semitism, or xenophobia and colonialism are taken as fundamental research concerns. Yet, while most chapters lacked a discussion of gender as a political and cultural artifact, some of them were able to reflect on the relation between medicalization and sexism/homophobia/transphobia.

We can conclude that, in general, the medicalization thesis is on the right path to consolidate as a critical theory in social sciences; throughout their writings, authors engage in understanding the relationship between moral entrepreneurs and patients/consumers through critical lenses.

5.1. Limitations

One limitation is that we might have missed identifying some elements of medicalization, though every chapter was examined multiple times. Another limitation is related to the type of documents analyzed in this review; a complete mapping review would benefit from the inclusion of peer-reviewed journal articles and grey literature as well.

A methodological limitation and potential bias of our study is the fact we selected books available in one library only. Peer-reviewed journals tend to be the most significant disciplinary arena for the studied topic, and they carry specialized academic expertise. Nevertheless, Harvard University has the first institutional and the largest library in the US⁵. Besides, the library articulates strategies to overcome bias in the selection of books, by incorporating a variety of subjects and theoretical perspectives in the catalog. In addition, the library offers access to part of the electronic resources to a wider audience.

5.2. Future directions

Due to its complexity, we suggest that the medicalization thesis shouldn't be the main center of the analysis of the medicalized body but one line that connects to other constructs, such as pharmaceuticalization, judicialization, biomedicalization and geneticization. It might be interesting to think of medicalization as one

⁵ Information available at <https://www.britannica.com/topic/Harvard-University-Library>

line of the rhizome that shall be connected to other lines - organizations of power, social struggles, relations of domination, political systems, and the myriad of social boundaries humankind can create through experience.

Applying the rhizome metaphor is an attempt to sensitize the theorists of medicalization to the complexity of the power and gender relations involved in the process of medicalization. We could explore the medicalization process by metaphorically comparing it with a habitat constituted by a variety of "mother" species (corporation, institutions, etc.). Part of their intentions, actions and strategies are more or less visible to the entities they affect (as the consumer, symbolic elites, etc.); other parts grow underneath the surface, and therefore are harder to capture in their movements without critical reasoning. The corporations, institutions and other social actors' actions are not isolated from each other; they develop underground connections (the rhizome) and create power relations. The rhizome helps the system to survive and reinvent itself according to certain interests. In this metaphorical way of understanding a system, we cannot "blame" the "mother" entity for producing medicalized bodies, because all entities and their stems work trans-dimensionally. Of course, that doesn't mean one entity cannot try to dominate an individual or a group of person, by imposing their views or using violence or symbolic violence.

Within a rhizomatic perspective, medicalization theorists may distance its practices from medicalization (and psychologization) and continue to collaborate other disciplines to disentangle medicalization and gender inequality. Elements of the "arbitrary-set system" (race/ethnicity, age, caste etc.) (Pratto et al., 2006), and their intersectionality, particularly regarding gender could be further explored in regard to medicalization.

Within interdisciplinary work, authors should be sensitive to the epistemologies of the Global South. By doing this, authors from different hemispheres could gather and co-author books more frequently and write multilingual texts.

Finally, we suggest that the authors explain in more detail how their studies were constructed and what main theories support their analysis. We even recommend providing more clarity on the evidence supporting the theories they create, how they define medicalization and, specially, how they understand gender.

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Brief CV of the author:

Adriane Roso is Ph.D. in Psychology (Universidade Federal de Santa Maria - UFSM, Brazil). Post-Doctor in Communication (UFSM). Associate Professor of Psychology at UFSM. Senior Post-Doctoral Student at Harvard University, Department of Psychology. Main lines of research: health, gender, and sexual and reproductive rights.