Chapter 8
Layering Control: Medicalization, Psychopathy, and the Increasing Multi-institutional Management of Social Problems

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Introduction

Scholars interested in the medicalization of deviance tend to draw a clear line between major institutions of social control – namely law, religion, and medicine – and describe a process whereby medicine becomes more dominant than other institutions in terms of defining and controlling problematic behavior (Friedson [1970]1988). This is not surprising, as the study of the medicalization of deviance has been primarily about a shift in both the definition and the locus of control of a problem from one institutional domain into another (Conrad 1975; Conrad and Schneider [1980]1992). However, some forms of deviant behavior cross-cut institutional arenas and the medicalization of these problems happen concurrently with other institutional controls, such as increased criminalization of mental illness, or the reverse, increased medicalization of criminal behavior (Hiday 1999). Instead of nudging aside law and religion in favor of medicine, these cases demonstrate the *layering* of institutional control and the increasing multi-institutional management of social problems.

Because of their substantive focus on medicine, medical sociologists have too often neglected the interplay of medicine and other dominant institutions when considering the management of social problems. Dingwall (2008) refers to this as a failure to look outside the medical "silo" and notes that, at least in the U.S., there has been a simultaneous expansion of the medical and legal systems that heretofore has largely been considered separately. Our aim in this chapter is to present a new approach to understanding medicine's role in the institutional management of social problems, one that considers overlapping institutional environments. It is our contention that what has been referred to as partial or "degrees of medicalization" (Conrad and Schneider [1980]1992) can often be better understood as a *layering* of institutional control over social problems. Multiple institutions – namely medicine, the law, and religion – can be involved simultaneously and with "profound complicity" (Foucault 2006, p. 85) in controlling a social problem. Instead of an either/or approach that views medicalization as a process that reduces the primacy of a religio-moral or legal understanding and control of a problem, we argue that medicalization is but one interesting institutional layer of an increasingly formalized process of social control over problems in modern life.

Here we focus on current debates and research on psychopathy as our illustrative case. Psychopathy is an increasingly recognized "personality disorder" that has as its hallmark the lack of moral conscience and empathy for the suffering of others. We argue that psychopathy stands at the intersection of law, medicine, and morality and highlights the institutional layering of deviance.

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While medical language and imagery is used to understand the problem of psychopathy, there are virtually no treatment regimens available for individuals diagnosed with this medical condition. Thus, while psychopathy is increasingly named and framed as a medical or biological problem, it is largely contained within a legal arena or through other social exclusion mechanisms. In fact, this illness designation often leads to harsher punishments in the legal system, as opposed to the reduction in responsibility often afforded to people diagnosed with other mental health conditions. The concept of psychopathy has also been exported into both lay and professional communities as a risk management tool designed to exclude "psychopaths" from social interactions and protect individual and business interests. Further, the concept of psychopathy continues to be laden with discourse about morality and, in particular, evil.

As such, the case of psychopathy raises key issues regarding the relationship among institutions of social control, namely medicine and the law, in the management of social problems. While the medicalization thesis often focuses on a linear progression from non-medical to medical (and perhaps back to non-medical) understandings of a social problem, this case highlights the need to look *across* institutions and consider *linked interactions* between these fields of knowledge.

We begin this chapter with a brief description of medicalization and medical social control and introduce the "twin process" of criminalization. Next, we define and explain the institutional layering approach to the study of deviant behavior. We then provide an introduction to the case of psychopathy as well as the related concepts of sociopathy and anti-social personality disorder. We use the case of psychopathy to illustrate institutional layering and the increasing multi-institutional management of deviance. Finally, we conclude with a discussion of future lines of research.

Medicalization, Criminalization, and the Institutional Management of Deviance

The medicalization of deviant behavior has been a prominent area of inquiry in medical sociology since at least Irving Zola's (1972) work on medicine and social control. Conrad and Schneider's publication, *Deviance and Medicalization: From Badness to Sickness*, has become a standard in this field of study and describes medicalization as "the definition and labeling of deviant behavior as a medical problem, usually an illness, and mandating the medical profession to provide some type of treatment for it" (Conrad and Schneider [1980]1992, p. 29). The medicalization concept has been applied to a broad array of behaviors including hyperactivity (Conrad 1975), excessive drinking (Schneider 1978), gambling (Rossol 2001), compulsive shopping (Lee and Mysyk 2004), and becoming "dependent" on welfare assistance (Schram 2000). However, this concept has also been used to discuss the medicalization of "difference," rather than behavior – such as the medicalization of family relations through new genetic information (Finkler et al. 2003) and aging (Estes and Binney 1989).

While the focus of medicalization scholars varies – with some focusing on the medical profession (e.g., medical imperialism and professional dominance) and others on the changing definition and conceptualization of deviant behavior (see Clarke and Shim 2010) – most classical theorists agree that medicalization has resulted in a weakening of the jurisdiction of more traditional institutions of social control, such as law and religion (Conrad and Schneider [1980]1992; Friedson 1970). Through its ability to officially label deviance as illness, medicine has expanded into areas that were previously understood and managed in a non-medical way (Conrad and Schneider [1980]1992; Conrad 2005). Increased medicalization is not just a product of medical professionals, to be sure (Conrad and Potter 2000), and it may be enacted outside a traditional allopathic medical context (Appleton 1995), but it continues to gain ground in the control of social problems at the expense of more traditional institutions of social control.

Some of the earliest sociological work in the area of criminalization was by Edwin Sutherland, who wrote about the creation and diffusion of sexual psychopath laws through the United States (Jenness 2004; Sutherland 1950). A key aspect to this diffusion was the roles of media and expert opinion. While criminalization lacks the same definitional core that Conrad provided for medicalization, the usage of the term appears to parallel Michalowski (1985), who describes it as a process whereby previously legal acts are transformed into crimes and individuals into criminals. Jenness (2004, p. 150) argues that "changes in structural conditions provide the impetus for the development of law that targets a set of activities perceived to be attached to a social group deemed 'in need of control' by those in a position to stimulate, define, and institutionalize criminal law." She maps a broad literature on criminalization and the many approaches used to study it, including social entrepreneurs, triggering events, interest groups and social movements, political opportunism, and structural factors. While criminalization work appears focused more on the structural position of the deviant person vis-à-vis the controlling agent than medicalization theory does, the emphasis on definitional issues is similar. Thus, while medicalization scholars are interested in how behavior comes to be defined and treated as medical, criminalization scholars examine the processes by which behavior becomes defined and punished as criminal. For this reason, medicalization and criminalization are often juxtaposed as twin processes with one ebbing as the other increases in its dominance (Jenness 2004).

For their part, sociologists have a long history of studying institutions of social control. Parsons (1951) explicitly defined medicine as an institution of social control and set medicine alongside law in this regard. In *The Social System*, Parsons discussed the practices and processes that contribute to stability in societies and argued that the criminal role and sick role exemplify two different mechanisms of social control. The criminal role functions primarily through defining criminal acts as illegitimate, holding the criminal responsible for his behavior, and punishing the criminal by excluding him from the social group. The sick role functions primarily through placing deviants under the care of a "technically competent expert" (Parsons 1951, p. 314), releasing them from responsibility for the onset of their conditions, and creating a therapeutic relationship that will assist in the return to the social group. While the criminal role is illegitimate, the sick role is conditionally legitimate. That is, the deviant act (illness) is legitimate as long as the sick person expresses a desire to get well and cooperates in this process. In this way, therapeutic support is given in exchange for taking on the obligation to get well. Because the therapeutic relationship is more effective than punishment in reintegrating the deviant back into society, Parsons believed that, given a choice, diverting deviants into the sick role was a more effective social control mechanism.

The pioneers of medicalization theory, namely Freidson, Zola, and Conrad, were influenced, sometimes to the contrary, by Parson's conceptualization of medicine as an institution of social control. These early scholars continued to make the treatment versus punishment distinction between medicine and law and to associate these discrete approaches to the imputation of responsibility. Freidson called this the "institutional division of labor for deviance" (Freidson [1970]1988, p. 247). In this division of labor, law punishes individuals who are held responsible for their deviance and medicine treats individuals who are labeled as ill it is this institutional division of labor for deviance that we address in the next sections. Specifically, we challenge the treatment/punishment distinction and its relationship to the label of illness as well as the claim that the extension of medicine into new realms necessarily weakens the jurisdiction of law (and the influence of a religio-moral discourse). While we do view medicalization and criminalization as twin processes, each highlighting a different form of social control, we shift our focus to the simultaneous development of a criminal and medical model of understanding, the co-occurrence of which highlights the increasing multi-institutional management of social problems.

However, before moving into our discussion of institutional layering, we address two concepts that motivate our approach: levels of medicalization and degrees of medicalization.

Institutional Layering and the Increasing Formalized Social Control of Problems

Classic theories of medicalization are flexible enough to accommodate the idea of layering and multi-institutional management of social problems, even if the explicit focus has not been applied before. Concepts of levels and degrees of medicalization provide a starting point. Conrad and Schneider (1980) suggested that medicalization can occur on at least three levels: *conceptual*, *institutional*, and at the *doctor–patient relationship*. In later formulations (Conrad 1992; Conrad and Schneider [1980]1992), the institutional is also referred to as *organizational* and the doctor–patient interaction is described more broadly as the *interactional* level. Medicalization at the conceptual level consists of using medical language or a medical frame to define and treat a problem (see also Brown 1995). Medicalization occurs at the organizational/institutional level if an organization adopts a medical definition of a problem in which it specializes. Conrad's and Schneider's use of "institution" appears to be focused on identifiable, specific organizations rather than the "more enduring features of social life" (Giddens 1986) that we prefer to use. At the level of the interaction/doctor–patient relationship, medicalization occurs when a problem in an individual is diagnosed and treated medically, most often by a doctor.

In addition to levels of medicalization, Conrad and Schneider argue that "medicalization is not an either/or phenomenon; it is better seen in terms of degrees" ([1980]1992, p. 278) and that older non-medical definitions of a problem can continue to exist alongside medical definitions. For instance, they claim that while madness has been fully medicalized, opiate addiction has been partially medicalized and sex addiction has been only minimally medicalized. Factors likely to affect the degree of medicalization include the availability of medical treatments and the existence of competing, non-medical definitions. State and popular support of the medical profession, availability of treatments, and financial incentives (such as insurance coverage) could also contribute to the degree of medicalization achieved. Further, the authors suggest that "medical social control does not preclude the simultaneous and even coordinated operation of legal controls" ([1980]1992, p. 283). While we are in fundamental agreement with this statement, we argue that this phenomenon has not been fully explicated, nor has a theoretical foundation for understanding this simultaneous and coordinated operation been presented. This is what we propose to do.

It is our contention that the social control of deviance is not a zero-sum equation, where one institution can gain only at the expense of another institution's control. In many of the classic studies of institutional social control of deviance, there appears to be an inversely proportionate amount of control that one institution (e.g., medicine) can have over the other, such as the criminal justice system. For instance, early efforts to have homosexuality viewed as a medical condition were focused on relieving the persecution of homosexuals through the protection of medicine, though that medical social control itself later became a source of contestation (Conrad and Schneider [1980]1992; Conrad and Angell 2004).

And yet, there are some instances in which the easy equation of decriminalization and increased medicalization do not hold. Armstrong's (2003) study of the case of fetal alcohol syndrome (FAS) shows that the increasing medicalization of FAS leads to an inherent maternal–fetal conflict and more restrictive and punitive approaches toward pregnant women. The outcome of the creation of the diagnosis of FAS is increased social control over all pregnant women and their alcohol-drinking habits. Armstrong is focusing on a conflict between the traditional Parsonian understanding of the sick role, which diminished personal responsibility in the face of illness and has a "restituitive" and "restorative" approach toward those who fall into its purview. But in the case of FAS, medicine is "neither restituitive nor restorative" (Armstrong 2003, p. 210). This paradox, we argue, is similar to that of psychopathy.

To account for conflicts in the theoretical underpinning of medicalization, we propose the idea of *institutional layering*. By this we mean that the social control of a problem can become the focus

of multiple institutions – such as medicine, law, and religion – simultaneously. While one institution may, over time, come to dominate control over a problem, we propose that multiple definitions and loci of control can exist simultaneously. Further, these institutions can either be cooperative, in conflict, or be agnostic toward one another in the construction and containment of the problem. In the particular case of psychopathy, they are so intertwined as to be inseparable.

The Psychopath, the Sociopath, and Others

"Psychopaths" have been described as "intraspecies predators" (Hare 1998, p. 196), people who lack in conscience and who use superficial charm, manipulation, and sometimes violence to satisfy their own needs. Popular press and media accounts tend to use the terms *sociopath* and *psychopath* interchangeably, to discuss people who hurt others without remorse or empathy. However, in the scientific literature, there is a distinction drawn between the terms. Both the *sociopath* and the *psychopath* are "characterized by a lack of the restraining influence of conscience and of empathic concern for other people" (Lykken 2006, p. 11). What distinguishes the *psychopath* in this formulation is that the individual "has failed to develop conscience and empathic feelings, not because of a lack of socializing experience, but, rather, because of some inherent psychological peculiarity which makes him especially difficult to socialize" (Lykken 2006, p. 11). The etiology of this "inherent psychological peculiarity" is at the root of much heated debate, but the understanding that sociopaths are made through some sort of social conditions while psychopaths are born with a predisposition of some sort not uncommon among researchers. In fact, Hare suggests that the terms *psychopath* and *sociopath* may well reflect the different understandings of the "origins and determinants of the problem" (Hare 1999b, p. 23). For instance, Hare states that social scientists tend to prefer the term sociopathy to emphasize environmental and social antecedents to the problem, whereas those who hold more closely to the "psychological, biological and genetic factors" prefer the term psychopathy (Hare 1999b, pp. 23–24).

Those who study anti-social behaviors sometimes claim that *sociopaths* are the real practical concern because they are "metastasizing" quickly (Lykken 2006, p. 4), are much more numerous, and as a group are responsible for a high percentage of violent crime. However the rare, curious, and potentially dangerous *psychopath* attracts more scientific attention. In 2005, a group of researchers founded an organization called "The Society for the Scientific Study of Psychopathy." This international society with biannual conferences numbers more than 160 members, according to the published accounts on the society's website in late 2009. The majority of members are from the United States, but Canada, Europe, and Asia are also well represented.

As scientific consensus has developed about what a *psychopath* is, Robert Hare's Psychopathy Checklist-Revised (PCL-R; Hare 1991, 2003) became the dominant diagnostic tool. Analyses of the coherence of the items (Hare and Neumann 2006; Neumann et al. 2007) yielded four major dimensions of psychopathy. The interpersonal dimension is associated with glibness and superficial charm, grandiose behavior, and conning or manipulative behavior. The affective dimension targets callousness, and lack of remorse, guilt, or empathy. The lifestyle dimension includes impulsivity, parasitic orientation, and stimulation-seeking behavior. Finally, the anti-social dimension highlights behavioral issues such as criminality or a history of delinquent behavior.

From that, they conclude: "…psychopathy is essentially a personality disorder involving a failure to: (a) adopt the common interpersonal conventions of honesty, modesty, and trustworthiness, (b) experience full-fledged emotions concerning one's relation to others (e.g., love, empathy, guilt), (c) adopt widely shared sociocultural norms pertaining to financial responsibility and safe conduct, and (d) obey the laws of society." (Neumann et al. 2007, p. 104)

Further related and potentially confusing categories are those included in *The Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR; American Psychiatric Association 2000).

The DSM IV-TR sees both sociopathy and psychopathy as synonymous with the diagnosis of *anti-social personality disorder* (APD), an Axis II disorder. This simple linking between APD and psychopathy, not surprisingly, is rejected by those who study psychopathy, specifically (Hare 1999b; Lykken 2006; Widiger 2006). APD is defined by a pattern (manifesting in some form from at least age 15) of acting with callous disregard for the rights of others that might be characterized by recklessness, breaking the law, or acting with little remorse upon mistreating, stealing from, or harming others.[1] While the description of the behaviors, namely breaches of social norms, is similar to the clinical definition of psychopathy, missing are the personality dimensions of psychopathy, such as callousness, egocentricity, and lack of remorse.[2] Hare has suggested that this is not a fundamental disagreement, but rather a "concept drift" (Hare et al. 1991, p. 393) by drafters of the DSM IV due to the concern that clinicians would be unable to reliably assess personality traits connected with this condition (see also, Hare 1999b).

It is also important to keep the research field's distinction between *psychopathy* and *psychosis* distinct, though it is clear that in popular media the terms *psychopath* and *psychotic* are used interchangeably to define individuals who are mentally ill, who behave in reckless and dangerous ways. While the term *psychosis*, introduced into the English language in the mid-19th century, originally referred to all manner of mental illness (OED 2007), its meaning has, at least in the psychiatric field, become a signifier for a constellation of symptoms (not all of which must be present for the label to be applied) such as delusions, hallucinations, disorganized speech, or disorganized or catatonic behavior. In DSM-IV, these symptoms usually would lead to an Axis I (clinical) disorder. While this constellation of symptoms is an important feature for several disorders (i.e., schizophrenia and schizophreniform, schizoaffective, and delusional disorders), psychosis is the defining characteristic of other disorders that are recognized to have distinct etiologies: psychotic disorder due to a general medical condition and substance-induced psychotic disorder. In addition, psychosis is recognized as an important potential feature in other disorders, such as those categorized primarily on their mood effects such as major depressive disorder and bipolar disorder. Finally, three disorders: brief psychotic disorder, shared psychotic disorder, and psychotic disorder not otherwise specified, cement this constellation of problems as a recognizable disorder when other conditions have been ruled out or the etiology is unclear. The DSM IV-TR notes this confusing mélange of terms (American Psychiatric Association 2000, pp. 297–298) and provides some distinction, though it offers nothing definitive.

To further muddy the waters, *psychosis* and the related term *psychotic* are often used outside of medical contexts (for instance, in films and books) to connote breaks with reality, particularly those that lead to frenzied, unpredictable, or possibly violent or murderous behavior. Occasionally, the terms *psychopath* and *psychotic* are used interchangeably to connote violent mentally ill individuals, though this conflation will often bring condemnation from those who wish to separate the "mad" with psychosis from the stigma of the "bad" with psychopathy.[3] However, within a psychiatric framework, psychosis is viewed as clearly distinct from psychopathy, which is characterized by more realistic thinking and knowledge of social norms. Some studies (for example, Nestor et al. 2002) have found the two disorders to occur largely exclusive of one another, though there can be some co-morbidity. In fact, there are numerous studies that isolate psychopathic tendencies or APD markers as one of the best predictors for violent or recidivistic behavior among people with schizophrenia (Mueser et al. 2007; Nolan et al. 1999; Rice and Harris 1992; Tengström et al. 2000).

[1] Conduct Disorder is a diagnostic category similar to APD, but applied to children under the age of 18.

[2] The tension that this issue has caused may well lead to changes in the criteria that will be adopted in the DSM V, currently scheduled for 2013. At least two workgroups, the ADHD and Disruptive Behavior Disorders Work Group and the Personality and Personality Disorders Work Group, are considering related issues.

[3] Two illustrative letters to the editor in the New York Times illustrate this perceived misuse and correction: one written by Jack Olsen, Feb 26, 1986, "Psychotic or Psychopathic" and another written by Janet Hebb, March 17, 1991, "Psychopaths on film; What's in a Name?"

Finally, the general term *psychopathology* refers to the field of study of mental illness or abnormal behavior (such as depression, psychosis, or anxiety) or maladaptive behaviors or personality characteristics. *Psychopathy* is but one pattern of behavior or set of personality characteristics that could be considered *psychopathological*.

Psychopathy and Institutional Layering: Who Takes Precedence?

Key to our proposed *institutional layering* approach is the claim that the increasing institutional control of a social problem in one domain (such as medicine) should not – and sometimes cannot – be considered in isolation from other domains. In what follows, we demonstrate that it is impossible to sort the institutional control of psychopathy into either a purely legal or a medical field, nor is it possible to consider medical, criminal, and religio-moral understandings of the problem in isolation. Instead it is necessary to focus on the increasingly complex relations between medicine and the criminal/legal system in simultaneously managing the problem of psychopathy, as well as the multiple frameworks used to order and conceptualize the problem (the person is sick, bad, evil, etc.). Once the state of "being a psychopath" becomes named and framed, efforts to contain (or quarantine or exclude) individuals so named become more pronounced in multiple arenas.

Medical Understandings of Psychopathy

Over time, a clear diagnostic history, codification of the clinical entity in diagnostic tools, and several well-developed etiological theories have developed, indicating that psychopathy has been medicalized to some degree. However, the attempt to contain this problem through medical means (i.e., treatment) has thus far largely failed. This does not represent degrees of medicalization; rather, we argue that medicalization is just one layer of the social control of psychopathy.

History of the Diagnosis

The definition of psychopathy has a long and varied history. In the 1800s, French psychiatrist Philippe Pinel developed the clinical construct *manie sans delire* (or madness without delirium) to describe a class of individuals who engaged in impulsive and socially unacceptable behavior while being fully aware of the irrational and potentially self-destructive nature of these actions (Herve 2007). What set this condition apart from other disruptive psychological conditions was the lack of any identifiable psychosis (Hare and Neumann 2006). At around the same time as Pinel, the American physician Benjamin Rush noted a similar condition that he called *moral derangement* or *anomia* (Herve 2007). Marked by the presence of manipulative, deceitful, and socially disruptive behaviors performed without remorse or guilt, Rush linked this condition to an impairment of the moral faculty, which he believed had a biological basis (Verplaetse 2009).

The British physician J.C. Pritchard later labeled this disorder *moral insanity*. Like Pinel and Rush, he noted that individuals with this condition had no impairment in understanding and intellect, but lacked a sense of decency, fairness, and responsibility. Pritchard argued that individuals with this condition were highly prone to criminal activity and because they lacked the ability to learn from their mistakes and could not be rehabilitated through punishment (Herve 2007). The term *psychopathic* was introduced to the psychiatric literature by the German psychiatrist J.L. Koch, who labeled the condition *psychopathic inferiority*. Koch argued that this disorder was chronic in nature and had an

underlying biological or organic cause (Herve 2007). Koch's contemporary, Kraepelin, refined this definition and described a set of p*sychopathic personalities* or *psychopathies*, each of which was marked by a deficiency in both emotions and will (Herve 2007).

Throughout the course of the 20th century there were many attempts to refine the construct; however, it was American psychiatrist Hervey Cleckley who exerted the most influence on future definitions (Herve 2007). In his seminal volume, *The Mask of Sanity*, Cleckley presents extensive case studies of psychopathic individuals conducted while in residence at a large neuropsychiatric hospital. He describes the psychopathic personality as one marked by an outward appearance of good mental health that masks a severe behavioral maladjustment. Importantly, Cleckley presents 16 specific criteria which stand as the defining characteristics of the disorder, including superficial charm, lack of remorse or shame, and a general poverty in major affective reactions (see Cleckley [1941]1964, pp. 362–400 for a full description). While prior psychiatrists defined the condition solely in terms of anti-social behavior, Cleckley argued that psychopathy was both behavioral and social–emotional in nature. He believed that a deficit in emotional reactivity was central to this disorder and argued that while the psychopathic personality had no deficit in emotions such as rage and frustration, a severe deficit in emotions such as love and empathy existed. This lack of complex social emotions makes the psychopathic personality immune to normal forms of social control, which either compels a person to act according to social norms out of love or out of fear of experiencing feelings of shame, remorse, and guilt (Cleckley [1941]1964; Herve 2007).

These "Clecklian" traits were operationalized in the Hare (1991) Psychopathy Checklist (PCL-R), which stands today as the dominant diagnostic tool (Conoley and Impara 1995; Hill et al. 2004). Developed in the 1980s and refined in the 1990s, the PCL-R is a clinical construct rating scale initially designed to identify incarcerated males who matched Cleckley's description of the psychopathic personality. The PCL-R consists of 20 items and is scored on the basis of an extensive file review and a semi-structured interview. Early analyses found two broad dimensions: Factor 1 characterized by a callous and unemotional interpersonal style and Factor 2 by impulsive and anti-social behavior. More recently a four-factor model – comprised of interpersonal, affective, lifestyle, and anti-social behavior dimensions – has been proposed and validated (Hare and Neumann 2008).

While the PCL-R was primarily constructed and validated using a forensic population, it has been adapted for use in the general population and among juvenile offenders. The PCL-Screening Version (Hart et al. 1995), which was developed for the MacArthur Violence Risk Assessment Study, is a 12-item scale based on a subset of PCL-R items that can be used in "psychiatric evaluations, personnel selection, and community studies" (Hare n.d.). The PCL–Youth Version is a 20-item rating scale for the assessment of psychopathic traits in juvenile offenders (Forth et al. 2003). A number of self-report measures have also been developed for use in the general population (Campbell et al. 2009). These include the Psychopathic Personality Inventory–Revised (Lilienfeld and Widows 2005), Levenson's Self-Report Psychopathy Scale (Levenson et al. 1995), and the Self-Report Psychopathy Scale–II (Hare et al. 1989).

The identification of psychopathy in children and adolescents has taken on greater interest in recent years. Because psychopathy is seen as a relatively stable disorder that is linked to aggressive behavior in adulthood, it is argued that the early identification of psychopathy in children could allow for early intervention measures that can protect the public from the "fledgling psychopath" (Seagrave and Grisso 2002).[4]

[4]Researchers also hope that studying psychopathy in children can contribute to the understanding of the developmental pathways that lead to adult psychopathy (Lynam et al. 2009). The most commonly used assessment tools for identifying psychopathic traits in children and adolescents (Campbell et al. 2009) include the Antisocial Process Screening Device (Frick and Hare 2001), the Childhood Psychopathy Scale (Lynam 1997), and the Youth Psychopathic Traits Inventory (Andershed et al. 2002).

Medical and Biological Theories of Psychopathy

If psychopathy is a brain disorder, what is its basis? The most dominant theories are described below.[5]

Fear-Conditioning Deficit. The low-fear hypothesis of psychopathy was proposed by Lykken in 1957 and continues today to spark great interest and debate (Fowles and Dindo 2006). Lykken (1957) suggested that psychopathic individuals suffered from defective emotional reactivity. He hypothesized that psychopathic individuals are comparatively less able to develop fear/anxiety in response to warning signals. Because of this defect, such individuals are incapable of learning to avoid circumstances that produce fear/anxiety or result in punishment. Using a series of experiments based on the classical conditioning paradigm, he found support for these hypotheses. For example, compared to controls, psychopathic individuals showed less electrodermal activity (a measure of sweat gland activity) to a conditioned stimulus associated with a shock, as well as poor avoidance of shocked responses on a mental maze game (Lykken 1957). Subsequent studies have provided further support for the low-fear hypothesis (Fowles and Dindo 2006).

Psychoanalytic Models. Those working within the psychoanalytic tradition argue that disturbed early relations are central to psychopathy (Blackburn 2006). The internalization of group standards is believed to be underdeveloped in psychopathic individuals due to poor parenting, specifically parental rejection, neglect, abuse, and abandonment. While the focus of these models is on disturbed relations that lead to attachment deficits, some researchers posit an underlying biological or genetic disorder that predisposes the psychopathic individual to react aggressively in response to traumatic early experiences (Kernberg 1992). Studies have found that psychopathic individuals display signs of an attachment deficit; however, there has been only moderate support for the connection between childhood abuse and neglect and psychopathy. For example, childhood abuse appears to be high among all young male offenders, both psychopathic and non-psychopathic (see Blackburn 2006 for more).

Cognitive Theories. Dysfunctions in cognition tend to be associated with either a deficit in cognitive processing (decoding, encoding, retrieval, and attention) or a distortion in cognitive structures (beliefs, schemas, and tacit assumptions) (Blackburn 2006). Those working within the deficit approach (e.g., Newman 1998) suggest that psychopathic individuals have poor response modulation that inhibits their ability to shift attention away from goal-directed behavior in order to accommodate environmental feedback. Several studies have found that in the face of cues that suggest the modification of behavior (e.g., loss of money or punishment), psychopathic individuals persist in their behavior (Blackburn 2006). Those working within the distortion approach (e.g., Beck 1976) suggest that psychopathic individuals experience cognitive distortions that cause them to employ dysfunctional strategies when interacting with the social world. Psychopathic individuals have dysfunctional schemas about the self, the world, and the future (e.g., "If I don't exploit/manipulate/attack others, I will never get what I deserve/need/want") which lead to distorted interpretations of events. Few studies have examined the relationship between distorted schemas and deviant behavior (Blackburn 2006).

Neurocognitive Theories. The burgeoning area of structural and functional brain imaging spawned numerous neurocognitive theories of psychopathy which try to link the theories above to abnormalities or impairments in the brain. For example, the hippocampus has been shown to play a critical role in fear conditioning (LeDoux 1996), with impairments linked to psychopathic behavior (Raine et al. 2004; Laakso et al. 2001). Blair and colleagues have proposed that the psychopath is ill

[5]The large majority of the studies mentioned rely on the PCL-R to identify their "test" (e.g., psychopathic individuals) and control populations and most, but not all (i.e., Raine et al. 2004; Blair et al. 2001) recruit their "test" subjects from forensic settings.

equipped to engage in emotional learning due to genetic abnormalities that disrupt the functioning of the amygdala (Blair et al. 2005), the center of fear and empathic processing (Blair et al. 2001). Studies have found decreased activation in the amygdala among psychopathic individuals when viewing negative affective images (Kiehl et al. 2004), and children with psychopathic tendencies have been found to have difficulty recognizing sad and fearful expressions, mistaking them for other types of expressions (Blair et al. 2001).

Psychopathy has also been linked to structural abnormalities in what is called the "moral brain" (de Oliveira-Souza et al. 2008). Using functional magnetic resonance imaging, researchers have identified a series of brain networks (e.g., the orbital and medial sectors of the prefrontal cortex and the superior temporal sulcus region) that are thought to specialize in the development of moral emotions, emotions that have to do with the welfare of others (Moll et al. 2002). Studies have found that psychopathic individuals display more structural abnormalities in the "moral brain" then do non-psychopathic individuals (de Oliveira-Souza et al. 2008).

The Treatment of Psychopathic Individuals

One critical part to medicalization is the understanding and adoption of a treatment regimen for the affected. However, in the case of psychopathy, the prevailing clinical view is that it is incurable (Minzenberg and Siever 2006). No single set of established protocols or approaches exists, and there is a general sense of pessimism about the prospects of effectively treating or curing psychopathy.

Even Hare, who, along with Wong (Wong and Hare 2005) published a set of widely cited guidelines for the treatment of psychopaths, has signaled caution: "There is little evidence that psychopaths can be, or even believe that they should be, rehabilitated… Unfortunately, psychopaths already are aware of their own motivations, see little wrong with them, and do not believe they need to change" (Carozza 2008).

Not only have effective treatments for psychopathy been largely elusive, but the message that treatment might actually be *counterproductive* has also found its way into the treatment literature and public understanding about psychopathy. One effort to reform psychopaths through a therapeutic community was not only ineffective, but actually had the opposite effect – the psychopathic subjects were more likely to violently reoffend, while non-psychopathic subjects who went through the same program were less likely to do so (Rice et al. 1992). Other published studies found alarming increases in violent recidivism after treatment (Seto and Barbaree 1999; D'Silva et al. 2004; Harris and Rice 2006; Lee 1999).

The case of the medical understanding of psychopathy indicates that the problem has not been fully medicalized. The lack of a psychopharmaceutical "silver bullet" and the muddled picture for the behavioral treatment, coupled with an increasing adoption of the medical and biological framework for understanding the etiology of the problem, have led to some frustration. Yet there is no retreat by psychopathy researchers who have formed a professional society dedicated to psychopathy studies and to research into nosological and etiological issues, and with pilot programs for treatment options.

Medico-Criminal Understandings of Psychopathy

While the case of psychopathy has been partially medicalized, the fact that its dominant diagnostic tool, the PCL-R, is situated within the field of forensic psychiatry and psychology clearly indicates an overlapping of the medical and the crimino-legal arenas. By examining the use of the PCL-R within the field of forensic psychiatry/psychology (a field that stands at the interface of medicine

and the law[6]), we argue that psychopathy as a diagnostic entity illustrates the “profound complicity” of these twin mechanisms of social control.

The PCL-R, developed and validated using a forensic population, has been shown to predict both recidivism (Hart et al. 1988; Serin et al. 1990) and future violence (Rice et al. 1990). For offender populations, the PCL-R has been hailed as being “unparalleled as a measure for making risk assessments” (Salekin et al. 1996, p. 211). For example, while 25% of non-psychopathic individuals reoffended within 3 years, 80% of individuals classified as psychopathic reoffended (Hart et al. 1988). The PCL-R has become the gold standard in psychopathy research in large part because of its ability to predict recidivism and violence (Salekin et al. 1996).

Courts of law have become increasingly reliant on expert opinions regarding the possible risk of violence among individuals standing trial or receiving sentencing (Salekin et al. 1996), and clinical assessment instruments are highly regarded among forensic psychologists/ psychiatrists for evaluating the mental state at the time of the offense, risk for violence, and competency to stand trial (Archer et al. 2006). Among members of the American Psychology-Law Society Division of the American Psychological Association and the American Board of Forensic Psychology, the PCL-R is the most commonly used assessment tool for evaluating violence risk assessment and psychopathy (Archer et al. 2006).

While a diagnosis of schizophrenia, mania, or depression can serve as a defensive claim, reducing one’s responsibility for the crime, a diagnosis of psychopathy is used, most often, as an aggravating factor (Morse 2008). A case law survey of published U.S. court cases involving the PCL–R from 1991 through 2004 found that the PCL–R was used in 87 reported cases (76 state cases and 11 federal cases), with the frequency of use increasing precipitously over time. Fewer than two cases were reported per year in the years 1991–1999, but from 2000 to 2004, 10–30 cases per year were reported (DeMatteo and Edens 2006). In most of the state cases and in all of the federal cases, the PCL-R was introduced by the prosecution to argue that the defendant is dangerous and should be (or continue to be) removed from society, particularly the sexually violent predator (SVP) subject to involuntary and indefinite civil commitment. The second most frequent use of the PCL-R was to determine future risk of danger in parole and probation hearings. In fact, a diagnosis of psychopathy is quite compelling in this area. A 2007 study found that a diagnosis of psychopathy was the strongest predictor of whether or not a patient would be recommended for release from a maximum security forensic hospital (Manguno-Mire et al. 2007). Finally, in capital cases, the PCL-R has been used during sentencing to determine the presence of aggravating factors required to impose a death sentence (DeMatteo and Edens 2006). A diagnosis of psychopathy is actually suspected to have a negative impact on sentencing decisions for an accused criminal. A recent study (Edens et al. 2005) found that jurors in a mock trial were far more likely to recommend the death sentence for a murderer who was labeled with the diagnosis of psychopathy (60%) than someone with no diagnosis (38%). A diagnosis of psychosis, in stark contrast, offered a protective effect (30%).

Importantly, a diagnosis of psychopathy is not considered a sufficient basis for raising an insanity defense (Morse 2008). The Model Penal Code, which includes an insanity test later adopted by many states, indicates that “the terms mental disease or defect do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct” (American Law Institute 1962). While psychopathy has been argued to have a strong biological and affective component, the association of this diagnosis with anti-social behavior often precludes it from being considered in an insanity defense (Campbell 1990). As Hare himself argues, this “would be appalling” (Hare 1996, p. 47).

[6]The Ethics Guidelines for the Practice of Forensic Psychiatry states that: “Forensic psychiatrists practice at the interface of law and psychiatry, each of which has developed its own institutions, policies, procedures, values, and vocabulary. As a consequence, the practice of forensic psychiatry entails inherent potentials for complications, conflicts, misunderstandings and abuses” (*Source*: http://www.aapl.org/pdf/ethicsgdlns.pdf, accessed January 27, 2010).

Beyond its widespread use in legal trials, the PCL-R is used frequently in decisions about treatment suitability in forensic settings (Gacono et al. 2001; Archer 2006). Because psychopathy is generally understood as an immutable personality disorder that increases one's propensity for violence, the diagnosis often disqualifies a person from participation in treatment programs (Skeem et al. 2002). As Megargee (2003, p. 374) explains: "In correctional facilities where treatment resources are scarce and access must be limited to those most likely to profit from interventions, such findings suggest that psychopaths should have lower priority than other offenders." Since the prognosis for effectively treating psychopathy "is practically zero," Kernberg (1998, p. 377) goes further to argue that "the main therapeutic task is to protect the family, the therapist, and the society from such a patient." In this setting, psychopathy is a clinical diagnosis that signals institutional management via containment and social exclusion rather than through medical means such as treatment. This reaction challenges in a fundamental way the claim that increased medicalization allows an individual to gain access to the privileges of the sick role (Gacono et al. 2001).

The medicalization thesis indicates that medicine has jurisdiction over anything that is labeled illness and that once deviance is recast as illness the problem moves into the jurisdiction of medicine. This claim was complicated, however, by the case of psychopathy. Instead of a weakening of legal jurisdiction over a problem in favor of a medical solution, the case of psychopathy highlights Foucault's notion of "profound complicity" (Foucault 2006, p. 85) between these twin mechanisms of social control. The problem is ordered using medical language, but medicine remains largely impotent with regard to containing the problem. Indeed, the diagnosis sometimes precludes individuals in forensic settings from receiving medical treatment. In this way, psychopathy is an illness designation that is controlled, not through treatment, but through punishment. The criminal justice system can be successful in containing psychopathic offenders for a time, but has no reach over the problem (to be discussed below) of those "successful psychopaths" who do not break laws in their abusive behavior.

A key component of the medicalization thesis is that labeling deviance as illness comes with certain humanitarian benefits, namely management via treatment rather than punishment. Conrad and Schneider [1980]1992) cite the insanity defense as a key example of this phenomena. However, a diagnosis of psychopathy is rarely, if ever used, as an insanity defense (Morse 2008) and some within the medical profession argue that it *should not* be used (Hare 1996). The label itself appears to be more effective in the prosecution rather than defense of a criminal.

While psychopathy is a medical diagnosis, the psychopath is hardly accepted as sick in the Parsonian sense (1951) and instead represents a complicated bad-sick hybrid role. The psychopath is understood to have a brain dysfunction that increases his propensity to commit criminal acts and he is held legally accountable for his actions. Once in a forensic setting, the label "illness" does not alter the imputation of responsibility and as such the management of the psychopath remains within the jurisdiction of the criminal justice system. Psychopathy, it seems, is a medical diagnosis that not only excludes individuals from treatment but leads to harsher punishment.

The Appropriation of Evil: Moral Discourse and the Medico-Criminal Understanding of Psychopathy

Scientists working within the field of psychopathy describe the psychopath as the personification of evil (Blair et al. 2005). This conceptualization, which combines disparate systems of knowledge, namely medical and religio-moral, is held by lay and professionals alike. *Evil Genes*, a popular press book, for example, expresses this hybrid understanding of psychopathy, one that attempts to explain evil through an appeal to biology. Some forensic psychiatrists argue for the incorporation of the concept of evil into the field of forensic psychiatry, arguing that the only way to understand

some predatory killers is to incorporate evil alongside biological, psychological, and social understandings of the problem (Stone 2009). This has led to a move by psychiatrists and psychologists to standardize the definition of evil, especially as it is used in courts of law to identify crimes that are "depraved" and "heinous" (Welner 2009). Psychiatrist Michael Stone argues that the discussion of the concept of evil has, in recent years, undergone a "sea-change." Once the exclusive province of religion, "evil has become an acceptable subject for study by the mental health professions, including general psychiatry, forensic psychiatry, and neuroscience. Rather than relying on the Bible (of whatever religion) for explanations about the nature and roots of evil, we now look where we should have been looking all along: the human brain" (Stone 2010, p. 15).

The attempt to localize evil, or more broadly morality, to the brain, is a bourgeoning area of study in the brain sciences. For example, Moll et al. (2002) claim to have identified, using functional magnetic resonance imaging, a series of brain networks that specialize in the development of moral emotions. de Oliveira-Souza and colleagues (2008) have applied this concept of the "moral brain" to psychopathy , arguing that individuals with psychopathic tendencies display more structural abnormalities in the "moral brain" then those who lack such tendencies.

While some scientists argue that the concept of evil deserves attention, others are less convinced. For example, Dr Saul Faerstein, a forensic psychiatrist, explains: "I don't know that we want psychiatrists as gatekeepers, making life-and-death judgments in some cases, based on a concept that is not medical" (Carey 2005). But regardless of whether or not the concept should be used in formal medical discourse, it is being used, at least on the ground. In a study of mental health professionals working in a high-security psychiatric hospital in the U.K., Mason, Richman, and Mercer discovered a complicated relationship between medical ideological discourse and lay notions of evil. Nurses not only use the term evil in their day-to-day interactions and considered patients with a diagnosis of psychopathy as "representing the epitome of evil" (Mason et al. 2002, p. 85), but nursing care plans were impacted by these lay notions of evil (Mercer et al. 2001). Nurses viewed patients with psychotic disorders as sick and developed nursing care plans based on a medical, symptom-centered, approach. Patients with a diagnosis of psychopathy, however, were viewed as evil, and nursing plans were constructed, as one nurse puts it, "for the commissioner. No one takes them seriously. Everyone knows they are meaningless, a front, that's all" (Mason et al. 2002, p. 87).

While religion is an institution of social control, it cannot be considered, at least in the United States, an official or state-sanctioned social control institution. The Constitutional separation of church and state precludes it from being so (Freidson [1970]1988). However, religion is thought to "leave its mark" on official institutions of social control through its influence on public opinion (Freidson [1970]1988, p. 248). Alternately, the medicalization thesis argues that a supernatural understanding of deviant behavior that invokes the concept of evil has been largely excluded from our lay and professional discourse and replaced by the more modern concept of illness. Conrad and Schneider ([1980]1992, p. 251) explain: "Medicalization contributes to the exclusion of concepts of evil in our society." Like the label crime, the label sin, and with it the power of religion to manage society, has been pushed aside in favor of the label illness and the medical management of society.

While the medicalization thesis argues that the concept of evil has become less important in both the lay and professional understanding of deviance, it does not argue that illness designations are morally neutral. For example, Freidson (1970) contends that while the label illness *appears* as morally-neutral, the person is nonetheless held morally responsible to rid himself of the disease. Zola (1972, p. 514) echoes this, writing: "Though his immoral character is not demonstrated in his having a disease, it becomes evident in what he does about it."

While the medicalization thesis suggests that the concept of evil has become less central to the discourse surrounding deviance, the case of psychopathy illustrates a complicated medical-religio-moral framing of the problem. Psychopathy is a medical diagnosis that continues to be linked, even by medical professionals, to the concept of evil. Further, there appear to be some attempts to use medical technologies to explain evil via an appeal to biology. This case highlights the liminal space

that lies at the intersection of medical, religious, and moral understandings of deviance. Even at the conceptual level, although the problem has been officially named and framed by medicine, at the edges, psychopathy is comprised of disparate dimensions. It seems likely that a certain class of phenomena is more vulnerable to this type of fragmentation. Problems that are highly socially and morally abhorrent and are not amenable to medical treatment, such as child abuse and pedophilia, are likely to be ordered using medical language yet infused with strong moral overtones. These behaviors pose a troublesome moral conundrum to societies that value humanitarianism and assume that people are rational and voluntary actors. Medicalization scholars would do well to examine more closely this class of deviant behavior. Advances in the brain sciences, especially around psychopathy, have complicated our notions of badness and sickness. While medical sociologists have been interested in the process through which badness gets remade as sickness, the claim that morality is localized in the prefrontal cortex and that murder, torture, and rape could be due to a brain disorder, forces us to move beyond a description of the medicalization process and into a much more complicated arena. While the question of how a set of behaviors once considered bad come to be considered sick is a necessary question, medical conceptualizations that incorporate religio-moral dimensions force us to look across dominant institutions and to examine the socio-political consequences of this institutional ideological interface where social and moral issues are reframed within a medical ideology.

The concept of evil appears to have both a moral and religious dimension. While some associate evil quite explicitly with Satan or evil spirits, others use the term to connote a moral transgression that is particularly socially abhorrent. Future research should examine what type of evil is being invoked with regards to deviance such as psychopathy. When lay and professionals use the term "evil," are they connecting this with the devil, or does this term connote an extreme transgression of the social contract?

The Irony of Psychopathy in Modern Society

An increasingly popular concept of the "successful psychopath" suggests that not all individuals identified as psychopaths are located in forensic settings. Both Cleckley and Hare argue that many individuals who could be classified as psychopaths never become involved with the criminal justice system; some are able to use the primary characteristics of the disorder, namely, superficial charm and lack of remorse or guilt to lead successful non-criminal careers. In fact, Hare writes: "I always said that if I wasn't studying psychopaths in prison, I'd do it at the stock exchange" (Deutschman 2007). Hare and others estimated that between 1% and 5% of the general population meets the clinical criteria for psychopathy (Hare 1999a; Hart et al. 1995; Salekin et al. 2001).

More recently, Hare collaborated with an organizational psychologist, Paul Babiak, to adapt the PCL-R into a screening device for use in the workplace. The Business Scan (B-Scan) is an instrument designed to "identify developmental needs in management and supervisory staff" and can be used to spot employees with psychopathic traits (Babiak and Hare (2006); http://www.b-scan.com). Hare and Babiak discuss the "corporate psychopath" as well as the B-Scan in numerous trade publications including Harvard Business Review, FastCompany, and Fraud Magazine as well as their popular press book *Snakes in Suits: When Psychopaths go to Work*.

So, in this way, psychopathy has leaked into multiple institutional contexts. Not only is psychopathy a medical condition that requires non-medical control and intervention, it is a medical diagnosis that has escaped the bounds of medicine, and the clinical rating scale has been adapted for use by the lay public. The public likely holds multiple and seemingly disparate knowledge about psychopathy simultaneously. Understanding the patterned and multi-dimensional ways the public makes sense of "deviant" behavior will help us to understand the layering of institutional control.

Discussion: The agenda for Sociology

While medicalization theory has provided very fertile ground for research, it has found itself in the crosshairs recently as a conceptual muddle. Davis (2006), for instance, argues that medicalization has "lost its way" by encompassing talk of medicalization without medicine. Dingwall (2006) notes that the sociological language of medicalization has slipped into everyday language and taken on new contexts. Hafferty (2006) wonders if medicalization has become less about medicine and more about science.

Clearly the concept of medicalization has encouraged scholars to apply it to phenomenon that do not stop at the interaction between the physician and the patient or on the policing of the sick role. Clarke and colleagues (2003) call this transformation biomedicalization, and consider it a radical shift in the way our society is organized. Conrad (2005) prefers to think of it as shifting engines, and has noted that physicians are not necessarily the primary drivers of medicalization.

We have attempted to step back from all of the instances of medicalization or partial medicalization and to reassess how it functions as a mechanism of social control in concert with other mechanisms. That is, medicine is but one set of potential *layerings* of institutional control over deviance that can be employed by different sets of actors with different goals. While this solution will likely not please those who wish to relegate medicalization to something that can only properly occur in the institution of medicine (Davis 2006, for instance), we think it can offer some conceptual clarity to those who find themselves dealing with cases of "incomplete" or "partial" medicalization and to those that see the parallels to processes in other fields that look quite similar. We would like for medicalization studies to step out of the "silo" (Dingwall 2006) that they are often a part of and consider how the layering of institutional control over deviance plays a part in the labeling and treatment of problems, whether they medical, scientific, technical, etc.

It is useful to think for a moment about the other "-izations" that are sometimes mentioned alongside medicalization. Criminalization is often used as a conceptual foil to medicalization, but it is far from the only other understanding of the nature of a problem. *Geneticization* (Freese and Shostak 2009) offers another window into the reach and march of science into understanding individual difference and similarity. *Biologization* is a less often used term, but Williams has used it to refer to the move within psychology to account for behaviors, emotions, intentions, etc. in biological terms (Williams et al. 2001). Habermas and Shapiro (1971) used the term *scientization* as part of a critique of the transformation of questions previously encompassed in a moral or political sphere into a techno-scientific sphere. The term has also been used to refer to the increasing levels of surveillance and prescriptiveness of recommendations about issues previously considered less "technical," such as infant nutrition or motherhood (Kimura 2008).

Medicalization is a very well-developed theory of the individualization of a social problem, both in definition and treatment. It provides a nice parallel to criminalization, which individualizes deviance as a personal fault and contains it accordingly. While geneticization, biologization, and scientization as concepts do not rely on the individualization of a problem (though often they do exactly this) they do provide a shift in institutional control. All five of these "-izations" can overlap, and sometimes do. They can all share some conceptually similar processes. As a case study, psychopathy has something for everyone: medicine, crime, genetics, biology, and scientization.

The relationship between medicine, science, law, and morality is becoming increasingly complex as we make our way into the 21st century. As such, the "siloed" approach to studying social problems can only take us so far. Instead we would be well served to draw on the most unique feature of sociology, the ability to look across institutions. Sociology as a discipline is not predominantly tied to any one institution but instead allows for a broad view across institutional arenas. The increasingly overlapping and cross-cutting nature of the organizations and institutions of the 21st century requires a broader perspective. The institutional layering approach is one such perspective.

How societies conceptualize and react to individuals who breach social norms, break the rules, and violate the social contract is a central area of inquiry for sociology. However, studies that start with the premise that a problem has been medicalized and attempt to document this process are limited, as they do not examine multiple mechanisms and processes of social control. The different -izations discussed above suggest a ramping up of a more formalized or institutionalized management of social problems. An approach to social problems that considers only one system of social control necessarily misses this phenomenon. A careful consideration of the layered conceptualizations of and reactions to the problem, the institutions and players involved, as well as the mechanisms, features, processes, and characteristics of each can shed a broader light on the fundamental organizing principles of a society.

Future Questions

Our work in the area of institutional layering is not complete and many questions remain. For example: Is institutional layering more likely when deviance is understood as being particularly abhorrent or threatening? Is there something about the problem itself – in this case, the inability to form a moral conscience and to empathize with others, which many might define as key components of "humanness" – that sets these types of problems apart? What are the causal processes and structures that underlie institutional layering of the increased institutional management of social problems? Can the institutional layering perspective shed light on the processes through which new scientific findings are interpreted, framed, and used by medical professionals, law makers, judges, juries and the lay public and how in turn these findings are remade within the scientific and medical realms? Can the institutional layering perspective shed light on how science is employed in different ways and in different institutional arenas to in the tension between private rights and public safety? The answers to these questions may lie outside traditional subjects of medicalization work, but we are confident that the strong base of medicalization theory – coupled with an increased attention to the other institutions of social control that surround a problem – will help yield the answers.

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