3. Clinical Authority in the Construction of Citizenship

DEBORAH A. STONE

In this volume, the authors turn the traditional question of democratic theory on its head and ask not what kinds of policies a democratic society should or does produce, but rather how public policies shape the processes of democracy. Does a policy encourage citizen participation? Does it create structures of influence that enable "little people" to express their views and see them translated into future policy? Does it tell citizens that political participation might be worthwhile? Does it enable citizens to participate in formulating the central political questions, or does it bring them into decisionmaking when they can only ratify preselected choices?

To talk about how and whether public policies empower citizens, one needs a definition of power. Political scientists have evolved a complex notion of power that is neatly captured in Steven Lukes's imagery of "three dimensions of power." The first dimension of power is the ability to influence the outcome of specific decisions. The second dimension is the ability to influence the agenda, or the menu of choices from which any specific decision is made. The third dimension (and the one least adequately addressed by empirical studies) is the ability to influence consciousness—to define core ideas, shape people's wants and tastes, frame issues, and define the standards of proof for evaluating claims to knowledge. Any inquiry into the effects on democracy of public policies must consider all three dimensions of power.

This essay addresses the third dimension, the one most neglected in analyses of citizen participation and democracy, and focuses on one particular form of third-dimension power: clinical reason. Clinical reason, I will try to show, is a pattern of thinking derived from clinical medicine and used to evaluate and classify citizens in many areas of social policy far removed from medicine and health. This mode of reasoning

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This essay addresses the third dimension, the one most neglected in analyses of citizen participation and democracy, and focuses on one particular form of third-dimension power: clinical reason. Clinical reason, I will try to show, is a pattern of thinking derived from clinical medicine and used to evaluate and classify citizens in many areas of social policy far removed from medicine and health. This mode of reasoning
has attained such enormous cultural authority and widespread popular acceptance that it has come to be a dominant mode of resolving social conflict and exercising social control. Further, I will argue, clinical authority often removes power from individuals, placing it instead in the hands of clinicians and professional researchers, and it defines political issues in ways that highlight individual behavior and ignore structural and relational understandings.

There are other forms of third-dimension power whose analysis is germane to democratic theory and public policy. Perhaps the most hegemonic idea-belief system in contemporary political and policy thinking is the nexus of rational choice theory, microeconomic efficiency models, and cost-benefit analysis, which might be called “the rationality project.” Another powerful form of cultural authority is the concept of rights and legal reasoning at the heart of a broad range of political issues and policy arenas where discrimination and civil rights are the inspirational metaphors: issues of race relations, gender relations, generational conflict, prisons and mental health institutions, and disability, for example. A third domain of cultural authority is certainly religion. Thus I do not pretend that clinical reason is the only form of cultural authority in contemporary politics, but it is probably the least recognized and the least well understood.

The Model of Clinical Reason

Clinical reason is a way of thinking about and acting on human problems. It derives from clinical medicine but has expanded far beyond the domain of medicine to be incorporated by a variety of professionals who process human beings. As I define it, clinical reason has three key components. First, it is based on observations of individuals, the derivation of norms from these observations, and the reappplication of the norms back to an individual. Second, clinical reason bases its observations of individuals on imaging techniques, that is, modes of observation and measurement that claim to render visible something that is invisible to the ordinary person. Third, it uses measurement and quantification to describe the characteristics of individuals and, through measurement, promises objectivity.

From Statistical to Normative Normality

Clinical reason begins with an examination of the individual. It expects to find the source of trouble in the individual, and it promises to locate and define problems by measuring something inside the boundaries of the person. At the same time, trouble is identified by comparing the individual to previously established norms. Those norms, in turn, are derived by compiling measurements of a large number of individuals. Thus clinical reason is simultaneously individualistic and comparative.

In this intellectual schema, trouble is defined as deviance from a group norm. As Michel Foucault noted about nineteenth-century medicine,

Medicine must no longer be confined to a body of techniques for curing ills... it will also embrace a knowledge of the healthy man, that is, a study of non-sick man and a definition of the model man. In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and the society in which he lives... Nineteenth century medicine... was regulated more in accordance with normality than with health.

The orientation of clinical reason toward statistical normality is still a prominent feature of contemporary medicine. Every new diagnostic technology requires calibration of norms, and at the time of introduction of a new technology, clinicians often have difficulty distinguishing mere statistical abnormality from pathological (harmful) abnormality. As breast mammography was introduced, for example, radiologists saw a high number of abnormalities in the statistical sense, simply because there is normal variation in breast tissue, and physicians did not know what to make of these abnormalities because they had never before had this kind of visual (radiologic) image to correlate with malignancy. Women with these abnormalities were (and are) treated as “cancer suspects,” and subjected to further diagnostic testing to determine whether the abnormal visual findings were true malignancies. This is typically true of new clinical technologies (whether they are physical diagnostic tests or psychological tests): statistical deviations are considered pathological until proven otherwise. With diagnostic tests for cancer, it is easy to see the

2. This is my own term (Stone 1988).
virtue of this assumption. Imagine a standardized test for intelligence or personality disorder, however, and the assumption becomes more troubling.

Observation as Imaging

Clinical reason promises to render visible something hidden. Its aim is to reveal the characteristics that define people's abilities to function biologically and socially. This aspect might be called imaging. All forms of diagnosis entail making visible what is going on in the body or mind and comparing the features thus revealed with population norms.

Diagnostic technique in medicine rests on three kinds of imaging. The earliest form was testing things extracted from the body, such as blood, urine, feces, air, or bone marrow, to measure the performance of organ systems. (Freudian psychiatry applies this same form of diagnosis, using slips of the tongue, word associations, dreams, and other "verbal excre- tions" to reveal what is happening in the psyche.) A second kind of diagnostic test invades the body with instruments or particles to render the inside visible. Examples of imaging technologies are cardiac catheterization, fiber optic examinations (for example, of stomachs, joints), X rays, ultrasound, sonograms, and magnetic resonance imaging. All these technologies produce literal pictures of the inside of the body. A third type of diagnostic test challenges the body and measures how it responds. Examples are the glucose tolerance test for diabetes (in which a patient drinks a highly concentrated sugar drink and subsequent blood tests measure how well the body can metabolize it), liver clearance tests, cardiac stress tests, and the various signs for pain (in which a physician moves a patient in a certain way to see whether the patient responds with "pain behavior" such as a scream or a grimace or a sudden stiffening). These tests are all based on the idea of forcing the body to perform in some way that reveals its true capacities.

Diagnostic imaging techniques liberate physicians from the subjective knowledge and reports of the patient. They give doctors direct access to what is going on inside the patient, so they are no longer dependent on the patient's description and interpretations. In the jargon of clinical medicine, they provide doctors with "signs," which are objective indicators of disease, and make them less reliant on "symptoms," which are only experiences and interpretations of the sick person. Embedded in the use of imaging technologies is a claim that they reveal an objective truth about the person, and that when there is a discrepancy between the subjective claims of the individual and the data provided by imaging, the imaging information is correct.

Clinical imaging technologies are often used precisely in political situations where there is a dispute between a citizen and an agency over some characteristic of the citizen. Indeed, several early medical technologies, such as the ophthalmoscope and the spirometer (a device for measuring lung capacity), were touted as means of detecting malingerers among military recruits who claimed to be unable to serve. Pain has proven to be a particularly nettlesome phenomenon in agencies that use disability as a criterion (for example, disability insurance programs or courts presiding over injury claims) because so far there is no uncontested means of translating pain into a visual image. Thermography, a technique of measuring heat waves generated by body tissues, is currently a major object of conflict in American courts. Its proponents say it is a sort of pain thermometer, a device that translates true pain into physical and visual correlates, and thus could indicate whether plaintiffs are exaggerating their "pain and suffering" to increase monetary damages they are awarded. Alcoholism is another area of social policy conflict for which imaging technology is offered as a resolution. Disputes over drunkenness and the prosecution of car drivers, ship and plane pilots, or workers for causing accidents turn on whether the defendant was "really" drunk. State laws generally use a measure of blood alcohol level as a standard and set a fixed standard for the entire population. Defense attorneys, naturally enough, argue that alcohol affects people differently and that only a behavioral—not a chemical—standard is fair. A new technology uses computer analysis of sound waves from tape-recorded speech to produce pictures of the speech patterns of people who are known to be either sober or drunk. Then speech patterns of individual defendants are compared with these norms.

The imaging aspect of diagnosis is central to political and social au-

6. Resier's (1978) study of the historical development of medical technology shows that new diagnostic technologies were extollled and promoted specifically for their ability to free the physician from dependence on the patient. For another excellent essay on the political import of diagnostic imaging, see Petchesky (1987).
Objectivity and Reification

Clinical reason is rooted in quantification and measurement. Through measurement, it promises objectivity. The assumption of clinical reason is that some feature of the person, such as tissues or organs, mental capacity, learning ability, or physical capacity, has measurable characteristics. These characteristics are relatively fixed properties of the person, and their measurement, if done correctly, remains stable across different observers.

A great deal of professional effort is expended in developing objective measurement technologies that are not susceptible to manipulation by the patient or client. For example, some measures of breathing capacity, known as lung function tests, measure the amount of air a person can inhale or exhale in a fixed time. Lung function tests are key diagnostic measures in occupational disability assessments and fitness examinations, but clinicians have always understood that these tests are “effort-dependent”: different readings result depending on how hard the person tries. Therefore, the test results are also somewhat sensitive to the interaction between the tester and the person being tested, since testers can coach, encourage, cajole, or provoke people into trying harder. Because respiratory difficulties are one of the three or four most common disabling conditions in work disability, clinicians are always searching for a new technique that is less subject to manipulation by the tester or testee.

Clinical reason actually claims two kinds of objectivity. First, there is objectivity in the measurement of individual characteristics, traits, or behaviors. And second, with proper statistical techniques, there is objectivity in the combination of multiple measurements into a predictive diagnosis. There is a branch of decision science and cognitive psychology that seeks to make clinical judgments more accurate, essentially by using mathematical formulas instead of individual judgment to derive the aggregate group norms from individual measurements and to make predictions about individuals based on the group norms. In this literature, the term clinical judgment is often juxtaposed with actuarial judgment, where clinical denotes reliance on intuition and actuarial denotes use of formal statistics. I see these approaches as aspects of the same method: both rely on comparisons between individual characteristics and group norms to determine the diagnostic classification of the individual. The push to bring formal decision science into clinical work is a way of bolstering the authority of clinical reason by giving it more statistical rigor.

Despite some realization that clinical measurements are in part subject to the influences of the person being tested and the tester, the assumption (or perhaps wish) that clinical measurements are objective often leads to reification of the qualities that are measured. They are taken as fixed, stable capacities of individuals. To see the import of this reification, imagine the opposite assumption—that physical capacity is the product of interaction between people and their social environment. Under this assumption, a worker does not have a fixed, static capacity for physical exertion. He or she might be able to lift a greater weight, for example, when the supervisor is encouraging, respectful, and humorous rather than punitive, degrading, and morose; when the worker feels part of a team; or when the worker can determine the pacing of the work, rather than accommodating to a pace set by someone else.

The Political Properties of Clinical Reason

Inside medicine, new diagnostic technologies are celebrated and promoted for their ability to yield objective information and to liberate physicians from the subjective reporting and claims of patients. Outside medicine, social institutions are eager to use clinical techniques and reasoning in various forms of the construction of citizenship: the allocation of social roles and statuses; the assignment of guilt, innocence, and punishment; the determination of eligibility for entitlements and monetary compensation; and the regulation of conflict more generally. Clinical reason seems to have important political properties that make it a desirable instrument for these purposes.

First, clinical reason purports to measure something in the individual, be it traits, capabilities, or behaviors. Since it is part of liberal ideology that individual status and rewards should depend on individual characteristics and achievements, clinical reason offers a seemingly objective way to measure deservingness that is consistent with liberal ideology.

10. See, for example, Dawes, Faust, and Meehl (1989) and literature cited therein; Elstein, Shulman, and Sprafka (1978); Schwartz and others (1973); Eddy (1982); and Sjoberg (1982).

11. For evidence on this score, see studies cited in Karasek and Theorell (1990).
Second, clinical reason purports to be objective, to rest on knowledge that is produced by independent observers, replicable, and unaffected by the subject of measurement. Liberal ideology also requires that people should not be able to claim statuses or resources merely because they want them. Claims must be based on merit or need. Clinical reason seemingly provides a way to validate individual claims objectively, using the knowledge of outside observers and insulating decisions from the will of the claimant.

Third, clinical reason seems to bridge the gap between the public and the private spheres. It is a form of power that makes the individual yield up private knowledge to the public domain. Through imaging, information previously available only to the individual in the form of experience is rendered accessible to others in the form of visual pictures, numbers, or precise verbal pictures. It is precisely the (alleged) technical ability of the clinical professions to reveal the hidden that gives them their claim to control citizen classification on behalf of society.

The Expansion of Clinical Authority

Clinical authority—the kind of knowledge used to define and identify diseases—is increasingly used as a mode of social power that defines the citizen's relationship to the state. It is not just that clinical methods are used to classify people into roles and statuses, but that government recognizes, indeed seeks out, clinical authority as the preferred method of legitimizing social classification. I will consider three key areas of social policy and political conflict—education, criminal justice, and the regulation of gender roles—that are rich domains in which to explore various aspects of clinical authority in politics.

Clinical Reason in Education

Schools have always been the premier institution for sorting a population into future occupational (and consequently socioeconomic and to some degree political) statuses. Schools in the United States are at the center of controversy over two forms of social classification, apart from tracking by social class. First, schools were institutions of formal legal racial segregation until 1954 and continue to perpetuate some de facto racial segregation. Second, schools were the first arena where the conflict over segregation of people with disabilities was fought. The two kinds of sorting come together in the new concept of identifying disabled children. (In the American penchant for euphemism, we often refer to these children as "special" or "exceptional" or "special needs" children.)

Under the Education for All Handicapped Children Act of 1975, public school systems are required to identify children with disabilities, to make special accommodations for them, and to educate them in the "least restrictive environment," meaning that they are to be integrated in regular classrooms whenever possible. Because the statute also provided for federal funds to local schools on a per-handicapped child basis, it created enormous incentives for the development of personnel and methods to identify handicapped children. The law had the ironic (but entirely predictable) effect of leading to the identification of more children as handicapped and of having more children educated for at least part of the day in separate classrooms apart from the "mainstream."12

The definition of "handicapped" was considerably broadened. Originally, this category contained primarily children with severe mental retardation, emotional disturbances, or physical disabilities, such as deafness, blindness, or cerebral palsy.13 It was these kinds of disabilities that were envisioned by legislators who passed the 1975 legislation. Because of the new fiscal incentives attaching to handicapped children, school systems employed learning specialists, psychologists, and other gatekeepers to identify such children. They placed children with behavioral and learning difficulties into this category and created medical "syndromes" to aid in diagnosis of these disorders. Thus disruptive children were identified as hyperactive (and sometimes treated with drugs).14 Children who could not concentrate and who formerly would have been blamed for not spending enough time doing their assignments were diagnosed as having "attention deficit disorder." Now, most children who are determined to be handicapped are classified on the basis of social and psychological criteria, including intelligence, achievement, social behavior and adjustment, and communication and language problems.15 The general category of "specific learning disabilities" named in the original statute

12. See Granger and Granger (1986, pp. 52–53) and sources therein.
13. The Education for All Handicapped Children Act of 1975 named eleven different handicaps, most of which were indeed medically identifiable: deaf, deaf-blind, hard of hearing, orthopedically impaired, other health impaired, speech impaired, visually impaired, seriously emotionally disturbed, multiply handicapped, mentally retarded, and learning disabled. See Gartner and Lipsky (1987, p. 173).
14. The classic study on the creation of hyperactivity as a medical syndrome is Conrad (1976).
became the tail that wagged the dog. Thus, in the decade from 1976–77 to 1986–87, the overall special education population grew by 20 percent but the learning-disabled population increased 142 percent, so that at the end of the period learning-disabled students made up 44 percent of the total.16

Imaging is central to educational gatekeeping. The various forms of testing used by teachers, school psychologists, and vocational and rehabilitation counselors, for example, are all forms of imaging. They purport to reveal some inner characteristics of the individual by eliciting answers, responses, and performances in a structured way. The enormous resources and attention these professions devote to "validating" their testing instruments all serve to promote a faith in these instruments as objective and beyond manipulation by interested parties. Meanwhile, some scholars of special education have found that tests are often designed and administered and sometimes even redesigned to confirm the referral decisions of teachers and the diagnostic decisions of educational testers.17

Specialized educational tests are supposed to reveal a truth that ordinary teachers cannot see and that parents might be all too prone to deny. In this way, the scientific imagery of the tests adds weight to the school system's side in conflict between the school and parents. When parents protest the placement of their child in a special class, their intimate knowledge of the child is pitted against and made inferior to the objective knowledge revealed by the tests.18

True to the model of clinical reason, the education profession deems learning disabilities to be qualities inherent in the individual. There has been a strong tendency to treat learning problems as biologically determined, especially as neurological defects or malfunction. Dyslexia, for example, is conceived as a discrete diagnostic entity with a neurological basis, although a recent study suggests that dyslexia is just the lower tail of a normal distribution of reading ability, and therefore there is no clear boundary between dyslexia and normal reading ability.19 Dyslexia is thus perhaps another example of how clinical reason finds pathology in deviation from a statistical norm.

Once children are designated with the label "special needs" or "learning disabled," important consequences follow. They can now be legiti-

18. For a gripping first-person account of such a struggle, see Granger and Granger (1986, chaps. 1–5).
characteristics of the mother, the family, or the home environment, rather than of the infant itself. Prominent among these social and environmental risk factors are parents' or mother's education (the lower the education level, the higher the infant's risk); parents' or mother's income (low income is associated with higher risk); parents' occupation (with lower-skilled jobs creating higher risk); and parents' race (with minority status generating a higher risk for infants via prejudice and segregation); and absence of a father. Through clinical reason, the socioeconomic disadvantages of parents are thus translated into individual risk factors for their children. Through a system of scoring to aggregate these factors, the parents' disadvantages become traits of the child. By identifying high-risk infants in this way, the early intervention system assures that the children of the poor and of minorities will be heavily recruited into the world of special education, where the cycle of disadvantage may repeat itself.

Clinical Reason in Criminal Justice

Clinical reason is often called upon to arbitrate claims of truth in the criminal justice system. "Rape trauma syndrome" is a good example of how clinical authority mediates power relations between large groups, in this case, between men and women and between accusers and defendants. The syndrome was first reported in a psychiatry journal in 1974 and eventually included as a subspecies of posttraumatic stress disorder in the psychiatrists' Diagnostic and Statistical Manual of Mental Disorder in 1987. While rape trauma syndrome is widely accepted among clinicians as a reliable diagnostic category, its use as evidence in rape trials is still disputed.

Rape represents in some sense the most fundamental form of gender conflict, and a legal system's treatment of rape sets a society's norms for how it regulates this conflict. The American legal system (like others) has historically been quite distrustful—if not hostile—toward women's claims of rape, so that it has been very difficult for rape victims to win convictions of their assailants, and ultimately, the power of the state is not used to deter or punish coercive sexual abuse of women. There is a widespread male cultural assumption that women often desire to be raped, which is embodied in the legal requirement that a woman must prove she did not consent to sexual intercourse with the defendant. This is an extraordinarily difficult evidentiary hurdle, since there are usually no witnesses to a rape and since if the assailant threatens the woman with a weapon, the threat leaves no physical traces and she is likely not to struggle for fear of injury or death. Thus the entire rape case often turns on conflicting stories of consent.

Rape trauma syndrome was created as a clinical category by a coalition of psychologists, psychiatrists, rape counselors, and legal advocates for women rape victims. The first clinical report of the syndrome came from a study of self-reported rape victims who sought help at a Boston hospital emergency room. In this study, as in all the subsequent ones, researchers and counselors observed the behavior of these self-identified victims over a period of at least several months and formulated a clinical picture of symptoms common to them. The cluster of symptoms includes recurrent nightmares about the event, recollections, hallucinations, or flashbacks; numbing of emotional responses; inability to recall aspects of the rape; efforts to avoid thoughts, situations, and stimuli associated with rape; and persistent symptoms of arousal such as difficulty sleeping or concentrating and an exaggerated startle response. Most of the studies also compared self-identified rape victims with a control group of female emergency room patients who had not experienced rape. Legal advocates began trying to introduce expert testimony about rape trauma syndrome as evidence that a woman did not consent. By now, several states have accepted the syndrome as evidence of nonconsent, while courts in other states have not, so the legal status of the syndrome is still very much in flux.

Rape trauma syndrome illustrates the use of clinical reason as a political resource in a major social conflict. In this conflict, advocates for the weaker side (weaker both physically and legally) used the observational methods and logic of clinical reason to bolster the truth claims of women. Rape, like so many of the situations in which clinical reason is called to bear witness, has been constructed as a contest about truth, and the gatekeepers (in this case, judges who dispense the power of state authority to punish and deter rape) are exquisitely concerned about deceit. (Women

24. Of course children might be helped by being drawn into the world of special education and given extra services, and many probably are. However, there is substantial evidence that segregated special education programs do not help students and may in fact harm them. See Gartner and Lipsey (1989, pp. 13-14) and studies cited therein.
27. For a review of state law through 1988, see Cling (1988).
might lure men into sex and then charge them with rape, or willingly engage in sex and then bring a rape charge to save their own reputations. The rape trauma syndrome is a form of imaging. It creates a clinical picture with precise, graphically described symptoms. Experts hold up this picture to courts to bear witness that a woman is telling the truth. Such a cluster of symptoms, the experts maintain, cannot be faked.

The use of clinical reason as a device to arbitrate claims of truth in political conflict is a double-edged sword. On one side, the construct of rape trauma syndrome has empowered women rape victims by giving them more credence in some courts. But at another level, the substitution of clinical knowledge for lay or experiential knowledge denigrates women as witnesses. The substitution of clinical observations for women’s own claims still denies them credibility in the courts. Clinical experts—not women themselves—are constituted as the bearers of truth.

Rape trauma syndrome is just one of many clinical syndromes developed by clinicians in cooperation with legal advocates to create evidence of victimization. Clinical syndromes can be useful in getting around difficult evidentiary problems when victims are very young or incapable of speaking, or when their victimization occurred without witnesses. Child abuse first began to be taken seriously by state welfare agencies and the legal system only after physicians defined a medical diagnosis called “battered child syndrome.”

The diagnostic criteria were rather straightforward—bone fractures, bruises, and burns and frequent visits to a hospital emergency room for these symptoms. Of course physicians in emergency rooms had been seeing these symptoms for a long time, but packaging them as a syndrome turned child abuse into a medical condition more easily reportable to authorities. Other examples of medical syndromes created by clinicians in conjunction with lawyers to prove victimization are “post-traumatic stress disorder” (to prove that soldiers were indeed injured by combat duty, but now expanded to include several varieties of traumatic stress), and “survivor’s syndrome” (to prove psychic damages caused by a community disaster such as flood and thereby increase the monetary awards going to victims in a tort liability suit).

Used in this fashion, as a sort of corroborating evidence for a person’s own story, clinical authority can enhance citizens’ power in an instrumental sense: parties that would otherwise be weak are more likely to prevail in disputes. They gain influence over specific decisions. On the other hand, clinical authority does not enhance their “third-dimension” power—clinical professions, not ordinary citizens, gain influence over the broader public’s understanding of a social conflict.

Clinical syndromes can function not only as evidence of victimization, but also as defenses or excuses on the side of defendants. The best-known example is the insanity defense, a legal move where the defendant admits to a criminal action but claims either a lack of intent to commit the crime or a lack of knowledge that his or her behavior was criminal, on account of insanity at the time of the crime. Psychiatrists are the gatekeepers for this kind of defense.

In the United States, there has been an expansion of what I would call clinical defenses, that is, the definition of syndromes whose chief function is to excuse otherwise criminal actions. These syndromes are behavioral patterns shown to be deviations from a norm. One example is the concept of “paraphilic rapist” articulated by the psychiatry profession as a defense to rape charges. Another is the battered woman syndrome articulated by some women’s legal advocates. When a woman assaults or kills a man, one of the few defenses available is “self-defense.” Since these activities are generally done quite privately, without witnesses, it is very hard for a woman to prove that her victim threatened her severely enough that she assaulted him truly in self-defense. Some legal advocates observed many battered women involved in violent relationships and constructed a constellation of typical behaviors called the “battered woman syndrome.” By showing that an accused defendant exhibited these behaviors, they could offer more convincing proof that she felt threatened and had good reason to believe her life was in jeopardy.

The creation of exemplary syndromes follows the standard logic of clinical reason: examination of individuals known to behave a certain way (for example, committing rape); identification of behavioral, physiological, or psychological traits; comparison of these traits with a group of “normal” individuals known not to exhibit the deviant behavior; and ultimately, comparison of a particular individual with the population norms as the basis for legal classification.

Clinical syndromes serve additionally as legal devices to mitigate punishment. In states where capital punishment is permitted, insanity and mental retardation have been used as criteria to stop a capital sentence.

28. For the political history of this issue area, see Nelson (1984). The seminal medical article that first defined the syndrome is Kempe (1946).
29. On the original development of “survivor syndrome” in the context of the Buffalo Creek flood in West Virginia, see Erikson (1976) and Stern (1984).
30. See Money (1990). Paraphilic rapist has the status of an experimental diagnostic category in the latest version of the psychiatry profession’s diagnostic manual, DSMIII-R.
Indeed, upon hearing an appeal by a man said to have become mentally ill after committing the crime but before the sentence was carried out, the U.S. Supreme Court articulated a rather bizarre notion of “competence to be executed” and concluded that insanity may render a person incompetent for this purpose.\(^{32}\) Criminal defense lawyers have created the syndrome of “fragile offender” to identify and designate people who are not capable of withstanding normal prison life. One of the most widespread uses of clinical reasoning to mitigate punishment is in predicting dangerousness, where psychologists use statistical models to determine whether an offender should be granted parole or put on probation.

As clinical authority enters the criminal justice system, citizens no longer tell their stories directly to each other, to judges, and to lay witnesses. Instead, clinical authorities construct “good guys and bad guys” by applying the tools of clinical reason. They become the arbiters of innocence and guilt, responsibility and incapacity, and truth telling and lying.

**Clinical Reason in the Regulation of Gender Roles**

Societal expectations and norms about the proper roles for women have been changing dramatically since World War II. Many conflicts center around motherhood: what it means to be a good mother, whether mothers should engage in paid labor or have careers, what kinds of jobs are appropriate for good mothers, and whether women should be able to choose whether to become mothers in the first place. These are highly politicized conflicts in which the sides tend to have intense feelings and are unwilling to compromise or adopt incremental reforms. Interestingly, clinical reason has become the dominant mode of discourse in these areas.

Social norms about good mothers are nothing new. The settlement house movement at the turn of the century was largely aimed at educating immigrant women with middle-class, white, Anglo-Saxon, Protestant values about household management and childrearing practices. Today there is a tremendous emphasis on a woman’s behavior during pregnancy as the indicator of proper motherly behavior, and to some extent, the mother-child relation has been drawn as one in which two people’s interests clash. States have begun to impose standards of good

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33. For a review of the literature, see Davis (1992, chap. 4).

34. Dorris (1989).
policies," the essence of which was to restrict certain jobs to men on the ground that these jobs could be dangerous to the fetuses of pregnant women. Restrictive fetal protection policies have been implemented almost exclusively in industries and job categories where women already constituted a small minority of the work force, and they have not been applied to men, despite evidence that offspring can be harmed by paternal exposure to toxic substances.35

This issue crystallized in the widely publicized case of Johnson Controls, a battery-manufacturing concern that excluded fertile women from its high-paying jobs involving lead exposure. The company presumed that all women between ages 15 and 70 are fertile and potentially pregnant and required female employees to produce medical documentation of infertility as a prerequisite to the desirable jobs. The terms of the legal conflict illustrate another use of clinical reason. Essentially, the debate was framed so that the question had a clinical answer: can pregnant women work in certain jobs without medical harm to their offspring? Or, slightly more broadly, can pregnant women work safely? That question requires the application of clinical reason to the individual, an inquiry into whether each female worker is pregnant or (as in some fetal protection policies) even merely fertile.36 An alternative framing of the question—one that does not take as a starting assumption that the model or normal worker is a man—might ask whether the job can safely be performed by any worker. That question would require an examination of all workers, not merely some to see if they deviate from a (restrictive) norm. Moreover, by making doctors the arbiters of a woman's potential pregnancy, the company treated women as if they were not agents in their own pregnancy, as if they were powerless to decide whether they wanted to become pregnant or to control their conception. A woman's knowledge that she was infertile, menopausal, sexually inactive, lesbian, or using birth control counted for naught in the company's eyes.

Finally, abortion is one more area where the regulation of conflict over gender roles has relied heavily on clinical reason. The availability of abortion determines whether women have choice about adopting the role of mother; restrictions on access to abortion obviously constrain that choice. Because most of the work of childrearing falls on women, as

36. This was the framing used by the majority justices in the 7th circuit in International Union, UAW v. Johnson Controls, Inc., 866 F.2d 871 (1989). The appellate court ruled for Johnson Controls, but its decision was overturned by the U.S. Supreme Court in International Union, UAW v. Johnson Controls, Inc., 113 S.Ct. 1196 (1993).

The clinical construction of the issue of abortion rights has meant that the fight about major social divisions according to gender was transformed into narrow disputes about clinical evidence: Does abortion cause psychological damage to mothers? Is the point of viability twenty-four weeks or twenty-six weeks? Is it possible to test fetuses in utero to determine their viability? The clinical construction displaces and masks the profound sociopolitical issue at stake: What roles can women have, and what degree of choice do they have in assuming those roles?

An alternative sociological construction of the abortion issue highlights the narrowness of the clinical construction. If one assumes that "viability" of a child entails not just sheer biological existence, but physical, mental and emotional development, then it is obvious that adult care is critical for viability. Assessing the availability of a willing adult caretaker would become a relevant question, and even questions about the quality of the relationship between mother and child would become relevant.38

All three examples of the regulation of gender conflict entail profound social conflict over the roles available to women, the authority to decide who may enter which roles, and the standards of behavior permitted to women in both the motherhood and work roles. In all three cases, clinical reason is invoked—by both sides—because of its important political

37. Luker (1984, especially chap. 8).
38. For a thoughtful and extensive relational analysis of motherhood and child development (quite explicitly contrasted with a clinical construction), see Goldstein (1988).
properties. It seems to reveal uncontroversial truths, it seems to be apolitical and objective, and it holds the potential for defusing intense political conflict. At the same time, however, clinical reason drastically narrows the terms of debate in areas of major social conflict. For that reason, it is likely to contribute to maintenance of the status quo.

Conclusion

These widely disparate examples of the rise of clinical authority in education, criminal justice, and the regulation of gender conflict elucidate different aspects of the use of clinical reason in the construction of citizenship. Clinical authority, when substituted for other forms of authority, profoundly changes the way social problems are defined, the political instruments used to resolve them, and the relative power of social groups. Through the rise of clinical authority, many of America's deepest social conflicts have been transformed into issues of clinical definition, classification, evidence, and judgment. It is worth speculating about why this transformation has occurred and what its consequences are.

Clinical reason has certain political properties that make it especially attractive to policymakers as a mode of conflict resolution. It accords with the liberal tradition of justifying differences in status and rewards by differences in individual achievement, merit, and even need. Clinical reason seems to give an independent source of knowledge to social and political authorities, rendering them less vulnerable to the (manipulative) desires of individuals; it offers a way to compel individuals to yield up socially relevant knowledge.

One question that has concerned social scientists is whether the medicalization of social problems is the result of professional imperialism—professionals seeking to enlarge their domains of power—or alternatively, whether social forces beyond the control of professionals are responsible. There is probably a grain of truth in both explanations. Because of its political properties, clinical reason offers politicians, judges, and other arbiters of dispute an attractive escape, or a way of defusing intense political conflict. These people are often all too eager to hand over a conflict to clinicians for resolution. There are many policy domains where clinicians are extremely reluctant to be drawn into political disputes, and where they resist providing clinical evidence for these purposes.

At the same time, once the pattern of conflict resolution through clinical reason is established, there are enormous incentives for professionals to serve the state, both by developing clinical paradigms of social problems and by applying clinical investigation to individuals. The state has become a major client for professional services, not just in its obvious role as payer and employer, but in its role as the ultimate political authority that now relies on clinical classifications and judgments as a major form of gatekeeping and conflict resolution.

The transformation of social problems into clinical syndromes is profoundly antihumanistic. It elevates a particular type of expert knowledge and denigrates or even ignores the knowledge, perceptions, and interpretations of ordinary citizens in their relations with other individuals and with social institutions. This sort of medicalization is also antiliberal. When clinical definitions of normality and deviation prevail, individual will or preference is no longer the standard for judging how a person should be treated. Citizens are prevented on the one hand from self-expression, and on the other, from using their own understanding and social experience to interpret the authenticity of other people's motives and claims.

The rise of clinical authority also constrains the realm of choice for individuals. The more clinicians define standards of healthy behavior—whether in learning styles, work roles, parental roles, or relations with others—the smaller the realm of deliberation and choice for individuals. To the extent that clinical authority constrains individual behavior as biologically determined or biologically limited, the importance of human will is also diminished.

Ultimately, the most profound consequence of the rise of clinical authority is that it disguises or displaces conflict in the first place. Once a situation is defined as a matter of health and disease, of normality and pathology, both the problem and its treatment appear to be dictated by nature and no longer a matter of value choice and political resolution.

References


