Il controllo sociale dei corpi: Biomedicalizzazione del genere e delle sessualità

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Argomenti della lezione:

- ✓ Perché la medicina può essere considerata uno strumento di controllo sociale
- ✓ Come il sistema della medicina può esercitare un controllo sociale sul genere
- ✓ Come il sistema della medicina può esercitare un controllo sociale sulle sessualità

Il quadro teorico

Costruzionismo sociale

- Ciò che definiamo “realtà” è colta dalle persone attraverso la mediazione di strumenti simbolici e cognitivi di natura sociale (come, ad esempio, il linguaggio)
- Una parte di questa realtà, la “realtà sociale”, è il prodotto dell’azione e dell’interpretazione delle persone. Le azioni delle persone creano la realtà sociale e, nello stesso tempo, la riproducono costantemente (talvolta, la trasformano)
- I prodotti delle azioni delle persone (che formano la realtà sociale) non vengono considerati come dei prodotti, ma come dati. La realtà sociale appare agli occhi degli uomini come «naturale e oggettiva»

Definizione di situazione

Se le persone definiscono certe situazione come reali, esse sono reali nelle loro conseguenze effettive

(Teorema di Thomas)

In science, just as in art and in life, only that which is true to culture is true to nature

(Fleck, 1979, p. 35)

Perché la medicina può essere considerata uno strumento di controllo sociale

Lo sviluppo della conoscenza e delle pratiche mediche sono il risultato di relazioni sociali e di potere e sono, quindi, dipendenti dal contesto storico-sociale in cui sono elaborate e soggette a continui cambiamenti e ri-negoziazioni

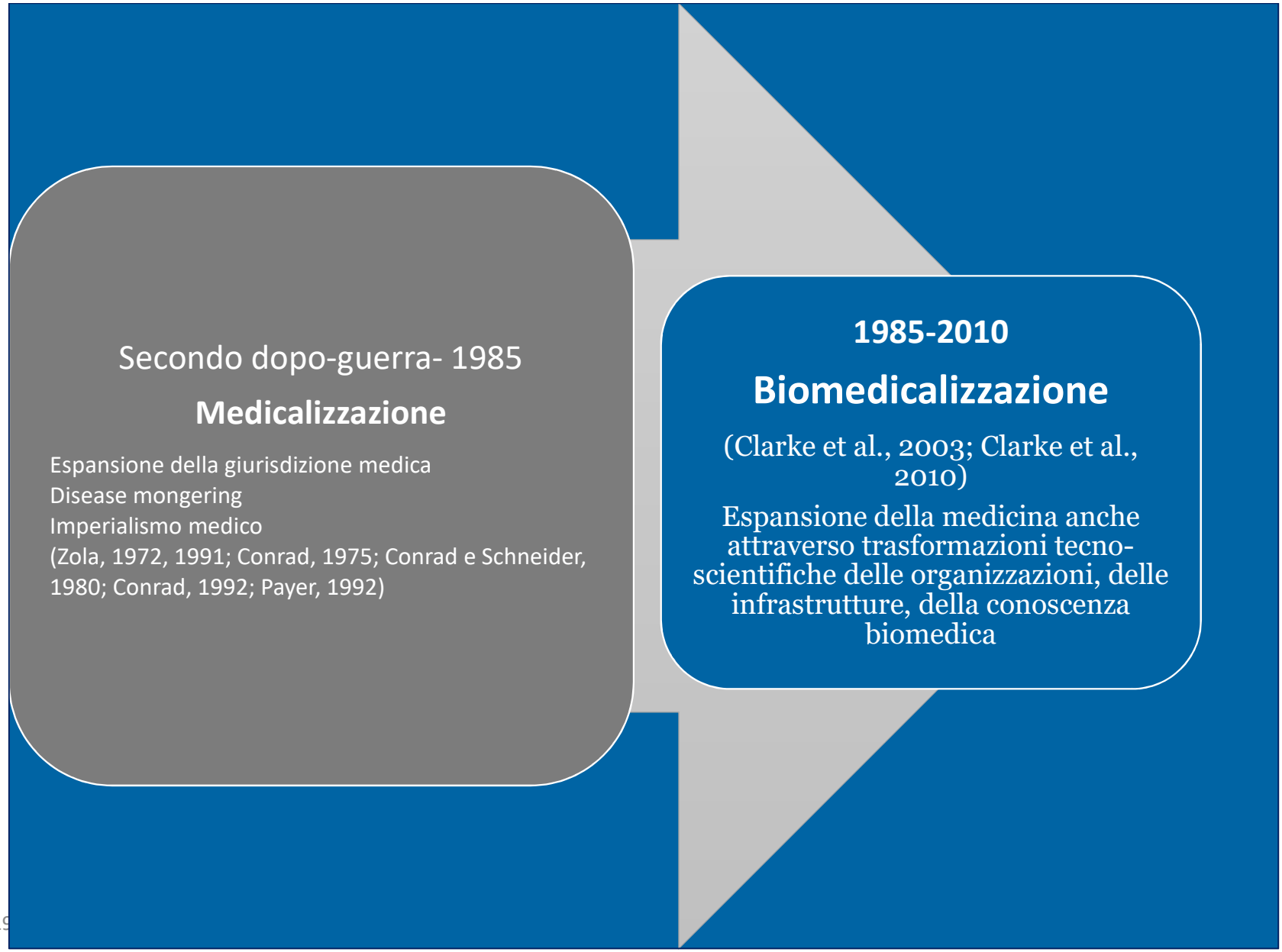
(D. LUPTON, Medicine as culture. Illness, Disease and the Body, 3rd ed., Sage, London 2012; B.S. TURNER, Medical Power and Social Knowledge, 2nd ed., Sage, London 1995)

La costruzione sociale di salute/malattia

Tratto da un testo di medicina del 1909, pubblicato in Inghilterra da dottori C. Allbutt e H. Rolleston, trattando degli effetti di una "sostanza" all'epoca assai utilizzata dai giovani riporta : «l'assuntore appare tremolante e perde l'autocontrollo; è soggetto ad attacchi di agitazione e depressione. Impallidisce e mostra un aspetto stanco… come con altri agenti simili, una dose ripetuta della sostanza [*poison*] fornisce un sollievo temporaneo, al prezzo, tuttavia, di un futuro tormento [*misery*]» (Gossop 1982: 5)

I DUE MEDICI
SI RIFERISCONO AL CAFFÈ

La medicina è considerata come un’istituzione rivolta ad esercitare funzioni di controllo sulle persone e di mantenimento delle strutture di potere e dei rapporti di forza tra categorie sociali contrapposte


Secondo dopo-guerra- 1985
Medicalizzazione
Espansione della giurisdizione medica
Disease mongering
Imperialismo medico
(Zola, 1972, 1991; Conrad, 1975; Conrad e Schneider, 1980; Conrad, 1992; Payer, 1992)
1985-2010
Biomedicalizzazione
(Clarke et al., 2003; Clarke et al., 2010)
Espansione della medicina anche attraverso trasformazioni tecno-scientifiche delle organizzazioni, delle infrastrutture, della conoscenza biomedica

La medicalizzazione

«Processo attraverso il quale un problema non medico viene definito come se fosse un problema medico ovvero, solitamente, come una malattia o un disturbo»

(Conrad 2007)

Medicalizzazione

One of my main concerns with the widespread medicalization of society is its transformation of many human differences into pathologies.
Differences in learning styles become learning disabilities or ADHD; divergences in sexual desires or performance become sexual dysfunctions (…); and individual differences become diagnoses such as social phobia or idiopathic short stature.
We have long turned normal life events into medical events, from conception to childbirth to menopause to aging.
We are now turning breast size, shortness, and male baldness into problems that are subject to medical enhancements.
Virtually any human difference is susceptible to being considered a form of pathology, a diagnosable disorder, and subject to medical intervention (Conrad 2008, p. 149)

	1st GENERATION			2nd GENERATION	Example
	Origin (Freidson; Foucault)	Imperialism (Zola; Conrad)	Iatrogenesis (Conrad;. Illich)	Optimalisation (e.g. Barilan; Clarke)	Childbirth (van Teijlingen)
Micro	-	Doctor-patient interaction	Social iatrogenesis	Individual bodies	Obstetrical versus midwifery practice
Meso	Institutionalisation of care	Institutional	Clinical iatrogenesis	-	Biomedical versus women-oriented ideology
Macro	Professionalisation	Conceptual	Structural iatrogenesis	Definition of normality	Medical versus social model

Biomedicalizzazione

(Clarke et al., 2003; Clarke et al., 2010)

Privatizzazione e mercificazione

Privatizzazione dei servizi sanitari e della ricerca biomedica, attraverso collaborazioni tra università e industrie farmaceutiche. Nuove stratificazioni nell'accesso alle cure

Rischio e sorveglianza

Paradigma di trattamento del rischio (il rischio di ammalarsi è di per sé malattia) e mercificazione della salute e degli stili di vita

Espansione di pratiche tecno-scientifiche

Emergere della biomedicina tecno-scientifica, molecolarizzazione, terapie genetiche, bioingegneria

Produzione e distribuzione della conoscenza

Produzione eterogenea di informazioni e conoscenza sul salute, malattia, medicina, ampiamente accessibile. Nuovi produttori di conoscenza: movimenti sociali per la salute, Internet, pubblicità, industrie farmaceutiche

Trasformazione dei corpi e delle soggettività

Corpi customizzati, individualizzati, nicchia di mercato ; farmaci e dispositivi tecnologici personalizzati

Cosmologie mediche

Cosmology	*Patron*	*Occupational role of investigator*	*Source of patronage*	*Perception of 'sick man' (sic)*	*Task of medical investigator*	*Conceptualization of illness*
Bedside	Patient	Practitioner	Private fees	Person	Prognosis and therapy	Total psycho-somatic disturbance
Hospital	State-Hospital	Clinician	Professional career	Case	Diagnosis and classification	Organic lesion
Laboratory	State-Academy	Scientist	Scientific career structure	Cell complex	Analysis and explanation	Biochemical process
Surveillance	State-Academy	Epidemiologist	Professional career structure	Risk assemblage	Convert epidemiological risk to clinical risk	Latent, deviation from norm

Surveillance medicine

(Foucault 1963; Conrad and Schneider 1980; Conrad 2008; Armostrong 1995; Ogden 1995)

- Dissolution of the boundary between health and illness
- emphases on symptoms in the eighteenth century, signs in the nineteenth and early twentieth and risk factors in the late twentieth century
- subject and object is the “risky self”

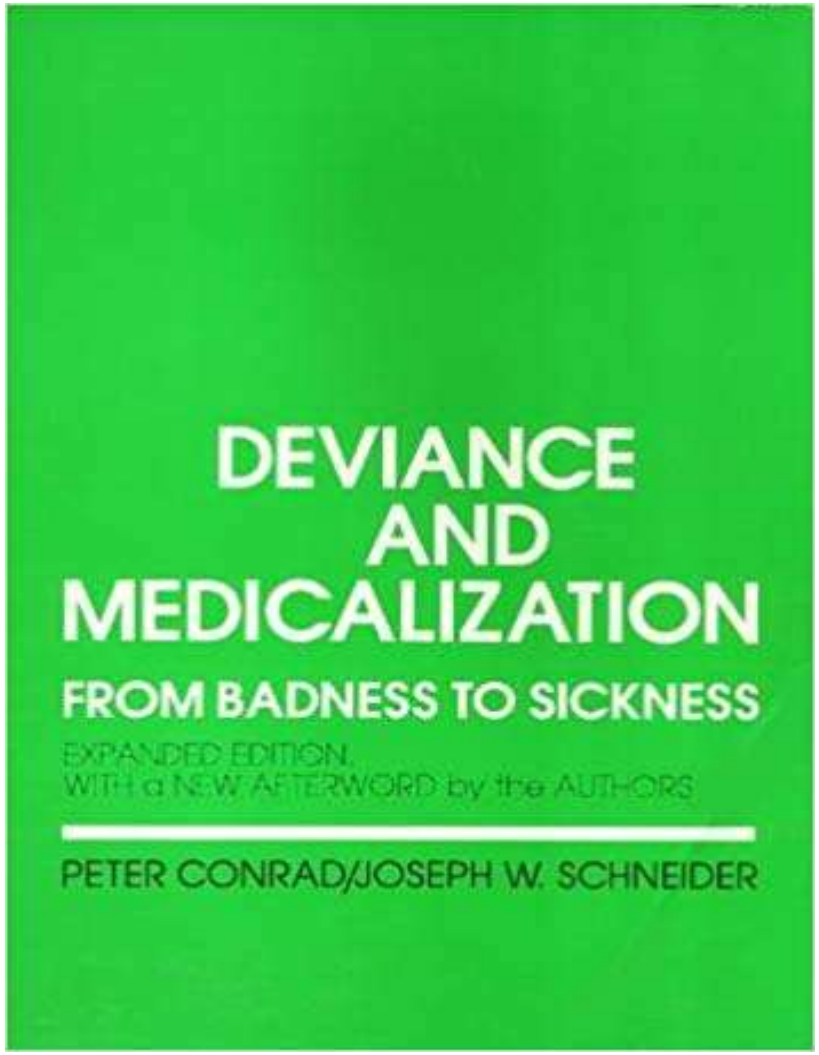
Come il sistema della medicina può esercitare un controllo sociale sulle sessualità: il caso dell'omosessualità

PROCESSO DI COSTRUZIONE SOCIALE DELL'OMOSESSUALITÀ MODERNA

A partire dal XIX secolo, la medicina ha svolto un ruolo decisivo nel modificare la definizione sociale attribuita all'identità sessuale delle persone omosessuali.

Nel modello medico, l'omosessualità deve essere intesa come una forma patologica di sessualità.

L'omosessualità diventa una ***condizione***, fisica e mentale, intrinseca a una categoria specifica di individui. Questa mutata concezione è stata propedeutica all'introduzione dell'omosessualità nella medicina, come oggetto di discorsi e di pratiche mediche



La costruzione sociale della condizione omosessuale

"Istinto sessuale contrario"
(J.C. SHAW, G.N. FERRIS, Perverted Sexual Instinct, «The Journal of Nervous and Mental Disease», 1883, n. 10, pp. 185–204)

«l'omosessuale del XIX secolo […] è diventato un personaggio»

(M. FOUCAULT, La volontà di sapere, Feltrinelli, Milano 2006, p. 42)

The Homosexual Role, Mary McIntosh

1. «se l'omosessualità è una condizione, allora le persone o la possiedono oppure no»; ciò vale a dire che la medicina ha prodotto schemi di classificazione dell'identità sessuale, organizzati in categorie distintive (omosessuale, eterosessuale, bisessuale), nelle quali riconoscere la propria appartenenza o l'estraneità.
2. crescente attenzione che la scienza medica dedica allo studio dell'eziologia dell'orientamento sessuale, ovverosia se la condizione sia innata o acquisita
3. All'interno di una società in cui l'omosessualità è socialmente condannata, tale concezione agisce come una forma di controllo sociale. L'etichettamento sociale che ne deriva, difatti, esercita un controllo sociale nella misura in cui permette alle persone di distinguere i comportamenti ammissibili, da quelli non accettabili e, in seconda battuta, separa il gruppo dei "devianti" dal resto della popolazione, relegando le pratiche non conformi ad un gruppo isolato di individui e rafforzando i comportamenti allineati ai ruoli sessuali socialmente approvati

Un’indagine condotta nel 1970 sugli atteggiamenti sociali della popolazione nord-americana rivela come oltre il 78% degli intervistati ritenga che l’omosessualità sia “una malattia che si può curare”

(E.E. LEVITT, A.D. KLASSEN, Public Attitudes Toward Homosexuality, «Journal of Homosexuality», 1976, vol. 1, n. 1, pp. 29–43)


Demedicalizzazione (1973, eliminazione della categoria diagnostica dal DSM)
La medicina ha continuato a considerare l'omosessualità come una condizione e a trattare la questione secondo una prospettiva medica

Le ricerche biomediche degli ultimi tre decenni tendono a concentrarsi su due aspetti: l'eziologia dell'omosessualità e l'individuazione degli omosessuali come "gruppo a rischio"

EZIOLOGIA DELL'OMOSESSUALITÀ

genetizzazione e
molecolarizzazione dell'omosessualità

Evidence for Homosexuality Gene

A genetic analysis of 40 pairs of homosexual brothers has uncovered a region on the X chromosome that appears to contain a gene or genes for homosexuality

How much of sexual orientation is determined by a person's genes, and how much by familial and cultural influences? That has proved to be an exceptionally controversial question. Several recent studies of twins and adoptive siblings have pointed toward a large genetic component in homosexuality, implying that a gene or genes should exist that create a predisposition for homosexuality, but there was no direct proof. Now, a team of geneticists at the National Cancer Institute has come closer to that proof.

On page 321, Dean Hamer and his colleagues Stella Hu, Victoria Magnuson, Nan Hu, and Angela Pattatucci report linking some instances of male homosexuality to a small stretch of DNA on the X chromosome. If the finding can be confirmed, it might eventually lead to a better understanding of the biological basis of homosexuality and of sexual orientation in general.

No one is breaking out the champagne just yet, however. The field of behavioral genetics is littered with apparent discoveries that were later called into question or retracted. Over the past few years, several groups of researchers have reported locating genes for various mental illnesses—manic depression, schizophrenia, alcoholism—only to see their evidence evaporate after they assembled more evidence or reanalyzed the original data. "There's almost no finding that would be convincing by itself in this field," notes Elliot Gershon, chief of the clinical neurogenetics branch of the National Institute of Mental Health. "We really have to see an independent replication."

Despite the caution, researchers familiar with the work say this study appears to have a very good chance of holding up because it avoids some of the methodological problems of earlier work. One way or the other, the verdict may be in before the end of the year since a replication can probably be performed quickly.

To look for a possible homosexuality gene, Hamer and his colleagues took a two-step approach. First they recruited 76 homosexual men and traced out pedigrees for each, determining which other members of each family were themselves homosexual. They found 13.5% of the gay men's brothers to be homosexual—much higher than the rate of 2% or so that the Hamer group measured in the general population. (While this is lower than previous estimates of 4% to 10%, other recent studies have come up with similar low figures.) Earlier studies had also found that brothers of homosexual men are more likely to be homosexual than are men in the general population.

But once Hamer and colleagues ventured outside the immediate family, they found something new. "When we collected the family histories," Hamer says, "we saw more gay relatives on the maternal side than on the paternal side." In particular, they found homosexuality to be significantly more common among maternal uncles of gay men and among cousins who were sons of maternal aunts than it is among males in the general population.

This implied that, for some male homosexuals at least, the trait is passed through female members of the family. And this in turn gave the researchers an obvious place to start looking for a homosexuality gene: the X chromosome, the only chromosome inherited exclusively from the mother.

To search for such a gene, Hamer recruited 40 pairs of homosexual brothers, took DNA samples from each, and performed a genetic linkage analysis using gene markers. The idea behind the analysis is simple: On average, each pair of brothers will have about half the DNA on their X chromosomes (and other chromosomes) in common. If both brothers are homosexual because they inherited a particular gene on the X chromosome, the gene must lie somewhere in the shared sections of the chromosome, which can be identified by the gene markers. The researcher examines many pairs of brothers, looking for a stretch of DNA that all or most of them have in common. If such a stretch exists, then it probably contains the target gene.

X marks the spot. The markers indicated pointed to Xq28 as the possible gene site.

HAMER ET AL.

When Hamer and colleagues performed their analysis, they found that such a shared stretch did indeed exist. Of the 40 pairs of brothers, 33 pairs shared a set of five markers located near the end of the long arm of the X chromosome in a region designated Xq28. It's unlikely the linkage between the markers and the homosexuality trait was due to chance, Hamer says. The linkage has a LOD score of 4.0—a technical measure that translates to a 99.5% certainty that there is a gene (or genes) in this area of the X chromosome that predisposes a male to become homosexual.

Hamer warns, however, that this one site cannot explain all male homosexuality. Although his pedigree analysis showed that the homosexuality trait is usually maternally inherited, he did see some families where the trait seemed to be passed paternally. And even among his 40 sets of brothers, chosen so that there was no evidence of the trait passing through male family members, seven sets of brothers did not share the stretch of Xq28 where the gene appears to lie. Instead, Hamer says, it seems likely that homosexuality arises from a variety of causes, genetic and perhaps environmental as well.

Still, researchers can hardly wait to get their hands on the gene in order to study just what it does. "It's very exciting," says Michael Bailey of Northwestern University in Chicago, co-author of a study 2 years ago that found half of the identical twins of gay men to be themselves gay. "If we can find a gene for sexual orientation, we can start to find out what the gene does."

The list of questions to be asked about

DARROW MONTGOMERY

Gene team. Dean Hamer, and *(from left)* Stella Hu, Nan Hu, Angela Pattatucci, and Victoria Magnuson are studying the genetics of sexual orientation.

Studio pubblicato nel 1993 sulla rivista *Science:*

Hamer, Magnuson e Pattatucci avrebbero individuato una correlazione tra il marcatore genetico Xq-28 del cromosoma X e l'omosessualità maschile

Un sondaggio condotto da Gallup su un campione rappresentativo di americani registra un dato rilevante. La proporzione delle persone che ritiene che gli omosessuali siano tali dalla nascita è costantemente cresciuta nel tempo: nel 1978, era il 13%, nel 2015 era il 51%, con un rapido aumento avvenuto proprio durante gli anni Novanta

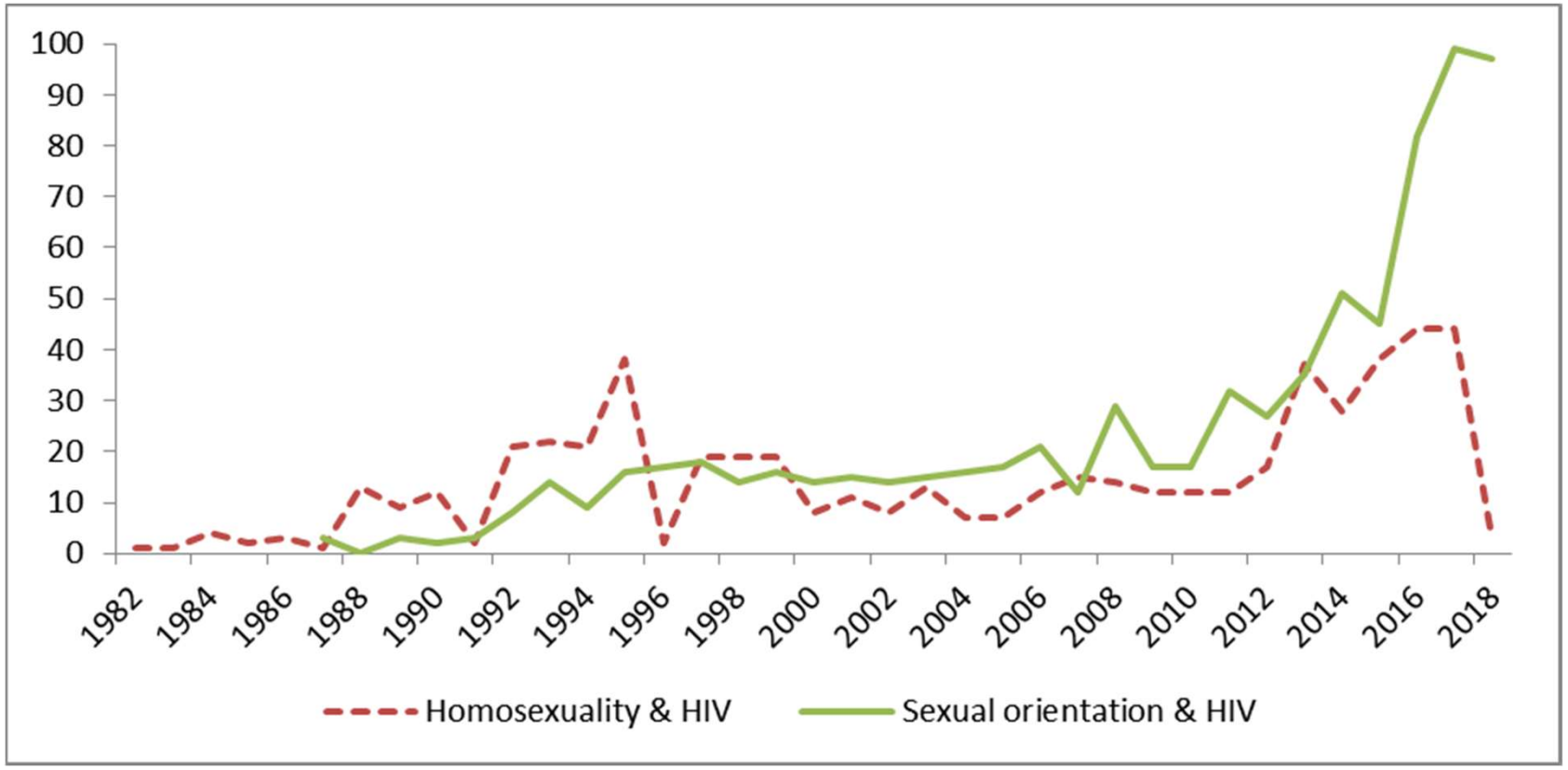
(Ricerca Gallup, disponibile al sito: https://news.gallup.com/poll/183332/majority-say-gays-lesbians-born-not-made.aspx; consultato il 29 marzo 2019)

Omosessuali
come gruppo a rischio

Gay Compromise Syndrome

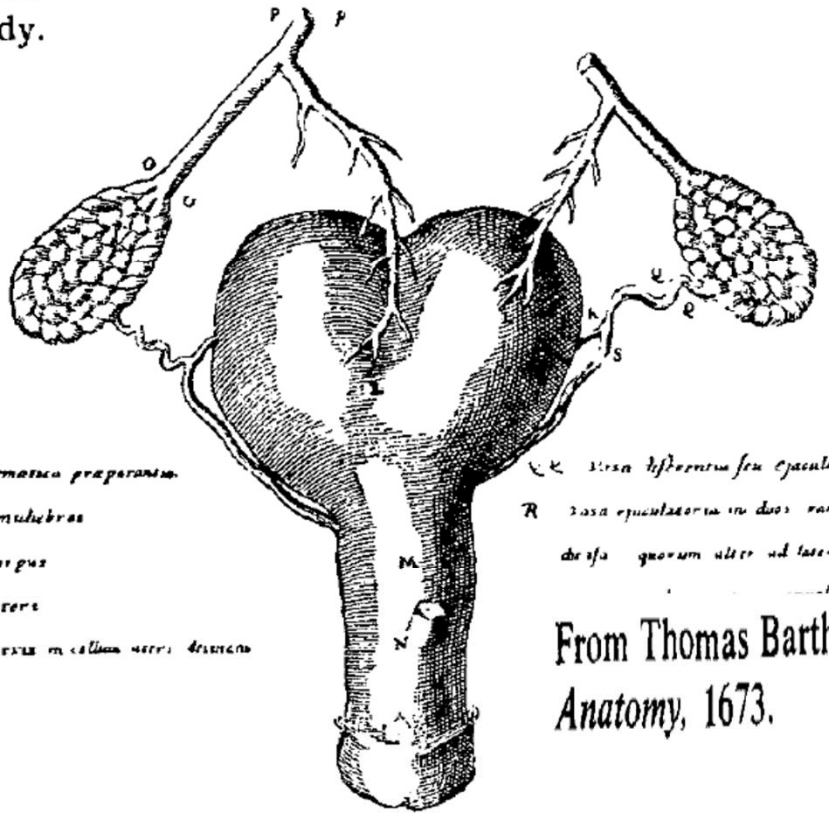
Nel 1981, i medici R. Brennan e D. Durack pubblicano una comunicazione nella sezione Lettere al Direttore della rivista “The Lancet”, in cui attribuiscono a questa nuova malattia il nome di Gay Compromise Syndrome

Articoli indicizzati in PubMed, contenenti nel titolo e/o nell'abstract i termini "Sexual orientation and HIV" e "Homosexuality and HIV" (1982-2018)

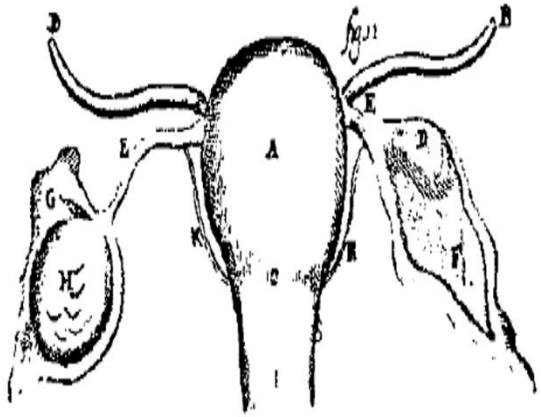


Come il sistema della medicina può esercitare un controllo sociale sul genere

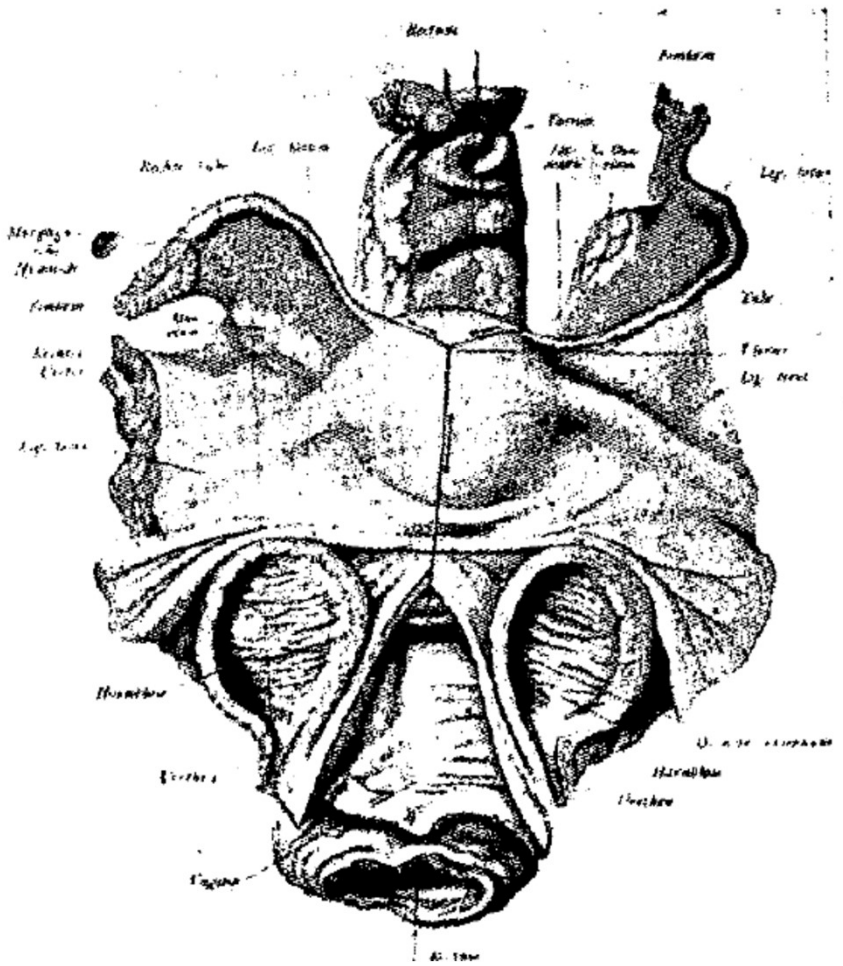
From Andreas Vesalius' books on the structure of the human body. After Fontanus 1642.



From Thomas Bartholin's *Anatomy*, 1673.



From Coelestin Nauwerck,
Technique of Dissection,
1912.



THE HYSTERICAL WOMAN: SEX ROLES AND ROLE CONFLICT IN 19th-CENTURY AMERICA

CARROLL SMITH-ROSENBERG

Social Research
Vol. 39, No. 4 (WINTER 1972), pp. 652-678

Alcuni aspetti della vita medicalizzati

- Dolore (fisico e psichico)
- Morte
- Parto
- Insonnia
- Depressione/Disturbi dell'umore
- Iperattività dei bambini
- Attacchi di panico/Disturbo da ansia generalizzata (*Generalized anxiety disorder*)
- Ciclo mestruale
- Menopausa

Il caso del ciclo mestruale

Negli ultimi anni, la condizione psicofisica della donna nei giorni che precedono il ciclo mestruale è peggiorata (?!):

da semplice sindrome (*Premenstrual Syndrome*)…

a vera e propria patologia (*Premenstrual Dysphoric Disorder*)

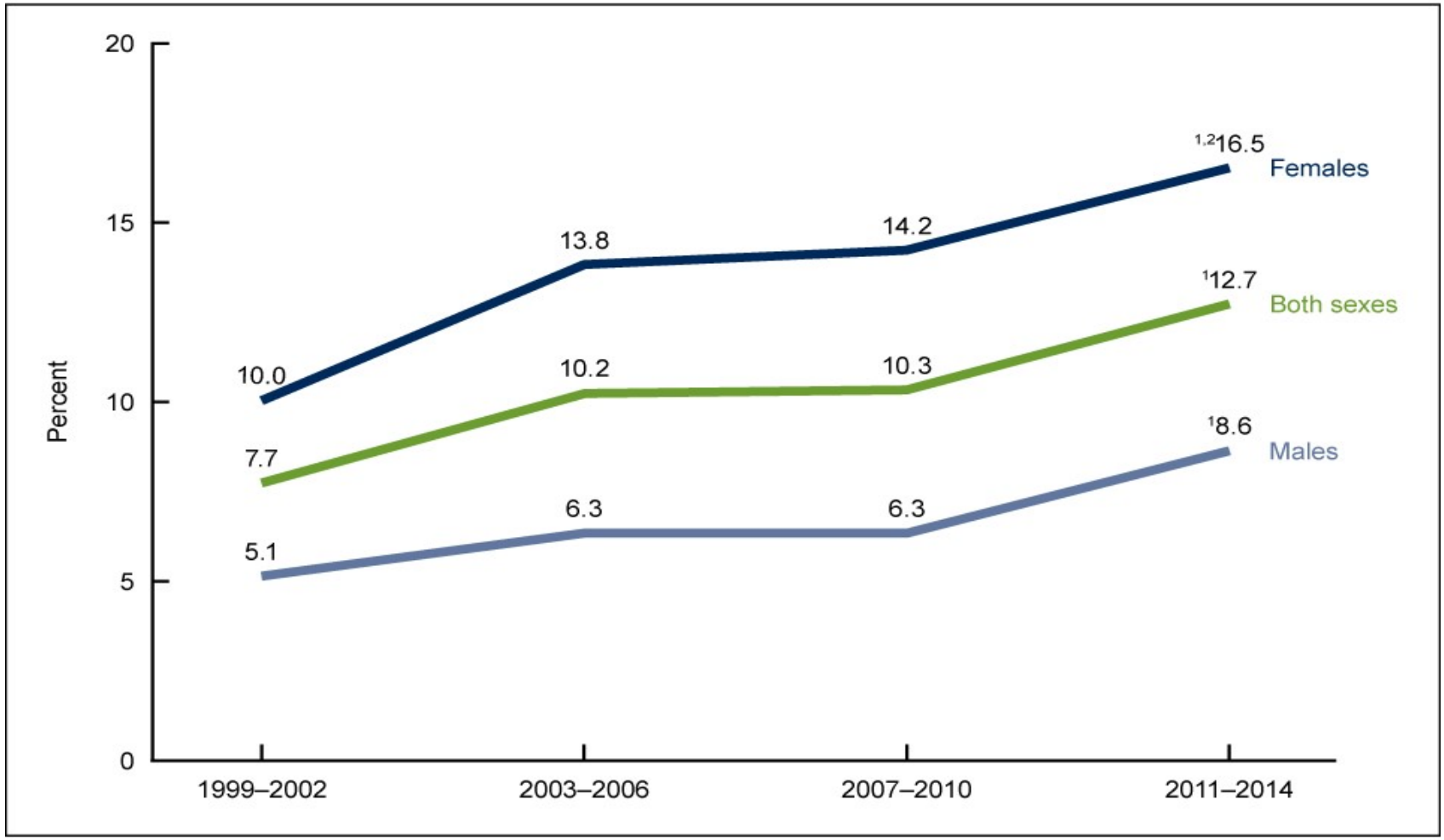
Table 1. Symptoms Associated with Premenstrual Syndrome and Premenstrual Dysphoric Disorder

Physical	Psychological and Behavioral
Abdominal bloating	Anger, irritability
Body aches	Anxiety
Breast tenderness and/or fullness	Changes in appetite (overeating or food cravings)
Cramps, abdominal pain	Changes in libido
Fatigue	Decreased concentration
Headaches	Depressed mood
Nausea	Feeling out of control
Swelling of extremities	Mood swings
Weight gain	Poor sleep or increased need for sleep
	Tension
	Withdrawal from usual activities

Information from references 2 and 3.

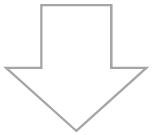
https://www.youtube.com/watch?v=2TPtuPt_5Uc

Figure 4. Trends in antidepressant use among persons aged 12 and over, by sex: United States, 1999–2014



[1]Significant increasing trend.
[2]Significantly higher than males for all years.
NOTE: Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db283_table.pdf#4.
SOURCE: NCHS, National Health and Nutrition Examination Survey, 1999–2014.

Too much medicine?



Over - diagnosis

Driven by
Increasingly sensitive tests finding things that didn't need finding
Expanded definitions of disease/lowering of disease thresholds
Creation of pseudo-diseases (disease mongering)
Clinicians fear of missing a diagnosis, or of litigation
Public enthusiasm for screening
Policy maker/commercial enthusiasm for screening and prevention
Patients' desire for testing for reassurance
Financial incentives

thebmj

MAURO FERNARIELLO/SPL

Should we screen for breast cancer?

Polarised arguments about the benefits and harms of breast screening are not helping women to make an informed decision. **Klim McPherson** looks at the evidence and calls for dispassionate analysis of all available data

The burden of breast cancer is unremitting and we must do anything we can to contain it. It seems obvious that detecting tumours before they are clinically apparent is a good idea. But screening all women aged 50-70 every three years is but one way of containing the disease, and its appreciable financial costs need to be borne in mind (£75m (€90m; $110m) a year in the UK: £37.50 per woman invited and £45.50 per woman screened).

Screening for a progressive disease is justified

and 32% for those aged 60-69.[4] The effect in women over 70 is estimated from only one trial with too little precision. These effects might seem adequate, but under age 60 the pooled effects are of marginal statistical significance, while some large trials show no benefit. Worse still, estimated numbers of women needed to be invited to a US screening programme in order to save one life are high. For the younger group it is nearly 2000 while in those aged 60-69 it is still nearly 400. The box

Reducing breast cancer burden

The incidence of breast cancer has risen by 50% since 1980, although age standardised mortality is thankfully falling (by 35%).[8] The reduced mortality is mainly down to a valiant concentration on therapeutics, research, and practice and a strong commitment to rationalise cancer services in the NHS. But screening has had its effect too: both on the rise in incidence and on the fall in mortality. Quantifying these relative effects when much else

HOME SEARCH The New York Times

HEALTH

Vast Study Casts Doubts on Value of Mammograms

By GINA KOLATA FEB. 11, 2014

One of the largest and most meticulous studies of mammography ever done, involving 90,000 women and lasting a quarter-century, has added powerful new doubts about the value of the screening test for women of any age.

It found that the death rates from breast cancer and from all causes were the same in women who got mammograms and those who did not. And the screening had harms: One in five cancers found with mammography and treated was not a threat to the woman's health and did not need treatment such as chemotherapy, surgery or radiation.

The study, published Tuesday in The British Medical Journal, is one of the few rigorous evaluations of mammograms conducted in the modern era of more effective breast cancer treatments. It randomly assigned Canadian women to have regular mammograms and breast exams by trained nurses or to have breast exams alone.

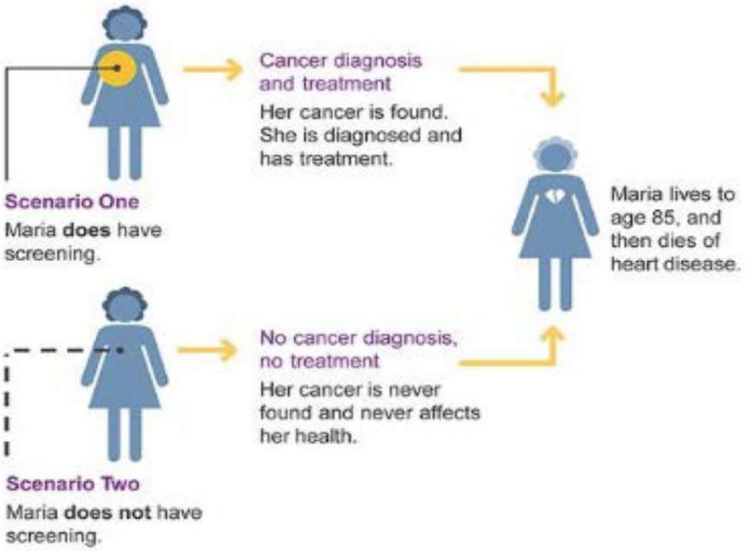
Twenty five year follow-up for breast cancer incidence and mortality of the Canadian National Breast Screening Study: randomised screening trial

Anthony B Miller, Claus Wall, Cornelia J Baines, Ping Sun, Teresa To, Steven A Narod

BMJ 2014; 348:g366 (Published 11 Feb 2014)

Over-detection: an example

Imagine a woman called Maria who develops a small, slow-growing breast cancer in her 50s or 60s. The picture below shows two possible scenarios that could happen to Maria: Scenario 1 (top) is with screening, and Scenario 2 (bottom) is without screening.



Maria's life span is the same, whether or not she has screening. So if she has screening, she experiences over-detection (a diagnosis and treatment she does not need).

Putting it together

For women in Australia who have breast screening over 20 years:

4 out of 1000 women avoid dying from breast cancer, and 19 out of 1000 women experience over-detection.

So that means **more women experience over-detection than avoid dying** from breast cancer.

HerschJ, Barratt A, Jansen J, et al.
Lancet, 2015;385, pp. 1642-52.