EQUILIBRIUM OF SOCIETAL PARADIGMS: A THEORETICAL ANALYSIS OF THE COMBATIBILITY OF MEDICALIZATION AND INCLUSION

Pro gradu- tutkielma
Laura Puumala
Turun yliopisto
Kasvatustieteiden laitos
Erityispedagogiikka 17.12.2018

TURUN YLIOPISTO
Kasvatustieteiden laitos

PUUMALA, LAURA: Equilibrium of Societal Paradigms: A Theoretical Analysis of the Compatibility of Medicalization and Inclusion

Pro gradu- tutkielma, 104 s.
Erityispedagogiikka
Joulukuu 2018

In this thesis, the social paradigms of inclusion and medicalization are analyzed through theoretical research methods. The two paradigms are simultaneously present in our modern western countries, guiding our understanding of and reactions to deviance and disability. The aim of this study is to examine if these two paradigms are compatible with each other, or if they cause contradictions and conflict in the definitions and demarcations of normality and deviance.

This is a theoretical study, where the traditional methods of analytical philosophy are applied. Most widely used methods in this study are concept analysis and reflective equilibrium. Through these methods, the concepts of inclusion and medicalization, as well as of normality and deviance, are analyzed, and their similarities and differences are evaluated in a holistic manner.

This thesis comes to a conclusion of profound contradictions between the paradigms of inclusion and medicalization. Although, there are some similarities between the ideologies and the historical package of these paradigms the differences between them greater, both in number and severity. Great differences themselves do not necessarily mean that the paradigms are incompatible, in this thesis it is argued that the differences between inclusion and medicalization are by their nature such that contradictions are incompatible. To solve this conflict, firstly, more explicit discussion and clearer definitions of the key concepts are needed. This thesis aims to accomplish at least that much. Further, also critical analysis and evaluation of the premises and policies of the two paradigms is also needed. This thesis also hopes to take a step into that direction.

Key concepts: inclusion, medicalization, normality, deviance, disability, sick role, societal paradigms, concept analysis, reflective equilibrium.

TABLE OF CONTENTS

1. INTRODUCTION

Social sciences and social-political debate is characterized by the changing dominance of different paradigms. In the lay-man discussions these paradigms are different frameworks and ways of understanding and seeing the world and its phenomena. In the academic fields these are the presuppositions and theoretical basis on which the research is conducted. (Stanford Encyclopedia of Philosophy[1] 2016; Kuhn 1985) These paradigms may change over time and culture, but each predominant paradigm has social power to control and regulate the society in which it is currently dominant (see Kuhn 1985). Two of the most influential frameworks in the western world at the moment are the paradigms of *medicalization* and *inclusion*. In this thesis, I will study the connection and compatibility of medicalization and inclusion.

Medicalization (*suom. medikalisaatio, lääketieteellistyminen*) means, that some phenomena and problems of human existence become defined, explained and treated in medical terms. Medicalization in itself means "to make medical", to view the phenomena predominantly through the science of medicine, and to include it to be primarily medical phenomena. However, in the social debate a negative connotation is often given to medicalization, as it is thought to mean exclusively *over medicalization* or *unfounded medicalization* (*suom. ylimedikalisaatio, aiheeton medikalisaatio*). (Conrad 1992, 209–210.)

Inclusion (*suom. inkluusio*), for one, means to include, welcome or accept someone or something in opposition of segregation and exclusion. (see Biklen 2001; Lipsky & Gartner 1999; Saloviita 1999; Turnbull 2016; Väyrynen 2001) The definition of inclusion in social settings is quite imprecise and it can be used to mean both a theoretical ideal, a

---

[1] from now on SEP.

philosophy of life, or more concrete, practical arrangements and setups – or anything in between. In the narrowest sense of the word, it can be understood only as a shared physical location. For example, when different people are placed in the same physical space, for instance in a classroom. On the other hand, inclusion can be seen as an ethos against discrimination, where our differences are taken as a value neutral starting point, not only for *equality*, but also for *fair* and *just* treatment, for genuine tolerance and participation of everyone. (Biklen 2001, 55–59; Lipsky & Gartner 1996; Lipsky & Gartner 1999; Saloviita 1999, 13; Väyrynen 2001, 12–21.)

The research problems of this thesis are built upon the different ways the concepts of *normality* and *deviance* are defined in the paradigms of medicalization and inclusion. Traditionally, the concepts of *sickness* and *health*, and the boundaries between these two, have been more central and important for the medical perspective. Nowadays, however, as the progress of medicalization is actually the quickest in the field of psychology, the concepts of normality and deviance have increased their significance, and even replaced the meanings of sickness and health in certain contexts (see Conrad & Schneider 1992, Watters 2010, Zola 1972). Inclusion, on the other hand, may be understood as a way to *relate* to deviance and abnormality. Along the lines of the ethos of inclusion, human difference and diversity are thought of as a starting point for social life. At the same time, however, it is also thought that ultimately people are essentially always more alike than different. So, what we all share as humans is way more significant than that which separates us. This notion is sometimes called *the dilemma of difference*. (Lipsky & Gartner 1996, 792.) Thus, it is the job of a truly just and *fair* society to take into account these supposed differences in a right way; not overemphasizing them, but constructively and committedly supporting individual features and skills in a way, that guarantees the same *rights* and *possibilities* for everyone. (Graham-Matheson 2012, 13–14; Lipsky &

Gartner 1996, 763-767.) In contrast to this, medicalization is more of a way to *erase* deviance and abnormality, and bring the deviant people "back to normality" much the same way the medical sciences aim to erase or alleviate sickness and make people healthy again. This implicitly means, that deviance and certain differences are unwanted and in need of changing by intervention, and precisely in a need of *medical* intervention. (Conrad & Schneider 1992, 32.)

The main research question of this thesis is: In what way and to what extent the basic principles of medicalization and inclusion are theoretically compatible? I search the answer to this question by first analyzing the ways, that both of these paradigms respectively define the characteristics and conditions of the pivotal concepts of normality and deviance. From this analysis follows a second question of, how these paradigms relate to these concepts. In other words, what theoretical attitudes these paradigms imply to the phenomena of deviance and normality? Also, a more applied question follows: What practical implications these paradigms have on dealing with normality and deviance in the society, and in the school world especially?

Medicalization and inclusion are largely defined by the conceptions on, and attitudes toward normality and deviance. By comparing the domains and definitions of these notions, and the logical consequences of the theoretical attitudes these paradigms hold, it can be analyzed, to what extend these paradigms share the same values, principles and objectives, and how much they differ from each other. In the case of different definitions, attitudes and objectives amongst the two paradigms, it is possible to determine, if these differences are conceptually contradicting each other, or if it is possible for them to live side by side without a logical conflict. In this thesis, I will support the view, that there are some fundamentally contradictory differences between inclusion and medicalization, and that these differences make it logically impossible for these paradigms to exist harmoniously together, without either a further division of domains or some supplemental conciliatory definitions. However, I will also note, that there are some common factors and some mutually supportive notions among these two paradigms, but the similarities seem to be more superficial than the differences.

My hypothesis is, that although both of these paradigms operate largely on the same concepts of normality and deviance, the definitions they give to these concepts are decisively different. To take things further, the differences in these definitions lead to contradictory conclusions, for example, on how to deal with deviance and abnormality, and how to manage the problems and challenges they provoke in the society. The supposed conclusion is, that although medicalization and inclusion may also support each other to some extent, to combine the basic principles of medicalization with the philosophy of inclusion will nevertheless be hard at best, and logically contradictory, at worst.

On the other hand, some may speculate, that the process of medicalization has opened the door for inclusion, or more precisely – and quite literally – for the deviant people, who earlier used to be defined as either sinners or criminals and thus were locked away. These definitions did not encourage tolerance or inclusion, and accomplished little more than segregation and punishment of already challenged and marginalized people. (Conrad & Schneider 1992, 17–57; Vehmas 2005, 53–59.) Compared to these historical perspectives on deviance and abnormality, both medicalization and inclusion represent progress toward a more merciful attitude. Medical language and intervention, for example, can be argued to remove and relieve the stigma of being different and deviant. In doing so, medicalization may in fact encourage inclusion and acceptance of widely different individuals back into the society. Furthermore, in some cases medical treatment will bring the deviant people closer to the accepted mean, or the so called normality, which of course, automatically makes it easier to include these people. (see Turnbull 2016.) However, I argue that it is precisely this aim to bring those defined as deviant closer to the socially accepted norm, that in fact stands against the most profound philosophical ideals of inclusion.

Along these lines, I assume, that medicalization may be found to go well together or even support the physical and spatial inclusion in society and its institutions, like the school institution. However, on the other hand, it may be contradictory, as for the most profound ideals, and most comprehensive practical implications of inclusion. Also, it has to be noted, that medicalization is not necessarily the only, or even the best, way to advance and facilitate inclusion. The ways in which medical sciences explain and treat certain problems and challenges of human life, may in themselves be harmful or cause negative side effects. To overcome the shortcomings and harmful effects of medicalization, the theory of social constructionism has been suggested as an alternative framework for understanding and reacting to deviance. (see Conrad & Schneider 1992; Vehmas 2005, 119–124).

The theme and research questions of my thesis are important and meaningful, because our attitudes, prejudices and beliefs guide the way we act around different people, and how we face and treat deviant individuals (Cornwall 2012, 135). The research is actual, as both paradigms are prominent in the society at the very moment. If they are in contradiction with each other, the problems most likely reflect to practice and the real word. In this case, the consequences, both for the individual, as for the specific institution or the whole society in which these actions are implemented, may be very concrete and grave. This study is also actual in the educational discussion specifically, because schools are one of the main playgrounds of inclusion at the moment. In the ethos of promoting inclusion, exceedingly diverse and different pupils, with their own individual capabilities and dispositions, come to the so called “ordinary” or “normal” classes and class rooms (see Skrtic 1991; Singer 1988; Kauffman & Hallahan 1993; Mock & Kauffman 2002). At least in Finland, the study program of the Department of Teacher Education does not yet seem to follow this trend. For example, the special educational teaching and experience provided by the studies of the future class teacher are almost nonexistent, although these would provide precisely the knowledge and skills now needed to answer the modern challenges of any teacher’s working life. (Pinola 2008, 40–43; Tutkinto-ohjelma 2018–2020.) Especially, when actual teaching and direct experiences are lacking, the prejudices and personal opinions of these to-be teachers will significantly influence their actions and attitude towards the different learners in their classroom. (Pinola 2008). Also, medicalization is an actual research topic in the context of education, because one of the most rapidly medicalizing fields is the field of psychology and psychiatry (Watters 2010, 3–5) which come close to educational sciences, and many forms of very mundane and typical deviances that teachers encounter in their work every day.

2. RESEARCH SETTING AND METHODS

This study is conducted by theoretical research approach. Answers to the research questions are searched on an analytical and conceptual level by non-empirical research methods. In a theoretical study, like this one, the methods of the analysis and the analysis itself are often so closely intertwined, that it is really hard, if not impossible, to make the difference between the two, or at least the difference will be rather artificial. In this thesis, the research material consists entirely of literary sources in the fields of philosophy, sociology and education. Most important and relevant pieces to this study on medicalization are the writings of Peter Conrad and Joseph W. Schneider, Irving Kenneth Zola, and those of Guy Kahane and Julian Savulescu, as well. When it comes to inclusion, most widely used pieces in this thesis are those of Helen Turnbull, Dorothy Lipsky and Alan Gardner. Especially on inclusion, also many Finnish sources are used in this study, although the thesis is not confined to the Finnish society or educational system, nor any other, as the research takes a more theoretical stance.

The most central methods of analysis in this study are *concept analysis*, *reflective equilibrium* and thought experiments as well as logical arguments in an informal form. Concept analysis (*suom. käsiteanalyysi*) means the definition of concepts, and the evaluation of these definitions, on the basis of how logically coherent they are, and how precisely they denote the wanted meaning of a given concept. The aim of concept analysis is to find and define the necessary and sufficient conditions, where the definition applies. (see Jackson 1998.) By concept analysis it is possible to specify the definition of the concepts, deepen their meanings, and on one hand, compare different concepts with each other, while also, on the other hand, comparing the superiority of different definitions of the same denoted concept. Concept analysis can be seen to consist of different phases or parts, although these are not in any specific order, or may not even be distinguishable from each other. A few of these phases, that can be noticed later on in this study are the designation of the critical features, the demonstration of different interpretations, the examination of proximate concepts and the forming of different examples on where, and how the concept and/or the definition can be used. (Puusa 2008, 36–41.)

Without going any further in to the epistemology, concepts can be understood as the tools of thought or *mental representations*. The latter is to say that they convey a meaning or carry a *mental content*. Therefore, concepts are psychological entities, which enable our cognitive functions, such as classifying, remembering and making inferences. Concepts can also be seen as a bridge between the mind and the factual world or between language and reality. Concepts denominate entities and states of affairs in the real world. In the *fregean* sense, on the other hand, concepts do not necessarily pick up real targets or events in the world. That is to say, they do not need to refer to any actual things or concrete events in the world. Instead, it suffices if they have *a sense*. This means, that by concepts we can also refer to things that are abstract, supernatural, contra factual or nonexistent, much like mythical creatures, for example. (SEP 2011.)

Our linguistic communication is based on concepts. Language in itself, describes and mirrors the reality but also modifies and reconstructs it. If we either talk of the same thing by different concepts, or use same concepts to describe different things, the possibility of misconception and misunderstanding is evident. Our layman terms and ordinary language greatly differs from academic and scientific language and terms, not to mention formal logical language. All the research is based on concepts, and the better a researcher can define her concepts, the more precise and well based her choices and conclusions will be. (Puusa 2008, 37-38.) So, to clarify and analyze the concepts of any research is important in itself, but at the same time, concept analysis also gives a justification for the *a priori* nature[2] of theoretical research. In analytical theoretical philosophy, there is an assumption, that the concept analysis will reveal the meaning of the concept by identifying its *necessary* and *sufficient conditions*[3] and by making the distinction between

---

[2] *A priori* means non-empirical or pre-observational. This means that in *a priori* reasoning conclusions can be made via deduction and theoretical logical reasoning only. (Aspenson 1998, 34.)

[3] Necessary condition is a condition that has to be fulfilled for the definition or argument to be valid. However, the necessary condition alone may not be enough for the definition or argument to be comprehensive. Sufficient condition is a condition that even alone can fulfill the definition or argument. The condition can be both necessary and sufficient. (Aspenson 32-33, 43; SEP 2017)

these two. Actually, this is possible *only* a priori, that is to say, only by *non-empirical* means. (SEP 2011.)

Reflective equilibrium (*suom. harkitun tasapainon menetelmä*) is a method of philosophical analysis in which separate assumptions, definitions and principles are evaluated and compared with each other in a process-like manner, to form a coherent set of beliefs, or a logically valid argument. (SEP 2016; Rawls 1971, 19–21, 48–51). The aim of this method is the highest possible level of coherence between the lower level judgements, intermediate level principles and the highest theories. (Arras 2009; Daniels 1996.) In this thesis, I use a method of *wide reflective equilibrium*. With this method, it is also possible to take into account the background theory. In this study, the background theory is sociological and has to do with the historical frameworks of deviance and normality. Assumptions that rise from this background to the research at hand, are the existence and nature of different frameworks in our society and the social power, authority and control they have over the members of the said society, or over the common atmosphere in that society. The sociological background theory can also take into account the change between different social paradigms and the evolution of social opinions over time. This theoretic-historical framework is further examined in chapter 5.

With the method of reflective equilibrium, it is possible to weigh the costs of different assumptions, so to say. In doing so, it is then possible to evaluate which assumptions or principles must be renounced in order to maintain the harmony between the basic principles and assumptions. These basic assumptions often rise from the background theory, and therefore, I find it more justifiable to use the wide reflective equilibrium, to explicitly take the background assumptions into account. Moreover, it is also possible to include empirical propositions and results into the process of reflective equilibrium. In this research, such applied empirical arguments are, for example, findings on the application of inclusion in practice, experiences over medical interventions, the contents of the doctor's oath (*suom. lääkärinvala*) and other concrete documents and treaties on inclusion and medicalization.

Considering that the aim of this thesis is to clarify the definitions of medicalization and inclusion, and to formulate a coherent analysis on how well (or how badly) they fit together on a theoretical level, the method of reflective equilibrium is well suited for my research agendas. The aim is not to come to any definitive solution or to find "the right answer", as this is rarely even possible in theoretical research context. Instead, it is enough to demonstrate, that the basic principles of medicalization and inclusion are in a fundamental contradiction with each other. The primary aim of this thesis is not to examine or analyze the documents, treaties or laws around these two social frameworks.

Firstly, when applying the method of reflective equilibrium, it is important to identify the so called reflected judgements (*suom. harkittu arvostelma*), ergo the basic assumptions or preconceptions where the analysis starts. The reflected judgements of this thesis are the descriptions and definitions of medicalization and inclusion, the different ways of defining normality and deviance, and the ways both medicalization and inclusion relate to these fore mentioned concepts. These reflected judgements are analyzed in the subsequent chapters in the abovementioned order. The main hypothesis is, that although both the paradigms of medicalization and inclusion operate largely on the concepts of normality and deviance, their respective definitions of these concepts are remarkably different, maybe even contradictory. These assumed, profound differences may, in turn, lead into contradictory conclusion on how best to relate to, and deal with, normality and deviance, and how to solve the challenges these phenomena – deviance in particular – may cause in the personal life of individuals or in the society in general. These contradictions may, in turn, lead to personal suffering and more costs to the whole society.

In conclusion, it can be said, that the wider framework of this thesis is sociological, while the applied methods are mostly familiar from the analytical philosophical research. This thesis proceeds from the concept analysis of certain key concepts into the process of reflective equilibrium. The conclusion of the reflective method is presented and evaluated in chapter 9 of this thesis. The process is started in chapter 4 by analyzing the first reflected judgements of normality and deviance.

3. RESEARCH ETHICS

As this study is theoretical, some of the so called “microethical” (see Hallett & Hallett 2012) questions of research ethics are redundant in this case, like for example, the questions about anonymity and consent. However, other, maybe even more profound ethical questions arise concerning the theoretical study on normality and deviance as well as inclusion and medicalization. First of all, I want to explicitly state, that my aim is not to promote or support one paradigm over the other, let alone to refute or debunk either of the two frameworks. Rather, my primary aim is to *analyze the logical compatibility* of the two paradigms with each other, and secondarily to propose some modifications or additions to the notion of these paradigms to solve the possible contradictions. These aims are pursued by analyzing the concepts of normality and deviance. These concepts, however, can be remarkably normative and full of hidden different meanings to different people and groups of people. In my analysis, I try to be sensitive and explicit of these different connotations and the meanings these connotations may have for different groups of people. Furthermore, especially with respect to the analysis of the concept of deviance, this is also partly a study of marginalized groups and individuals. There is always a distinct tension in studies, where a non-marginalized, so called “normal”, privileged researcher studies the marginalized, the deviant, “the Other”. (Hallett & Hallett 2012.)

This setting has also been increasingly criticized especially from the field of disabled studies (for similar discussion in Finnish see for example Vehmas 2005, 136–140), and perhaps quite rightly so.

However, this tensed up setting is also one of the reasons and justification of why I chose the theoretical research setting: The theoretical set up allows me to be more mindful about the divisions of normality and deviance, of "Us" and "Them", and of the marginalized and the majority. With this theoretical positioning, I recognize that I am neither giving a voice, nor taking or distorting it from the silenced, marginalized and deviant individuals. Instead, I see this thesis as a study of the foundations of the societal discussion and discourses of deviance. Ironically enough, those foundations were primarily set by the non-deviant, non-marginalized majority of the society. Thus, it can be said that this thesis focuses more on the analysis and deconstruction of the dominant, general foundations.

The fields of special education and disability studies, are highly normative and value-laden sciences. I also believe, that in these fields, the aim is always to support and empower the deviant and the disabled people. Yet, it is important to acknowledge, that we can give support in many different ways. I have come up with at least three different ways: 1) by *standing in front of* the disadvantaged individual, sheltering and protecting them from harmful influences, 2) by *standing with* them, supporting their views and opinions, emphasizing equality and unity or 3) by *standing behind* the disadvantaged people, building the foundation and basis for them and for all of us to participate and feel included, and offering the tools and resources to advance the discussion and practices on their own terms. I feel that the traditional special education has widely concentrated on the first way, and thus, earned the critique of succumbing to paternalism. More modern studies on inclusion and deviance have explicitly tried to lean more towards the second way, building a fairer and more just educational system and a sense of equality despite the differences. By this theoretical setting, I identify myself as contributing to the third way, by opening up the discussion and revealing the premises and definitions underneath the unclear and changing discourses and paradigms.

4. NORMALITY AND DEVIANCE

Normality can be defined in multiple different ways. That, which definition is chosen at any given time, depends on the context, background assumptions, and to what ends the concept is used for (Mercer 1973, 25, 32). So, it depends on what is the function of that concept in the discourse it is applied to at that time. This function, in turn, is often dictated by the primary purpose of the definition and the reason, why we feel the need to make the distinction between the normality and deviance in the first place. At times, both the contents of the definition and the reason behind choosing a certain definition over another, might be quite arbitrary (Ibid, 1–2). Especially in those cases, it is important to keep in mind the reasons and contexts behind the definition. In this chapter I briefly present the different ways of defining normality and examine the distinction between these definitions into *normative* and *non-normative* definitions of normality. Before going into this, however, I also briefly explain the problem of demarcation (*suom. rajanveto-ongelma*) and arbitrariness of normality a bit further. Furthermore, I want to note that this chapter is loosely based on my earlier master's thesis study in philosophy. The said thesis discussed the naturalistic fallacy (*suom. naturalistinen virhepäätelmä*) in medicalization, and some of the ideas in that thesis are also examined in this one by applicable parts (see Puumala 2017).

4.1. THE DEMARCATION PROBLEM

The term *demarcation problem* in philosophy refers to all such situations, where it is not unequivocally clear where, for example, some concept or property begins and ends, or where it ceases to exist or stay the same. In these cases, the outlines of such concepts or properties are often said to be "blurry", "sliding" or flexible in a sense, that the demarcation is artificial and often based on other external reasons. (SEP, 2017.) To my understanding, "external reasons", in this case, mean that the demarcation is not conceptual, ergo, the reasons for defining the boundaries of the concept to a certain point are not derived from the conceptual *conten*t of the concept itself. Instead, these reasons can be, for example, political or economic reasons. In any case, the reasons may wary and they can be more or less well-founded – or sometimes even totally unwarranted and fully arbitrary. In these cases, the outlining of a concept is motivated by personal or other irrelevant reasons. The concept of normality is an excellent example of such "blurry" concept, and the demarcation between normality and deviance is "sliding", flexible and dependent on external motivations of demarcation.

The arbitrariness and the problem of demarcation originate partly from the so called *substantive hungry* nature of normality. By the substantive hungry nature (*suom. substantiivinälkäisyys*) of normality a philosopher John Dupre (1998) means, that there is nothing normal *per se*. Because there is nothing intrinsically or *ipso facto* normal, there is no point in talking about normality, without first specifying, what "host" thing or phenomena we are talking about. This means, that we cannot talk about normality, without first stating, *whose* or *what thing's* normality we are talking about. Therefore, the definition must always refer to a normal *something*: normal liver, normal weight, normal short-term memory or normal concentration span, for example. (Dupre, 1998.) According to Dupre, the substantive hungry nature is an inseparable part of the concept of normality (and abnormality), and there is no point in talking about normality in itself, without first pointing out the subject of normality. Thus, normality in itself does not exist independently. (Ibid.)

In my other master's thesis, I went to greater lengths in examining the substantive hungry nature of normality, but in this current thesis it suffices to conclude, that the substantive hungry nature of normality often leads to speciesism (*suom. lajiajattelu*), and thereby to the demarcation problem by producing both too broad and too narrow definitions of normality. According to Dupre (1998), the requirement of specifying a target for normality leads to classification and categorization, in which normality is defined either by the specified, *stereotypic proponent* of a class or an artificial abstract *prototype of a creature*. This, in turn, more often than not, leads to stipulating some *typical* or *natural* distribution of characteristics or behavior in a given species. (Ibid.) At this point it is also worthwhile to notice, that both the concepts of species and naturalness are highly ambiguous and undefined. Especially the concept of naturalness is, if possible, even more unclear than the concept of normality and has many hidden normative connotations (for further discussion see Siipi 2008; Siipi 2004). Therefore, these concepts actually only make it harder to define normality in an unambiguous fashion.

When we need to resort to speciesism and categorization, the definitions of normality are constantly either too broad or too narrow. This is the result of different degrees of variation between properties inside the same species or population, and between different species or populations. It is perfectly possible, that in some cases the natural variation in a certain property of a given species is actually *greater inside* that species, than it is *over two different species*. Consequently, the substantive hungry nature of normality ends up producing too narrow definitions, when it determines the outlines of normality based on some arithmetic mean of the population, in such cases where the variation is extremely large inside one population. At the same time the definition of normality, denominating a single category (like species) as its target, might also be too broad, because other factors, like age, gender and ancestry, could also be important when stipulating normality. (Dupre 1998.)

Let’s take ovulation as an example of this problem:

> Ovulation, ergo the detachment of the egg cell, is normal for our species. It can be said, that it is normal for humans to ovulate: It happens naturally, it is part of the normal functioning of the ovaries, as well as a prerequisite of conception and becoming pregnant, which is the usual (if not the only) way for our species, as mammals, to reproduce. However, firstly, this is a too *broad* definition of normality, because it only applies to one gender of the species, and only to those individuals in it, who belong to a certain, quite restricted, age group and physical fitness and constitution. Secondly, note, that at the same time the definition is also too *narrow*, as it excludes all the other mammal species altogether, though it is just as normal for them to ovulate, as it is for the human species.

Even if we feel that there could be a way of defining normality in a satisfactory way without confusing the concepts of normality and naturalness Dupre’s notions are beneficial and important in determining, how useful it is, in the first place, to even assign normality to anyone or anything. If we were to take Dupre’s thoughts seriously, should we then only use normality assigned straight to the individual person or thing we are at that exact moment talking about. And if we can only assign normality individually, case by case, then it seems to lose at least a part of its meaning and function, becoming almost redundant. All that is left to say then, seems to be, that all individuals are different and special in some way.

Although this may be true, the way I see it, there are two problems with this. Firstly, also individuals change through time and context. For example, some things that were normal for me as a baby, now would be considered extremely abnormal. Also, some things that are now within my normal competence and abilities, will not be possible for me in sixty years, although that will then also be normal for me at that time. Secondly, it seems, that the way we use the concept of normality makes it almost necessarily a *comparative* term. For a meaningful and interesting comparison, we need to be able to say *something about* normality either regarding a group of at least some statistical value or in contrast with some other opposing phenomena, individual or thing. On the other hand, we can also use the term free of any statistical claims in comparison to other proximate interface concepts, like deviance and abnormality. These observations bring us to the introduction of different ways of defining normality.

4.2. NORMATIVE AND NON-NORMATIVE NORMALITY

There are many ways of understanding and defining normality. Different definitions and uses of the term carry different connotations and implications. This diversity in meaning and connotation may lead to misunderstandings in discussions, where the parties unknowingly use different conceptions of normality. (Soan 2012, 91–92; Cornwall 2012.) In this thesis, I will introduce four different uses and meanings of normality. These may not be the only possible definitions there are, but I examine these in detail, as they are the four most relevant definitions to our current subjects of inclusion and medicalization. I will get to these different meanings a little later on in this chapter, but first, I want to draw the attention to *normative* and *non-normative* connotations of different definitions of normality.

The definitions of normality can be divided into normative and non-normative definitions. Non-normative definitions of normality state, what is most *common* or *typical* in the population. Normative definitions, in turn, state, what is *good* or *how things should be*. So, by non-normative definitions we want to stipulate the average, the mean, the most common state of affairs, without saying anything else *about* the state of affairs. By normative definitions, on the other hand, we want to stipulate, that a given state of affairs is *good* or *desirable*, even an *ideal*. (Mercer 1973, 7–8.) The normative definition, in turn, is said to be a value-laden term (*suom. arvolatautunut käsite*). That is to say that, that which we think of as *normatively normal*, is in part dictated by our personal *values* and *the norms* of our society. The norms and values of people and society are, in turn, molded by their culture, custom, time and place, and will change accordingly, like we will see later on in chapter 4. (see for example Conrad & Schneider 1992.) Note that, that which is normatively normal might not be common at all. It means, that something may not be statistically normal, although it would be desirable, as in, normal in the normative sense. On the other hand, it can also be the other way around; That which is non-normatively normal, as in, usual, might not be desirable or good. Even further, sometimes they may also be the same; That, which is common is also good and desirable. This might actually be the most common case, especially with many health and mental health related conditions. A few examples to clarify all of these situations:

1) *The language genius*:

   It would be highly desirable to learn a new language right away, just by reading through all the grammar rules and a few dictionaries, without the need to cram and study, and to hear and use the language on an almost daily basis for years.

Instead, you would be ready to go and babble on after a few hours of reading. In fact, you could learn the country's language on a flight over there and as you touch down, you would be ready to speak as a local native person. Sounds ideal, but this is not normal by any means, and doubtfully even possible.

2) *The yeast infection*:

   Yeast infection is a highly common ailment, especially in the mouth. It has been estimated that the majority of people actually have the yeast bacteria *Candida albicans* in their mouth. Although not perilous, of course, this is not an ideal condition either, as it can cause unpleasant symptoms, like pain, a burning sensation in the mouth and bad breath. Thus, although it is very common and typical, and in that sense quite normal, it is by no means ideal to have a yeast infection.

3) *Psychological adaptations:*

   (A) The overwhelming majority of people have a typical working memory range of 5 to 9 units. This is the statistically normal working memory capacity and a deviation from this range is almost always caused by some neurological condition, progressive degenerative illness or head trauma. To function satisfactorily and to live independently with a working memory of 2 or 3 units is undoubtedly hard, if not impossible – at the very least clearly not ideal. However, also a working memory capacity of, say 100 or 1000 units could be quite painful and frustrating, as it would be impossible or hard, to let irrelevant information go adaptively. So, in the end, it would not be ideal to have a large or infinite working memory capacity. It may quite well be that the 7 units, give or take 2 units, is quite as ideal, as it is typical, too.

> (B) People's moods vary somewhat: sometimes we are happy, sometimes sad, anxious or enthusiastic. However, people's moods are typically somewhere in between the two extremes, we are seldom extremely happy or extremely sad, and usually not for a long time either. We are almost always somewhere in between; we are mostly OK. Of course, it goes without saying that it is less than ideal to be extremely sad for long periods of time. However, constant happiness may not be unequivocally desirable either. When extremely happy and carefree we tend to be less cautious, for example, taking more risks and ignoring warning stimulus, or less emphatic to other people's problems or sorrow. It has even been argued that it is not physically possible to be extremely happy all the time, as extreme emotions take up so much energy, be they positive or negative. Thus, we would burn out sooner or later. So, the typical in-between, OK mood may also be the most ideal state to be in, for the majority of time at least.

Consequently, we notice that there could be a connection between that, which is typical and that, which is regarded as desirable. Sometimes the norm depends on how things would be anyway – we want to preserve the status quo. But how can we distinguish between what is normal in a *neutral* sense, and what is an *ideal* notion of normality? Philosophers Guy Kahane and Julian Savulescu (2012) introduce the concept of *harm* (*suom. haitta*) as a tool for making these distinctions. Kahane and Savulescu separate the definitions of normality and deviance from the definitions of ideals. They argue, that it is normal, in a neutral sense, for people to have a given set of statistically common prerequisites, so that they are not lacking in any such typical human abilities and properties, which would make their life somehow significantly worse, or *cause them harm* with respect to others. In turn, it would be abnormal to be lacking or deprived of these human prerequisites in an extent, that would cause the person *harm* and bring about inequality between them and other people. Such abnormal states could be, for example, blindness or quadriplegia. Kahane and Savulescu also state, that as such states cause people harm, we should try and aim to eliminate and cure these harmful states. (Kahane & Savulescu 2012, 318–322.)

Ideals, on the other hand, exceed the neutral normality; They are something *extra* or something better than the average. This seems quite plausible. Kahane and Savulesu (2012) also state, that there does not seem to be any moral obligation to guarantee ideal abilities or traits to anyone. For example, it might well be ideal to have the IQ of 160, exceptional artistic talents or life expectancy of 200 years. Furthermore, in a sense, it might even be considered *inconvenient* to lack these abilities in comparison of possessing them, but it still does not compel the individual or the society to find a cure for mediocrity. Thus, it is thought that mediocrity, or typical set of talents and skills, does not produce *harm*. (Ibid., 319.)

So, striving for the ideal and alleviating harm seem to be morally different situations. For example, not being super talented may only rob the person of some extra advantages, whereas a disability can actually cause harm. The actual harm caused by the disability generates the moral obligation for others to try and remove, or at least minimize that harm, so that everyone would have the same possibilities and equal opportunities. Then again, striving for the ideal special talents does not compel action in the same extent, at least not from the part of the society towards helping the individual in their personal perfectionist aims. (Ibid., 318–325.) It may be noted here, that these notions are related to the luck egalitarian views on distributive justice. According to luck egalitarianism (*suom. sattumaegalitarianismi*), it is morally wrong, that some should suffer with respect to others for reasons they themselves had no control over. (SEP 2013; Rawls 1973.)

Although many of the points made by Kahane and Savulescu appear quite plausible and intuitive, I present a possible critique to their views. Kahane's and Savulescu's view seems to be based and focused on a notion of disabled people *lacking* in some fundamental skills. It can be questioned, how constructive and genuinely empowering such a negatively constructed view could be, and how it could even negatively impact the self-image of disabled people (Hahn 1994, cited in Lipsky & Gartner 1996, 776) feeding into learned helplessness and other such byproducts of the traditional paternalistic thinking (Lipsky & Gartner 1996, 763–764). Instead, we so called normal people maybe need a new perspective, where we would understand that disabled or deviant people are not l*acking* or *missing* anything but rather, they are just different to some extent in some respects. Also, them being different does not necessarily mean that they are totally and profoundly different. (Ibid., 777.)

As we have seen here already, the definition of normality depends on the context, preconceptions and values. Different definitions in turn influence the way we relate to normality and deviance, and how we treat the people we deem normal or deviant. First two definitions of normality I am going to examine next, fall primarily into the non-normative definitions of normality, and they are the most important normality conceptions in the medicalization paradigm. The last two definitions of normality are more prominent in the inclusion debate, and they lean more towards the normative definitions of normality.

4.3. STATISTICAL NORMALITY

Statistical normality denotes simply *the typical* or *the general*, ergo that which is close to the population mean, or that which most often appears in the population. Statistical normality is, in a sense, quite straightforward, as it is purely a mathematical, numerical attribute. According to its name, statistical normality is a statistical term, and in statistics normality is defined through *the Gauss curve*, ergo*, the bell curve* (*suom. Gaussin käyrä, normaalijakauma*). The bell curve is a graph of a symmetrical distribution, where statistical normality is found on the mounting center of the curve. (Gräsbeck 1995, 66; Mercer 1973, 3–4.) In a symmetrical distribution, like the bell curve, the population mean, mode and median are equal. In other words, the mean really is both the centermost and the most typical value in the population. If the distribution would be cut in half through the middle, half of the observational values would be on the right side and an equal half would stay on the left side symmetrically. This also means, that exactly half of the values on the distribution are smaller than the mean, and half are bigger than the mean. In a bell curve 95% of the observational values are located only two standard deviations (SD) (*suom. keskihajonta*) away from the mean. Consequently, both, the really big and the really small values, are rare in this distribution. (Mercer 1973, 3–7; Nummenmaa 2009, 129–130.)

All such phenomena and properties, in which the observational values are *free to variate* up and down, conform to the bell curve. When such properties are numerically measured multiple times, the distribution of the measurement results will eventually start to follow the shape of the bell curve. A property is thought to follow the normal distribution, whenever the property is c*aused by more than one factor*. Whenever multiple factors have an effect on the manifestation of the property or phenomena, that property or phenomena will be symmetrically distributed (given that it is free to variate), be it a property of nature or of human behavior. (Nummenmaa 2009, 129–130.) By this remark, the statistical principles of normality have also come to be applied on social sciences and the societal conception of normality, as almost every characteristic of human phenomena and behavior is such, that it is generated by more than a single factor. These phenomena are often referred to as multiple factor phenomena. (Nummenmaa 2009, Gräsbeck 1995.)

Although the statistical definition of normality seems explicit and reliable, it becomes problematic when it is applied to measurements, which are not truly equally distributed, although they may first seem so on the surface. In a matter of fact, although almost all social and human phenomena are generated by multiple factors, they do not fully qualify as bell curve distributions. This results from the fact, that most human and social properties are actually not perfectly free to variate. They cannot variate endlessly up and down. This fact usually manifests as an impossibility of these properties to have smaller values than 0. (Gräsbeck 1995, 71.) Moreover, these values often also have at least a practical maximum as well.

Let’s take height as an example of these restrictions:

> Height is one of the easiest human properties to measure numerically. It is, per se, a numeric property, and on the surface, it certainly seems to follow the bell curve and normal distribution. Both extremely tall and extremely short measurements are rare, and so, also often thought to be caused by some developmental abnormality. However, the variation of the height is not completely free. It is simply not possible for any (living, already born) human being to be only two centimeters long, for example. So, height cannot actually get values of only few centimeters, let alone smaller than zero – that is to say, negative values of height (like -30 cm long). The same goes for the top of the scale; huge values are practically impossible. In fact, with height the top is reached quite quickly. For example, a ten meters long person would be an impossibility (at least with current technologies), let

alone, say, ten kilometers long person.

Of course, the situation only gets more complicated when we measure traits, which are not outright numerically measurable. Such traits need to be operationalized first, meaning that they have to be converted into a numeric form. A good example of such operationalized trait is intelligence. Intelligence is measured by points and expressed by the intelligence quotient (IQ) (*suom. älykkyysosamäärä, ÄO*). The distribution of IQ points can be placed on a bell curve, with the result of 100 points as the mean value. However, this is only an illusion, because intelligence, any more than height, is not free to variate endlessly. For example, IQ scores of less than 0 are impossible. Both the measurement, the quotient and the symmetrical distribution of scores is completely man-made, artificial and forced. (Mercer 1973, 5, 130.)

All in all, statistical normality in itself may be a clear and functional concept, but problems arise when we attach normative value judgements or social opinions to it. This is a well-known deduction error in philosophy, and it is often called *Hume's guillotine* or *the is-ought-gap*. According to the famous enlightenment philosopher, David Hume (2000), one must not infer, how things *should be,* solely based on how they actually *are*. Thus, there is a gap between the descriptive reality and the normative statement, and this gap cannot be overcome by solely describing the states of affairs in reality. To cross the gap in a logically valid way, one must also provide normative, in other words, value-laden, premises. (Hume 2000, 3.1.1.27; Norton 2000, in Hume 2000, 178.) I have examined this error in medicalization more profoundly and extensively in my earlier master's thesis (see Puumala 2017).

In the social and educational sciences, the is-ought-gap-like error occurred, when the so called healthy individuals were most often found to get measurement results, that would be located in the centermost area of the normal distribution's bell curve. In other words, they would get the so called "normal" values, in a statistical sense. Most of the population are comparatively healthy, so the majority will understandably get these mean values. In turn, some few individuals will get very rare values located on both far ends of the continuum. These rare values started to be seen as the opposite of healthy, therefore *pathological*, although, as a matter of fact, they are just *uncommon* or *rare*. (Gräsbeck 1995, 69; Mercer 1973, 2–7.)

So, the distribution in itself does not imply, that the values in the middle of the curve are somehow good, correct or ideal values. On the contrary, the bell curve is a completely value-neutral, symmetrically curved line on a paper. The value-laden aspect is man-made. This man-made deduction error occurs, because we imperceptibly start to think, that these typical values must be *natural* and somehow ideal, *the way they should be*. The rare values then are seen as anomalies and *deviances* from this nature-intended golden mean. (Gräsback 1995, 69.) Of course, when we think about it rationally, it is clear, that nature does not *intend* anything, and there are no "correct values", from which the deviation would be "an error" in the natural order. In a matter of fact, not even nearly all properties related to sickness and health follow the normal distribution. And on the other hand, it is not always desirable to be located in the middle of the curve, in terms of some properties concerning sickness and health. For example, dental caries and high blood pressure are statistically normal in that they are very common, especially in all the western populations. However, they are both also pathological and potentially quite dangerous conditions, too, as they can even lead to more severe and even potentially lethal conditions, like heart attack and inflammation of the pericardium.

What is more, many health conditions are *categorical*. This means, that they are so called on/off-conditions, so the amount of that characteristic does not vary at all – it either exists or it does not. (Launis & Räikkä 1995, 81–84) Actually, this seems to be the case in almost all traditionally medical conditions. For example, the test result for chlamydia is either negative or positive, not somewhere in between. Also, there are no such things as borderline pancreatic cancer or an averagely broken shinbone. Later on, we will see, that this is not necessarily the case regarding the fields of psychology and psychiatry, where medicalization is said to advance most rapidly at the moment (Conrad & Schneider 1992; Watters 2010; Szasz 1974). Paradoxically, however, medicalization most often uses the statistical view of normality especially when categorizing mental states and behavior as normal or deviant (Mercer 1973, 7–8).

4.4. BIOFUNCTIONAL NORMALITY

A better way to define medical normality and conditions regarding sickness and health is to define them through the *biological constitution* and/or *function* they have. In the functional definition normality is specified by certain specific capabilities and functions the organism or part of the organism has. (Launis & Räikkä 1995, 81–84). Along with statistical normality, biofunctional normality is the other most dominant view of normality in the medicalization paradigm (Mercer 1973, 7–8). Once again, this definition converges to some kind of species thinking, where it is thought, that some capabilities and capacities are significant for certain species- or organism-typical behavior or function. This definition also automatically implies more normative statements than statistical normality, as in the functional view we often see deviation or abnormality as some kind of *deficit* or *weakness*. The presence of some basic capabilities is related to our views on ideal or at least adequate health. (Dupre 1998, 4.) Some functionally normal abilities for humans include, for example, the ability to walk upright with two feet and the ability to communicate verbally through speech. Functional normality can also be perceived on an organ level. For example, a normal heart is such that it pumps enough blood in a sufficiently regular basis throughout the whole body. Else, if these abilities and functions are lacking, we typically think that the organ is not only statistically unusual, but also *defective* and faulty – sometimes even to a lethal extent. (Launis & Räikkä 1995, 82–83.)

By concentrating on the abilities and functions, the functional conception of normality must also take into account the connections between the abilities and the environment. It seems that with every ability, environmental factors have at least some effect on the extent to which these abilities can be used, and the way they manifest themselves. Normal functional abilities can be divided into *relational abilities* and *intrinsic abilities* (Dupre 1998, 4.) For example, the ability to move your fingers volitionally is an intrinsic ability, it is an ability in itself. In turn, the ability to cut a circle from a piece of paper is a relational capacity, as other factors, including the intrinsic ability to move your fingers, the availability of good scissors and visual contact with the scissors and the paper, greatly affect the manifestation of the ability. Thus, all the relational capacities depend on other intrinsic capacities. Yet those intrinsic capacities alone do not suffice either; a favorable environment and certain working conditions are also needed. (Ibid.) On the other hand, it is noteworthy, that if the environment and conditions are favorable, some such abilities, which the person usually lacks, can also become possible. For example, a person who normally does not have sufficient control over their larynx or tongue muscles, usually cannot communicate verbally. However, through specific technological aids it can become possible for them, too.

So, it would seem that, that which is regarded as normal behavior or normal set of abilities, should depend on both, how we can use our intrinsic capacities, and on the other hand, how we can utilize the environmental conditions to make the most out of our relational capacities. So, it is also interesting to examine, which of these capacities carry more importance in our social opinions on normality. Should we regard as normal only those individuals, who have the ideal intrinsic capacities? Or would it be enough to be able to perform, even with some possible external aids, the functions associated with the intrinsic capacities? Dupre (1998) points out, that actually also the majority of the so called normal abilities the normal people possess, are also dependent on the environmental conditions. For example, our ability to walk upright without stumbling is extremely good in modern paved city roads, but it quickly deteriorates when we have to walk in the rocky, wet jungle terrain. (Ibid., 5.) In conclusion, I would say that it is the *outcome* that matters the most. For me, the real question is, if we can, in the end, perform a certain function well enough or not.

The skills in themselves, or the amount of help and external aids we need to achieve the wanted end result does not seem to matter much from the perspective of the wanted outcome. Therefore, I find it quite problematic, that this seems to be the other way around in our modern medicalized society and schooling system. As the intrinsic capacities are all more or less biological abilities and features, the medical framework will always define the lack of these abilities as deficits and deprivation, which in turn are pathological and abnormal conditions, regardless the performances the person is nonetheless capable of doing. In the social constructivist models of disability, it is often stated, that the most harmful effects of the disabilities are brought about, not by the handicap in itself, but by the environment, social arrangements and the attitudes of other people. (Vehmas 2005, 124–140; Lipsky & Gartner 1996, 777, 789.) The medical model, on the contrary sees the deviance as pathology, and the pathology is always in the individual (Mercer 1973, 7.) If, for example, someone is immobilized, he or she is lacking the intrinsic capability of walking with their own two feet. Therefore, according to the medical model, he or she is abnormal, irrespective of whether they can still move with an aid, for example with a wheelchair. In the medical view, the aid is only a symptomatic treatment (*suom. oireenmukainen hoito*) to the pathological condition of immobility. (Skrtic 1991, 150–152 cited in Lipsky & Gartner 1996, 777.)

Also, it is important to remember, that our society and environment have been formed over a long period of time and often quite arbitrarily. Or rather, to the direction the majority and the dominant culture have dictated. For this, different times, cultures and continents offer different environments. On the other hand, the changes can be also quick and consciously made, to be better suited for everyone's abilities. For example, by building ramps and wider doorways we are making everyday life so much easier for the people in wheelchairs, without in any way complicating things for the walking people.

4.5. SOCIAL PSYCHOLOGICAL NORMALITY

By social psychological normality I mean our conceptions on what is socially acceptable and desirable behavior, and what are the psychologically normal or understandable ways of reacting to certain situations. I coined this term in my earlier thesis (see Puumala 2017) to differentiate it from the more biologically orientated functional normality, but also, to differentiate it from mere *social* normality. Social psychological normality most often has to do with the psychological behavior, abilities and reactions. Both statistical and functional normality are mainly non-normative definitions of normality, and both, for the most part at least, are quite easily measurable concepts. Jane Mercer (1973), for example states that pathology (ergo bio functional abnormality) is universal in a sense that they manifest in the exact same way across culture, environment and time. For example, the valvular defect (*suom. sydämen läppävika*) and the surgery to mend it are essentially the same in Finland as it is in, say, China, Ghana and Argentina.

Social psychological normality, on the other hand, is something quite totally different. Our conceptions of social and psychological normality are strongly culturally and contextually bound, and therefore often quite problematic and arbitrary. Our normative conceptions on what is socially appropriate behavior, and our expectations about other people and the way they will, or *should,* act in certain situations are determined by the norms of the society we live in. (Wachbroit 2003, 52–54.) This results in differences and nuances in the characteristics and manifestations of most social psychological abnormalities across cultures. Watters (2010), for example has written about differences in the manifestation of depression between the American and Japanese psyches, or differences in the meaning of anorexia between American and Chinese cultures.

It can be said that social psychological conceptions of normality are based on the stereotypical *preconceptions* we have of the everyday-life situations and how they normally unfold, or how they *should* go, and how the people acting in them should be able to behave. If we time and time again fail to fulfill this stereotype or conform to the norms in the society, we will be labelled as deviant or abnormal, at least as to that particular behavior.

To clarify, I will give a couple of examples:

1) *The saluter:*

   In probably all the cultures in the world, it is common conduct to first introduce yourself by name to people you meet for the first time. In the western countries, this is often done by shaking hands at the same time. Also, failing to do so upon meeting someone for the first time can be regarded as quite rude. So, that would be at least a little deviant. On the other hand, if I would walk the streets introducing myself and shaking hands with every single new passer-by I come across, my behavior would be regarded extremely abnormal, maybe even as a sign of a severe mental illness.

2) *The dinner date:*

   We all have a stereotype in our heads of a typical dinner in a restaurant: You sit at the table, the waitress comes, you order the food, eat and chat with your friend, pay the bill and leave. In this order, for the most part. Actually, a failure to do any of these would be regarded as deviant or abnormal, some of these even illegal. Imagine that on a dinner date your friend cannot sit at the table for more than ten minutes, then stands up, starts to scream mimicking bird noises and waving her hands at the sides of her head, while walking around in small circles. Now that would be highly unusual. Most people would call her "crazy".

With these examples, we can also see that there might be different degrees of social psychological normality unlike in functional normality, where many definitions are categorical, on/off-characteristics. That could be one of the reasons why the social psychological normality seems to be so ambiguous and unclear. It can include established habits and social *manners*, as well as cultural, institutional and even ethical *norms*. Social psychological normality is highly dependent on environmental and cultural factors and its boundaries wary according to time, space and culture. (Wachbroit 1994, 580.) Thus, something that is normal in this culture at this time may not be normal in some other culture at the moment, or even in this culture in a few-hundred-year's-time. As it is so dependent on many environmental factors, it is extremely hard to say anything general about social psychological normality. It is a dynamic conception on what people find acceptable and what they find insulting in given situations.

4.6. SOCIAL CONSTRUCTIVIST NORMALITY

The social constructivist definition of normality is the most value-*aware* of these definitions of normality. It suggests that judgements of normality and deviance are *first and foremost* value-laden statements. According to the social constructionist model, normality and deviance are not objective, independent states of affairs, but rather *culturally constructed* phenomena. Conceptions about normality and deviance are based on the values of the society. (Conrad & Schneider 1992.) This means that it is logically impossible to determine their objective truth-value. This, in turn, leads to relativism concerning the contents of the concepts of deviance and normality. This can easily be observed in reality in different and changing, culture and time dependent definitions of normality. Therefore, normality, abnormality and deviance are *labels*, that are primarily represented in the minds and discourses of those people, who describe them onto others, and *not in the objective reality* per se. (Launis & Räikkä 1995, 85–90; Vehmas 2005, 121–124.)

The social constructivist model abandons the view, that there would necessarily be something wrong with the deviant person himself, but rather construes deviance as a statement about the cultural and social norms of the persons environment. Social constructivist views acknowledge that our cultures are based on values, opinions and attitudes, which in turn are based almost entirely on the assumption of the goodness of normality. Therefore, these attitudes are inclined on discriminating against deviance and abnormality. (Vehmas 2005, 110, 112, 116–117.) Of course, no one is raised in a vacuum, and so the surrounding society has an impact in all of our abilities and the interpretations they are given. Thus, in social constructivist definitions normality or deviance is not determined by some set biological or functional properties or abilities, but rather they are seen as generated by some social arrangements, attitudes and values. Consequently, the labelling of deviant, abnormal, sick or disabled people is also seen as something similar to other forms of discrimination, like homophobia or racism. All the cultures tend to develop different superstitions or myths about deviance and disability, because they give a name to the fear the so called normal people have over disabled or abnormal bodies and minds. This way the conceptions of normality and health, deviance, abnormality and sickness, help the normal people to draw a line between them and the deviant people – *the Others*. (Launis & Räikkä 1995, 85–90; Vehmas 2005, 121–124.) To me, the biggest difference between social psychological and social constructivist definitions is the way the social constructivist definitions of normality take the social control and power, as well as the cultural connotations, even better and more explicitly into account, when describing the process of assigning deviance to some people and normality to some others. Although social psychological normality also recognizes certain amount of relativism in assigning normality, it may still regard social psychological deviation as pathology – psychopathology, more precisely.

The social constructivist conceptions do not necessarily deny the impact that biological aberrations may have on the individual's life, but the focus is more on the social and political factors, that can be much more disabling to the person, than his or her handicap in itself. Social constructivist definitions make a separation of *impairments* (*suom. vamma*) and *disabilities* (*suom. vammaisuus, kyvyttömyys*). Impairments are regarded as organic aberrations, whereas disability refers to the social situation, which makes the impairment harmful or challenging. The idea is, that organic impairment alone rarely produces disability, but disability is produced in interaction with the culture and social environment which discriminates against the individual's biophysical, psychological or cognitive impairments. (Vehmas 2005, 110, 115.) The history of normality and deviance is very much a history of discrimination (see Conrad & Schneider 1992; Vehmas 2005, 75). Next, I will turn to examine the history of these concepts, and I will briefly touch on the different practical suggestions these changing definitions have had in our society and culture in the past.

5. THE HISTORY OF NORMALITY AND DEVIANCE

The way we understand the reasons of deviance strongly influence the way we react and relate to deviance and normality and the people labelled as such. Roughly generalizing, it can be said that the conceptions of normality and deviance have shifted from *superstitious*, to *moralistic* to *scientific* conceptions. Originally, the conceptions of normality and deviance were dictated by religion and myths. Attitudes toward deviance and abnormality were strongly superstitious. For example, all through the middle ages deviance, disability and mental disorders were seen as signs of sin, and so, either as the punishment from God or the possession of the Devil. Hence, also the attitudes towards these individuals were strongly religious or moralistic, but also two-fold. On the one hand, the deviant people had to face a lot of hatred and prejudice, which often also led to violent acts and even persecution, like the famous witch hunts of the middle ages. On the other hand, the deviant and disabled were a way for the normal people to practice the acts of clemency and compassion, like giving alms, which in turn would make the benefactor pious and guarantee them a place in Heaven. (Conrad & Schneider 1992, 38–39, 41–44;

Vehmas 2005, 24–44.) Also, it may be noted, that almost all cultures recognize some acceptable or desirable forms of deviance. For example, different prophets and shamans have always been quite esteemed and admired, although they are highly unusual and deviant people and the explanation of their deviance has been supernatural and religious just as well. Only instead of a punishment or sin, their deviance was seen as a gift from above. (Conrad & Schneider 1992, 39.) Thus, that what is seen as an adverse deviance does not depend only on the deviant property itself, but on the interplay of that property and the environment or the community where it manifests. This interplay between the property and the culture determines how the deviance is understood, and if it is ultimately deemed negative or positive. (Zola 1966, 618.)

The Renaissance, and especially the age of Enlightenment, brought back the scientific world view that had started developing in the Antiquity, with the humorism (*suom. humoraalioppi*) and other such theories. Naturally, this also changed the definitions of, and attitudes towards normality and deviance. The shift from the agrarian society towards industrialization produced two new division in the definition of deviance. Firstly, the so called *able-bodied* were to be divided from those who could not work. Secondly, the so called "lunatics" were to be divided from the otherwise merely bodily handicapped people. Those who were non-able-bodied lunatics were strictly, and often violently, confined into institutions called hospices, as though out of the way of the society. Otherwise handicapped people also often lived in such institutions, although they were not necessarily deemed as totally incapable of any work. In the 18th century the lunatics and the handicapped or otherwise ill people were separated into different institutions, so as to prevent the "lunacy" from transmitting to the sane. (Conrad & Schneider 1992, 39–45.)

By the beginning of the 19th century the situation got worse for the physically handicapped, too. As the industrialization advanced, the ability to work became the indicator of the person's value to the society. If that value for some reason was low, they were entirely excluded from the society, and thus began the segregation and institutionalization of deviant people. Bodily or mentally deviant people were not only seen as non-profitable, but also as harmful for the whole society. The deviant people at the time were seen as morally divergent, as if some kind of criminals, or at least as disturbers of the social peace and order. So, the hospices were used as direct and concrete devices of social control and power. The inhabitants were not treated or rehabilitated in any way, as the institutions existed primarily to guard the normal people against the detrimental effects of deviant influences. (Conrad & Schneider 1992, 44–47; Vehmas 2005, 53–57.)

All the same, the effects of the medical treatment or rehabilitation of that time, may well have been more injurious than advantageous for the patients. Medical advancements, right until the 20th century, were painstakingly slow. Usually the doctors would not actually have any concrete knowledge over mental illness or disability, or how to cope with them. Although "the treatment" was most often just physical confinement and/or social control, terms like treatment, cure, medicine, patient and illness were still already used. (Conrad & Schneider 1992, 45–48; Vehmas 2005, 56–59.) However, the scientism of the Enlightenment, generated a strong belief that (medical) science *will eventually* have all the answers to any and all human problems. Thus, it can be crudely generalized, that medicalization of deviance was initiated by science optimism and semantic tricks, that are very much alive to this day. Next, I will turn to a deeper analysis of the modern-day medicalization and its consequences.

6. MEDICALIZATION

In short, medicalization means making or becoming medical. Something becomes medical when it is understood, explained and treated with the terms and interventions of medical science. Historically, the evolution of the norms of our society has led to medicine becoming the most dominant field of explanation for human social phenomena: Our personal problems as well as our whole society is being medicalized. This means that certain types of behavior and certain properties come to be redefined in medical terms, although they may not have been seen as medical phenomena ever before. Thus, they become examined and treated in medical means. So, also the attitudes and problem solving becomes redefined as medical interventions and medical (pharmacological) treatment. This also reflects to the language we use. Terms such as healthy, sick, ill, normal, abnormal, deviant and pathological become important in describing the spectrum of human existence. (Zola 1972, 492–497; Conrad 1992, 209– 212, 214–223; Mercer 1973, 16.) Examples of this development are the medicalization and medical treatment of alcoholism, ADHD and depression, among others.

Medicalization is a fashionable topic in popular writings and discussions, too (for popular discussions in Finnish see for example: https://www.rapport.fi/journalistit/jani-kaaro/too-much-medicine-special-nain-normaali-patologisoidaan?rs=art_355207&rsd=13298.) In lay-man terms, medicalization is often used to refer to *unwanted medicalization* or *over medicalization.* This means that people sense medicalization is taking over such fields of human life, it for some reason *should not*. In these cases, the attitude towards medicalization is often negative and prejudiced. It may well be true, that in some cases over medicalization has actually happened or will happen in the future, but the *medicalization term* does not necessarily have this negative connotation in itself. The term is used to describe any and all medical advancements, from which most part is extremely positive, lifesaving and enormously praiseworthy. (Conrad 1992, 209–211.) Thus, it is medicalization, both to know how to apply plaster to a broken limb, or how to do a heart by-pass surgery, and to allegedly over diagnose and over medicate young boys with ADHD.

According to sociologist Peter Conrad (1992, 209–213, 223) medicalization is first and foremost a question of definition. Everything starts with the medical lingo and understanding the phenomenon in medical terms and through the medical framework, then describing the individual and their problem with medical concepts and diagnosis, and finally applying medical methods for solving the problem. The individual becomes a patient, the problem becomes an illness and the solution becomes a treatment or cure, most often medication. (Ibid.)

Like Peter Conrad (1992), another famous medicalization researcher, philosopher Irving Kenneth Zola (1972) argues, that medicalization is a form of social control. As a social framework, medicalization has replaced the religious and secular moralistic frameworks of before. In a way, medicalization can appear a lot more humane way to face human deviance, than these two earlier ones. However, Zola and Conrad point out, that the aim of these different orientations is the same, in that they all attempt to *erase and abolish deviance*. Of course, the means to that end are different and even contradictory depending on the viewpoint. You can choose from praying, punishing and medicating. (Conrad 1992, 213–218; Zola 1972, 492–499.)

The way we relate to the concept of medicalization and its practical advancements depends on the way we understand the definitions of sickness and health. Veikko Launis and Juha Räikkä (1995) present a division of *naturalistic* and *normative* conceptions of sickness. These roughly correspond to the statistical and normative notions of normality. Naturalistic view of sickness does not need any normative statements. In this view sickness and health can be determined in purely biological grounds. It is thought, that the natural sciences reveal which states are illnesses and which are not. Therefore, in the naturalistic view, illness is most often seen as a dysfunction of the given organism or some organ of the organism. The optimal function of the organism, in turn, is a purely biological matter. Thus, the definition is also value-free, as sickness and health are seen as real, objective and independently existing states of affairs in reality. (Ibid., 81–85.) Note, that this corresponds most closely to the bio functional view of normality.

Most proponents of medicalization take this viewpoint. Many medical professionals, for example, think of illnesses and deviances as objective, naturalistic *facts*, which are *discovered* by the science of medicine. These deviances and illnesses exist regardless of our knowledge of them and can be ignored or *found* and brought to attention. This way, as medicine advances we will little by little become enlightened about certain conditions being illnesses, although *we did not realize it before*. As the objective act of diagnosing advances and develops, it will reveal new illnesses, and thus, it will only be a question of time, when all the sicknesses and their cures will be found through the scientific method. (Mercer 1973, 16; Skrtic 1991, 150–152 cited in Lipsky & Gartner 1996, 777.)

On the other hand, according to the normative view of sickness, there are always at least some normative notions included in the definition of states as illnesses (Launis & Räikkä 1995, 85). Like we already saw with the social psychological and social constructivist definitions of normality, such normative notions can, for example, be the concepts of harm or extra advantage. Furthermore, like noted earlier, that which is harmful or advantageous to the organism can be individual or depend on the environment. Thus, it is not, at least not fully, definable in purely objective, biological terms. Also, Launis and Räikkä (1995) note, that we cannot deem all harmful properties as illnesses either, or else we will have quite an arbitrary definition of sickness on our hands yet again. Instead, the harm must be such, that it *requires medical intervention to be overcome*. (Ibid., 85–87.)

Still, in the normative view of illness, the definition of illness is seen as, at least to some extent, value-laden concept, and so, not totally objective and neutral. Often the value of health is understood negatively, in a way that the lack of health is regarded a bad thing. Thus, we learn to appreciate and give value to health, when we notice that it is missing, or it has become threatened. (Launis 2007, 24.) So, the notions of sickness and health depend, at least to an extent, on our own attitudes and opinions on what is sufficiently good health and what is harmful to it.

Correspondingly Peter Conrad and Joseph W. Schneider (1992) make the distinction between *positivistic* and *interactionist* interpretations of sickness and health. They parallel the concept of sickness with the concept of deviance, which is reasonable in the context of the expansion of medicalization into new fields of human psyche, cognition and behavior (see also Mercer 1973, 7–8). Positivistic view of deviance understands deviance or sickness as something objectively real and independently existing. Maybe a little surprisingly, there is also room for social norms in the positivistic view. However, they are also thought as something quite clear and unequivocal: something which everyone at large recognizes and accepts. Deviance is differing notably from these known and respected common norms. Positivistic views focus on examining, *why* someone would differ from these norms and *how could we stop* this deviant behavior. Thus, it is about finding the objective reasons for deviance. (Conrad & Schneider 1992, 1–2.)

In the interactionist view, in turn, social norms are context dependent. The dominant norms depend on the time and place and social settings. Therefore, social norms are a structure that we ourselves build to fit to a specific social context. Normal or healthy behavior is such behavior that takes place inside the boundaries of typical norms in a specific context. Deviance, for one, is something that in that context has been defined as disagreeable according to the dominant norms. Those who have the power to make these definitions, are typically those who have a high social status and hold the dominance in that particular context. Thus, in the context of medicalization these people are the experts of medical sciences (Ibid., 2–3; Mercer 1973, 15). According to the interactionist view then, both the social context and the dominant set of norms are social constructs. Therefore, it is more reasonable to examine *how* and *why these definitions* are created and *by who*. (Conrad & Schneider 1992, 2–3.) In many ways, this view is close to and compatible with the social constructionist models of deviance.

6.1. THE GOOD AND THE BAD OF MEDICALIZATION

Those who criticize medicalization most often take the stance of interactionist, normative and social constructivist views of normality and deviance or health and sickness. Those defending the propagation of medicalization, in turn, often support the naturalistic and positivistic views. Before next turning into examining the positive and negative consequences of medicalization, I have first collected the different definitions of normality (and health) and the abovementioned stances toward medicalization into the following chart, to make better sense of the interconnectedness of these conceptions.

Conceptions of normality and deviance		**Corresponding conceptions of sickness and health**	**Corresponding approach to deviance and sickness**
Statistical	= Usual, typical, mean, most common Mathematical, statistic: clear, objective, neutral and unequivocal Statistically/mathematically measured	Positivist, non-normative, naturalistic	No approach in itself; purely descriptive term. However, used to justify normalization and segregation.
Biofunctional	= Functioning, executes the task it is meant for, is of the right/"natural" constitution Biological physiological, medical Can be measured by measuring physiological indicators.	Positivist, naturalistic, non-normative, (relies partly on statistical normality), (normative)	Make healthy, cure sickness through medical intervention.
Social psychological	= Mentally, psychologically normal; behaves, thinks and feels in an understandable way, can execute mental and cognitive tasks as others; behaves in an understandable manner Arbitrary, social construct, changing Hard to measure, needs operationalizing (like IQ)	Normative, idealistic, (naturalistic; relies partly on biofunctional normality)	Make normal, "neurotypical" or "sane" through therapy and medication. Accept and include, dismantle harmful social structures and norms.
Social constructivist	= Fulfills social and cultural expectations, follows the society's norms, behaves in a desirable manner, agrees, submits Arbitrary, social and cultural construct, abstract, changing Cannot be measured.	Normative, idealistic	Include, accept and tolerate. Adapt the society to individual needs. Deconstruct labels.

An adaptation of Conrad & Schneider (1992) and Launis & Räikkä (1995).

The protagonists of the medicalization movement argue that medicine is a scientific, efficient and humane way to treat and solve the human problems of deviance and illness. This is a worthy defense, as we can quickly come up with multiple examples of medical and humane developments advancing hand in hand.

For example, this is the case with alcoholism:

> Before, even as late as the beginning of the 20th century, alcoholism was regarded almost as a sin. At the very least it was a sign of lacking moral backbone. So, it was thought, that the flaw is in the alcoholic person themselves. They must have been somehow evil, or at least faulty as a human being. The usual reaction was public condemnation and sometimes the drunk would even get punished by arrestment. Nowadays instead, alcoholism is seen as a psychophysical illness, not a moral deficit. Many physical and genetic risk factors have been identified. The forms of treatment are often rehabilitative medical interventions and therapy. Thus, the solution now is therapeutic, not punitive. (Conrad & Schneider 1992, 246.)

The medical stance is primarily seen as scientific, and so, also as an objective view. This in turn, is thought to make the approach more humane, and to erase and prevent social stigma. (Ibid., 35, 246.) For example, an over active child is no longer seen as mean or wicked, or intentionally difficult, but instead she has an illness, ADHD, which explains the way she behaves. This is thought to reduce condemnation and discrimination. (Ibid., 247.) Instead, of the stigma, medicalization assigns the so called *sick role* for deviant people. The sick role is most often assigned through formal diagnosis. When some properties and behaviors are seen as illnesses or consequences of some illnesses, the people assigned the sick role, are freed from responsibility regarding that property or behavior: Because it is an illness, it is not their fault. Therefore, medicalization can lift the stigma, responsibility and quilt. (Ibid., 246–247.)

Furthermore, instead of shame and punishment, medical interventions can be seen as positive future perspectives for the treated individual – now called "the patient". The ethos of therapeutic treatment brings hope of better times, when the ideal state of normality can be achieved again. At its best, optimism and hope can turn into self-fulfilling prophecies, through which the patient really is ultimately cured. (Ibid., 246–247.) Also, medical interventions are actually often very simple and quite efficient, too. Medical interventions are far more quick and cheap to give out to people, than for example, legal judgement, let alone prison sentences. For example, medicating heroin addiction with methadone treatment is far more cost-efficient, than putting these people in jail. (Ibid., 248.)

With all this said, it is clear, that the consequences of medicalization are not all positive. By this, I do not only mean, that some medical interventions can be painful in themselves, or that there can be negative side effects, but instead, that there are also larger, more abstract social and political consequences. Conrad and Schneider (1992) have listed different negative consequences in their book called *Deviance and Medicalization: from Badness to Sickness*. I will examine these negative consequences next.

Firstly, Conrad and Schneider mention the shift of responsibility away from the individual. By this they mean, that when the sick role is assigned to somebody, their responsibility over their own behavior and situation diminishes considerably. On one hand, this can make things easier on the individual, but at the same time it also restricts their *autonomy*. If the person does not have full control or charge over their own situation, they cannot be fully accountable, and so, are not *plenipotentiary* (*suom. täysivaltainen*) agents over their illness. (Conrad & Schneider 1992, 248–249.)

Autonomy can be defined in many different ways, but at its simplest, it means the agents power to make his or her own decisions. An autonomous person can choose their own goals and priorities, based on their personal values and opinions, although they may need help in reaching those goals. (Oshana 1998, 82; Beauchamp & Childress 2001, 58; Launis 2007, 47.) Many times, medical patients do not have this level of autonomy, and actually the doctors prioritize and set goals *for the patient* (Launis 2007, 49). Of course, this is all done in the best interest of the patient, but it can, nevertheless, be problematic, as in almost all codes and manuals in biomedical ethics, the doctors are required to respect the autonomy of the patient and their right to self-determination. (see Beauchamp & Childress 2001; ten Have & Gordijn 2014; O'Neill 2002; Wright 1987). Also, it has to be noted that even persons with diminished autonomy can act autonomously in certain situations and their autonomy has to be respected just the same. Autonomy is not a categorical property, but rather a continuum. An autonomous person can also make non-autonomous choices and a non-autonomous person can make some decisions perfectly well on their own. Thus, autonomy depends on the type of the decision and the decision-making situation. (ten Have & Gordjin 2014, 58–59, 70–71.) I will return to the questions of autonomy in chapter 8 on the compatibility of medicalization and inclusion frameworks.

Next three consequences mentioned by Conrad and Schneider relate to the status of medical sciences in the western society. First of them is the alleged moral neutrality of medicine. The medical sciences claim to handle some highly value-laden concepts of human life with purely scientific, objective ways, through the concepts of sickness and health. However, Conrad and Schneider argue, that these concepts are not value-neutral, but instead are highly normative in themselves: Health is something desirable, whereas sickness is a bad, unwanted state. (Conrad & Schneider 1992, 249; Launis 2007, 24.) Secondly, Conrad and Schneider argue, that medicalization leads to the supremacy of the medical professionals in our society. What is meant by this, is that, when something becomes medicalized, that phenomenon shifts from the public discussion into the scientific one, and more precisely, into the medical discussions. Consequently, the layperson is not able to form a worthy opinion or make judgements or decisions on the matter on their own, although some of these phenomena may well have been very mundane before. (Ibid., 249; Mercer 1973, 15; Zola 1966, 629.)

To take an example, in many popular discussions, this has been the case with the diagnosis of ADHD:

> A century ago no-one was diagnosed with ADHD or medicated accordingly. Such diagnosis, ergo, such illness, did not even exist back then, nor did the corresponding medication. Yet the human brain has not changed notably since the Pleistocene. Hyperactive, lively individuals with problems of concentration and attention deficits have probably always existed. A few decades ago these individuals were thought of and treated as misbehaving, unruly kids. Often, they themselves and their parents were blamed for the unwanted behavior, and punishments and social condemnation could be severe. Teachers and parents, the extended family and even the whole village would discuss, how to get those unruly individuals under control. Even earlier in the Pleistocene, or perhaps nowadays in some hunter-gatherer societies, the characteristics of ADHD may even have been advantageous and desirable. In certain social and environmental settings, it

> may be ideal to have the tendency to shift your attention quickly, according to the smallest new stimulus or other change in the environment, or to be able to get excited, interested or worried about certain fixed, small things.[4]

Fourth of the negative consequences mentioned by Conrad and Schneider is the intrusive way and massive amount of social control performed through medicalization. Through medicalization, such properties and forms of deviance, that were not seen as medical problems before, can now be subjected to major medical interventions in the name of therapeutic ethos of medical treatment. For example, hyperactivity can be treated with medication from a very young age, when the medication may interfere with the rest of the child's development. Or depression can, in some severe cases, be treated by electroconvulsive therapy (*suom. sähköshokkihoito*). According to a famous critic of medicalization, Irving Zola (1971, 490), such treatment methods can sometimes feel, if not quite torture, but at least as some kind of a punishment. Conrad and Schneider (1992) even go so far as to argue, that sometimes the discovery of some new efficient medication generates the need to develop a diagnosis of a condition to fit new pharmacological developments. [5]

---

[4] I am not saying that diagnosing and treating individuals with ADHD is wrong or unwarranted, or that many modern interventions have not helped these individuals and their families to cope with their ordinary day-to-day life. On the contrary, I acknowledge that it could well be the opposite way around. Rather, I am pointing out that the spectrum of conditions now diagnosed as ADHD, have not always been seen as illnesses, and these conditions have been more freely present in the layman discussions and decision making earlier.

[5] I need to explicate, that I do not want to deny the existence of different mental disorders or underestimate the effects they have on the patients and their families. Rather I am explaining the possibly negative effects of medicalization by Conrad & Schneider, and want to note that in some cases medicalization and medical treatment can be better founded than in others.

In western countries, our society has individualized significantly: individual trends, lifestyles and choices are emphasized. This development goes well together with the ethos of medicalization. In the medical framework, the problem is localized in the individual. Although blame, or even responsibility, is not placed on the individual, the diagnosis and the treatments are always focused on the individual patient. In a way this is quite sensible, as only an organism can really be physically and clinically sick (Mercer 1973, 7). The sayings about a "sick" society or a family unit etc. are only figurative. However, there is a grain of truth in those sayings: localizing the problem in the individual, ignores the possible effects and consequences of the individual's social (and other) environment. This view ignores the possibility, that the problems in the society are actually causing the person to suffer and show symptoms of adverse deviance. This way social problems come to be seen as individual illnesses. Thus, by treating the individual, we only treat the *symptoms*, while the *source* of the problem is somewhere else. (Conrad & Schneider 1992, 250.) In my opinion, this is one of the most significant points, when we examine the compatibility of medicalization and inclusion later on. How can we genuinely and fully include the person into our society, if at the same time, we dump the problems of the society on the individual, then expecting them to get rid of the symptoms those problems cause? We will get back to these thoughts later in the last chapters of this thesis.

Medicalization and the individualization of our culture are related to the *de-politicization* (*suom. epäpolitisoituminen*) of human problems. When we cannot see these problems as social problems, we cannot deal with them through politics, although these problems may come from the social and political structures and socioeconomic circumstances. (Conrad & Schneider 1992, 251.) Some such problems can be the so called functional alcoholics at work places, depressed marginalized youth or overanxious housewives. With these cases, the most pressing question, to me, is not, how we can make these people normal again. Instead, the question is: What is the normal amount of pressure, loneliness, fear and hopelessness, that the person should be able to take, without developing some kind of deviant condition? In other words, how much is it normal to suffer in silence before something brakes through the surface? And what could we, as a society, do to prevent or ease that suffering, before it causes additional problems for the individual? With many modern-day social structures, norms, responsibilities and expectations, it actually feels quite understandable or even *normal*, at least in the statistical sense, if someone loses the control from time to time. It seems to be quite *usual*. For example, the three conditions mentioned above are not isolated incidents. On the contrary, they are quite common and typical demographics to stereotypically suffer those illnesses or deviances – or should I say symptoms. Maybe this should tell us something; The individualistic (medical) treatment of certain human problems might not be enough. Rather, it is just a quick fix for the most adverse symptoms these people are showing. Meanwhile many more will get ill or show symptoms the same way, if the harmful structures of the society are not changed. With the de-politicization of deviance, it is harder to intervene with these issues deep down.

Interestingly, Conrad and Schneider (1992) lastly argue, that one of the negative consequences of medicalization is the disappearance of evil. Indeed, to them, this is a bad thing. By the disappearance or *exclusion of evil*, Conrad and Schneider mean, that when all the problematic and adverse sides of human existence and action are redefined as illnesses, there is no longer room for evil in the spectrum of human behavior. Through medicalization the term illness, and more often particularly *mental illness*, has become the term used to describe people's inhumane actions against each other. Now we say that bad, evil people are sick, when we actually mean that the unspeakably horrible things they did disgust us. For example, we could say that Adolf Hitler was sick, or that it is sick to torture innocent animals or babies. In these cases, the word “sick” is almost synonymous with the word *evil*.

Furthermore, this also yet again diminishes the blame and responsibility, and maybe even makes the actions more understandable. Of course, they are still not acceptable by any means, but being a product of a diseased mind explains or *excuses* some amount of the behavior. Else, these acts are so unbearable, that they are hard for us to even comprehend. But whether we can understand it or not, history shows us, that evilness is very much a possibility for any of us as human beings. The exclusion of that possibility is to twist the truth and to dwarf the spectrum of human action, and in doing so, we lose something from the multitude of human behavior. (Ibid., 251–252.)

In addition to these listed above, I want to mention one more problematic side of medicalization, although it is not necessary a consequence in the same sense as the ones mentioned earlier. Just like the concept of normality, medicalization also faces the demarcation problem. As the medical sciences advance to new fields, problems of demarcation include questions about which human problems, qualities and phenomena are seen as medical problems, on what basis, and where to draw the line on sickness and health regarding these phenomena, that have only recently come to be treated medically. According to Zola (1972, 498), it is theoretically possible to label almost any condition, that has at least the slightest impact on bodily functions, as an illness. Now, the demarcation problem arises, as almost everything we do and experience in life effects our physiology and the function of our biological body at least *in some way*. Mercer calls this the biology bias. (Mercer 1973, 10–11.) Furthermore, because many minor ailments are so common, virtually everyone has at least some symptoms almost all the time, be they just minor lower back pain, head ache, tinnitus, fatigue or bad breath. Now, if physical symptoms constitute an illness, virtually no one can escape the label of deviance. (Zola

1966, 616–617.) Combining these two biased notions, we could, in theory, say, that everything we experience (that we interpret to be negative) is an illness. So, the question is, where to draw the line of the effects, that are *significant enough*. And how about the line between good, neutral and bad effects on the body? Who is to determine where these lines are drawn and why?

Zola (1972) points out, that part of the problem is that the power to make these decisions is in the hands of one specific profession – that is, of course, the medical profession. Medicalization is coupled with the notion of objectivity, but in reality, the medical professionals may make these decisions and demarcations based more on their own personal prejudices and values, than on the scientific procedure and evidence. What is more, even these scientific procedures and protocols can be normatively charged and value-laden. (Zola 1972, 498; Mercer 1973, 15, 34)

The concepts of sickness and health are challenging to define. Health, for example, can be seen as the absence of sickness or, on the other hand, it can be seen as an optimal functioning or wellbeing. Sickness, in turn, can be defined as a bodily malfunction. However, it is actually never the case that an organism is completely and utterly healthy or completely and utterly sick.[6] No one functions absolutely optimally all the time, nor does anyone have sickness all over their body and mind. Instead, we always seem to linger on the interface, on the grey area, so to say. It is human to have imperfect and fluctuating wellbeing. The demarcation becomes especially tricky with the definitions of mental health and psychological wellbeing. (Boorse 1977, 542–543, 569–571; Tulloch 2005,

---

[6] Note, that this is a different notion than the categorical nature of some pathological conditions discussed earlier. For example, an HIV-virus is still a categorical on/off-condition. What I mean here is, that not having HIV does not mean, that you are completely healthy. You may still have some other, less or more perilous ailment. Also, having HIV-virus does not mean, that you are utterly diseased in all parts of your body.

320–322.)

Let’s take an example of anxiousness:

> It is perfectly normal to be *somewhat* anxious *in certain situations* and *about certain things*. It is normal to be anxious before a job interview or before meeting the future in-laws for the first time. It is normal to have anxious feelings and thoughts about climate change. It is normal to feel anxious in a car crash or straight after it, but at some point, after some time, it just has to stop. There are also physical phenomena on the background of these mechanisms of anxiousness. They even serve a purpose, they can be adaptive. Some people get more anxious more easily than others. Some people cannot do certain things because their anxiousness will not let them: Some do not want to drive a car, some cannot go to a rollercoaster or on a plane, some cannot eat broccoli. Some people even subjectively suffer from their anxiousness. Of course, we want to help at least the people who suffer for their level of anxiety. But at what point does the amount of anxiousness become pathological and demanding of treatment and on what basis? No one wants to deny the help from the suffering, but the valid definition of the boundaries of sickness and health cannot be subjective experiences alone. When, how and why does anxiousness become an illness in some situations?[7]

---

[7] Note, that the demarcation problem also seems to be somewhat in contrast with the biophysical definitions of health and normality, where many phenomena are categorical. Perhaps it is for this, that some have come to think that these categorical health-related phenomena are the “real” illnesses, and other, more arbitrary and ill-defined illnesses (like some mental illnesses) are examples of the so called over medicalization or false medicalization.

The same problems of definition, which we looked at in previous chapters, seem to lie in the foundations of the demarcation problem here as well. For example, it is clear that health and wellbeing are good and desirable things. Still we cannot define everything that is somehow non-optimal as deviance or sickness. In doing so we would get a way too broad definitions of sickness and deviance. Launis & Räikkä 1995, 83.) For example, deviating from optimal body mass index (BMI) is not yet sickness, although it may challenge optimal wellbeing. Or think about mental and cognitive capacities; For instance, what would be the optimal set of arithmetic skills or speech recognition? How would they be defined and why, and how many people could actually achieve them? On the other hand, health is not just the absence of sickness or deviance, either. Otherwise we would probably never be healthy, as we almost always have some minor fungal infection, acid reflux, gum disease, caries, acne or whatever small inconveniences. So, it seems that we would need additional conditions to these definitions, but there is no consensus on what these conditions could be, as different viewpoints on health and normality (ergo normative vs. interactionist, statistical vs. social constructivist etc.) dictate these opinions.

Often it is suggested as an additional condition for the definition of sickness, that diseases are such conditions, which are 1) harmful for wellbeing and 2) treated by medical professionals. Thus, the concept of sickness would be defined *through* the ethos of therapeutic treatment. Ironically, this viewpoint summarizes the demarcation problem perfectly. The boundaries of medical theories, treatments and practices, and the boundaries of medical institutions change over time, and thus, also influence our views on what is healthy or sick and in need of treatment and cure. (Boorse 1977, 545.) This would seem to be the case with many ordinary and normal life span phenomena like

---

pregnancy, delivery and menopause, for example. These conditions have come to be medicalized, because in the modern Western societies we know how to intervene medically, should something abnormal happen. (Zola 1966, 617–618.) Defining sickness through the possibility or demand for treatment, begs the question at best, and quite possibly leads to a vicious circle, at worst. On the other hand, with the demarcation problem, it is sensible to take the practical viewpoint into consideration as well. If we see, that the goal of the medical profession is to maintain and promote health and wellbeing, this task becomes quite hard, if we do not even agree on the boundaries of the goal condition. (Tulloch 2005, 321–323.)

Because of the demarcation problem and because medicalization advances on the fields of human psychology and behavior, many such properties that earlier were just regarded as different personality traits, individual ways of reacting or uncommon habits, now become seen and treated as illnesses. How far can we take this advancement and is there anything “normal” left after that? Will we at some point, or even already, medicate some personality traits, moods or feeling, like Zola suggested in the 70s? (1972, 495.) Also, with the high social status and the mechanism of social control, medicine often comes to our lives *before* any major, treatable illness even exists. These are called the *pre-emptive measures* (*suom. ennaltaehkäisy*), and they take place, for example, during pregnancy and child delivery, or if a person is part of a health risk group etc. (Launis & Räikkä 1995, 87; Zola 1972, 493–494.)

Thus far I have analyzed the concepts of normality and deviance as its reverse side, and in this chapter also the paradigm of medicalization and its consequences. Simultaneously with medicalization, another social framework, *inclusion*, is also prominent. Inclusion can be seen as a counter force to *segregation*, marginalization and institutionalization. Later on, I will argue, that to some extent the advancement of medicalization and inclusion go together hand in hand. In the earlier social paradigms, deviance has been seen as a sin or criminal disposition. It is only logical that the reaction has thus been to segregate and punish these people. Through medicalization, however, it has become more feasible to accept and accommodate the deviant individuals to the main-stream society. On the other hand, the situation is also more complex and even problematic. It could be argued, that the tactics of medicalization mainly (or only) enable the *physical inclusion* of deviant people in to the same concrete *spaces* with the so called normal people. To see this polymorphous relationship between these two paradigms, we now first turn to the concept analysis of the notion of inclusion.

7. INCLUSION

In the crudest sense, inclusion can be understood as *taking along, going along* and *belonging together*. We can talk about inclusion on many different levels of society and concerning different kinds of institutions. We can talk about the inclusiveness of the society as a whole, the inclusiveness of some institution as a whole (like a school, for example), or of some smaller part of that institution, or as a property of some physical space, construction or building, meant for social use (like the school building). In this thesis, my analysis concentrates mainly on the first two levels mentioned. I analyze inclusion as a societal phenomenon, but through concrete examples and thought experiments I try to tie the concept more closely to the school environment. Moreover, it must be noted, that these different levels and layers of inclusion are interconnected and influence each other. For example, working toward more inclusive schools and educational systems, will also, in the long run, improve the inclusiveness of the society and the societal ethos in its entirety. (Biklen 2001, 55–61; Lipsky & Gartner 1996, 788; Moberg 2001, 84–85.)

As I may have already insinuated, inclusion can be understood, not only on different levels, but also as taking different dimensions or scopes. It can be defined both extremely theoretically or in a very hands-on manner. In the narrowest sense, inclusion can be understood simply as a *physical proximity* of different kinds of people. Practically this means the desegregation and deinstitutionalization of deviant people. In the school context, for example, this means that all kinds of different pupils will sit together in the same classroom, regardless of their special needs, individual strengths and talents, possible disorders or handicaps. Thus, instead of segregating into special schools or classrooms, the disabled and the deviant will also attend the same schools, and basically the same classes, as the so called normal pupils do, in the so called ordinary schools and classrooms. This is often also called *integration*. Many times, inclusion in school context is also described with the term of "least restrictive environment", ergo LRI. This means that every pupil has the right to attend a normal class and not be excluded from the ordinary classroom unless absolutely necessary. (Crockett & Kauffman 2001.)

Then again, in the broadest sense, inclusion can be seen as an all-encompassing *philosophy of life*. According to Dorothy Lipsky and Alan Gartner (1996) inclusion is not a question about space and location, it is a question about the *redistribution of power*. Inclusion can be seen as a comprehensive anti-discrimination, anti-marginalization and all-accepting ideal – much like the ideal of *ahimsa*, for example.[8] In this broad sense, inclusion is seen as a social ideal or theory, which advocates equal participation and involvement of everyone in our common society. At least on the surface, this seems to be

---

[8] Ahimsa is a philosophical ideal of pacifism and anti-violence, most famously advocated by Mahatma Gandhi or the Buddhist religion, especially Jainism. The ideal can be summarized as a single statement: "*Do no harm*". In the broader sense, it also advices us to be benevolent and accepting toward all kinds of living beings, from plants and bacteria to other human beings, and to treat everyone and every*thing* with equal respect. (Tähtinen 1976.)

well compatible with the other social values and ideals of free, egalitarian and democratic western societies, with the famous motto of the French revolution “freedom, brotherhood and equality” still very much alive. The basis of this broad interpretation of inclusion is the notion that *difference is a riches*, an asset, and something to be cherished, coupled with the idea, that equality is the key to prosperity and well-being. (Biklen 2001, 55–59; Saloviita 1999, 13; Väyrynen 2001, 12–21.)

Undoubtedly this is a noble idea. Hardly anyone (at least in modern western cultures) will directly resist these beautiful principles. Unfortunately, however, such sublime wording provides very little practical advise on how to realize these great ideals in the real world. Maybe it is partly for this lack of concrete advise, that the applications of inclusion have so many times only concerned the physical closeness and accessibility, thus falling short of the deeper meanings of inclusion. Unfortunately, the physical proximity alone can hardly ever promote genuine connections and meaningful interaction between profoundly different people. Thus, it seems, that if we want to pursue inclusion, as is aligned in the UN general assembly of 1993 and the Salamanca declaration (1994), we need a more commonly understandable and more easily applicable, but also, at the same time, more wholesome and deeper notion of inclusion, instead of these two above examined extremities.

Actually, this is exactly what the modern inclusion discourses have aspired for in the recent years. More fruitful and applicable definitions of inclusion have been developed through a *process-like description* of inclusion. According to these descriptions inclusion is not something that just happens or takes place easily, spontaneously and once and for all. Instead, it is a *process of social change*, that is always in motion, as long as extensive societal efforts are made together towards the common goal of more and more inclusive society. As soon as inclusion is seen as a common goal demanding common effort, the pressure to change lifts from the shoulders of the deviant individual, and becomes the burden of the society and its institutions to become suitable environments to all kinds of people. (Thompson 2012, 65; Lipsky & Gartner 1999, 99–100; Väyrynen 2001, 16–19.)

According to Lipsky & Gartner (1996) inclusion is the combination of integration and individual approaches to support justice, fairness and equality. The relationship between inclusion and the individual is more complex than the patient-professional-relationship of medicalization. Inclusion sees both the individual skills, strengths, needs and impairments as well as the social surroundings of the individual. We are moving from the medical model towards a more inclusive society when we start to talk about *needs* instead of disorders or *disabilities* (Graham-Matheson 2012, 8–11). In the Finnish school system, this notion has been internalized as the model of special support in schools (*suom. erityisen tuen malli*). The decisions over special support are always done *individually* and based on the special assistance *needs*. Decisions must also be re-evaluated as the needs may change. (Opetushallitus 2016.) Furthermore, everyone has needs and the different needs can be divided into individual, special and general needs. When we talk about needs instead of disorders, we can understand the environmental factors more easily – and especially the non-physical social factors as well. The discourse should eventually move further from needs, to rights and the equality of possibilities. This guarantees that the inclusion does not stop at the level of mere integration, and that it does not concentrate on unidirectional adaptation of the pupil to her physical and social environment, but also, and even primarily, the adaptation of the environmental structures to enable the equal rights and possibilities for different learners. (Graham-Matheson 2012, 13–15.)

At the same time, this means that the discussion no longer concerns only some small, marginal group of deviant people, but it actually concerns all of us just the same. Now, to take an example of the school context, we want to make the teaching methods, as well as the school and classroom environment, more flexible, so that it will be a reasonable and pleasant environment for every pupil, be their individual challenges and strengths whatever they may be. In this sense, the pupil as an individual and the school as an institution are in a process-like interaction, which ultimately strives to remove the obstacles in the way of the full participation of the individual, and does this primarily by changing the *environment*, not the individual. (Ekins 2012; Väyrynen 2001, 16–19.) Described this way, inclusion is much easier to implement, assess, and develop further. Examples concerning the school world are many: We can use different and diverse teaching methods and pedagogies, build more accessible spaces and truly inclusive settings, like nurture group areas (see for example Middlemas 2012, 78–84) introduce different aids and tools, engage personal assistants and use different evaluation methods etc. Many times, the more diverse and flexible methods are actually the best ones for all students, even for the so called "normal" (healthy/neurotypical/without learning difficulties) learners (Lipksy & Gartner 1996, 767; Staub & Peck 1994, 36–39 cited in Lipsky & Gartner 1996, 786–787).

7.1. THE GOOD AND THE BAD OF INCLUSION

When it comes to the practical implementation of the ideas of inclusion it can be hugely advantageous to see inclusion as a dynamic social process. However, there are at least two main problems or worries about this position. Firstly, we have to keep in mind, that the experience of belonging, just as well as the experience of being marginalized, is a *subjective* experience. Although we can maybe improve the chances of feeling included, participation and being along is something everyone does and feels personally and subjectively. (Väyrynen 2001, 20; Biklen 2001, 61–77.) It has also been pointed out that inclusion is also an emotional process (Ekins 2012, 61–63). The idea of inclusion is that the *right* to these positive social feelings and experiences is equal for everyone (Lipsky & Gartner 1996; Salamanca statement 1994). Therefore, as every person is an individual with their own wants and needs, strengths and shortcomings, the ways of accommodating everyone's needs have to be extremely diverse. Guaranteeing equal chances for everyone, does not mean the same or *similar treatment* for everyone. On the contrary, many times it means *diverse and different* approaches to treat people according to their *needs*. Thus, approaches of an inclusive society or an inclusive school must be creative and flexible. For example, in the school world we want to tailor the curriculums more and more individually to suit the specific skill profile of every individual pupil. (Väyrynen 2001, 21–26; Rawls 2001.)

The need for diverse and different methods generates the second worry related to the resources for successful implementation of inclusion. To treat everyone, not only similarly and evenly, but *justly and equally*, we need to implement diverse methods, tools and aids etc. The diversity of tools means, that we need more resources, than in the ordinary homogenous classroom. In the ordinary classroom, it is usually the case, that one teacher teaches maybe 20 children in the same way at the same time, while they sit in the same room in their similar desks looking at their similar books. However, *everyone does not learn* the same things *the same way*, rate or time. Now, for this, we want to bring in more diverse teaching methods, tools and aids, different curriculums, new ways of evaluating, maybe even bring new personnel to the room, and preferably also less pupils per classroom. All these changes are said to *require more resources*. Partly for this, the attitudes towards inclusion amongst teachers have, in many different studies, been quite negative. (Moberg, 1998; 2001; Pinola 2008; Naukkarinen & Ladonlahti 2001.)

However, quite many studies have also already been conducted on the best ways to implement inclusion and for example Lipsky and Gartner (1999) have written a lot about the practice and application of inclusive principles in schools. It is not in the scope of this thesis to examine or speculate on the practices of inclusion any further. Instead, I will conclude this matter by noting, that many practical problems also arise from different interpretations on, and ways of understanding inclusion. Thus, confused, unclear and changing concepts and definitions of inclusion, deviance and normality clearly contribute to the practical problems as well. (Graham-Matheson 2012, 11). As stated earlier, the aim of this thesis is, in part, to clarify and open up these concepts and definitions to clear up the discussion, or at least to point out all the possible points of misunderstanding.

In the following chapter, I will go further into the reflective equilibrium and the analysis of the compatibility of these two paradigms. The analysis begins by examining the similarities and differences between the two paradigms and their stances on deviance and normality. Note, that the similarities or differences per se do not yet state anything about the compatibility or incompatibility of the paradigms.

8. REFLECTIVE EQUILIBRIUM: ARE THE TWO COMPATIBLE?

In this chapter, I apply the concept analysis' of the conceptions of medicalization and inclusion, and of their respective ways of defining and reacting to normality and deviance, all examined earlier in this thesis. These earlier analysis' are reflected in a holistic, process-like manner, to notice their similarities and differences, their compatibilities and incompatibilities. The aim is to spot the possible contradictions and incompatibilities and the reasons and factors behind the development of these problems.

8.1. THE SIMILARITIES BETWEEN THE TWO PARADIGMS: INDIVIDUAL TO THE FOREFRONT

In this subchapter I argue, that there are two main similarities between the frameworks of medicalization and inclusion. First of these similarities is the *motivation* or intent behind the practices and the other one has to do with the *targe*t of the rationale or operations in both paradigms.

Firstly, the motivational similarity between inclusion and medicalization is the endeavor towards more *humane practices*. The ideology and practices of both these paradigms are clearly striving towards less suffering, punishment, pain and blame compared to other social frameworks in the history of deviance. Both ideals claim to pursue better well-being inclusively for everyone: Not only for the so called normal majority, but also for the deviant or sick individuals. This is in clear contrast with the earlier moralistic and punitive paradigms, where it was more important to segregate the deviant away from the majority, to make the ordinary people feel more at ease – although often at the cost of the well-being of the so called deviant people. Both medicalization and inclusion aim to *help* (not punish or condemn) the individual.

Now we get to the second similarity: *the individual*, which is the target of action in both paradigms. Our western society is all about well-being, but it is even more about the individual – and so are the paradigms of inclusion and medicalization. Both paradigms raise the individual to the forefront of practical action and change. The ways they do it, however, are a bit different. Nevertheless, the aim of the actions taken is ultimately the same – the well-being of the *individual*.

Firstly, let’s examine medicalization, where this individualization is more prevalent. Medicalization uses the concepts of deviance and normality synonymously with the concepts of sickness (pathology) and health. Like mentioned before, sickness seems to be necessarily a property of an individual. Else, the term is only figurative. Only an individual can be sick or ill. Sickness exists only inside the body of the individual, often more specifically inside a certain organ, structure or function of the body. For this, of course, also the operations and interventions of medicalization target the individual. Many times, they even target more specific diseased body parts, or even distinct symptoms of the disease or malfunction. Like already became clear earlier, Conrad and Schneider (1992) have criticized medicalization for this individualistic stance, arguing that it makes it impossible to address social and socially generated problems, for which the individual is only showing some adverse symptoms. [9]

Although medicalization does not blame the individual, it also takes more theoretical attitudes toward the individual. Instead of blame, the individual is assigned the sick role – a part to play. According to medicalization, we do not want to label or stigmatize the individual, but we want to diagnose them. All done, of course, in the best interest of the individual. And so, the individual becomes *the patient*. The sick role obligates the patient to want, seek and receive medical help and treatment, but it also diminishes their responsibility and the level of their autonomy, at least in regards of their illness. However, this decrease in autonomy is not seen as a problem, precisely because of *the role*, the part

---

[9] Note, that these symptoms do not need to be only psychological or psychosocial abnormalities – they can be physical, too. For example, hypertension can, to an extent, be seen as a social and societal problem. It is often said to be a lifestyle illness. In the modern western societies, basically all of us have enough wealth to smoke tobacco, drink too much alcohol, eat too much meat and other greasy, sugary, unhealthy foods. At the same time, we live fast-based, competition and success orientated, yet comparably lonely lives, with demanding and stressful work lives and long working-hours often in sedentary office environments. These are all social, societal, cultural and environmental factors making many of us ill in the first place. Medical treatments only focus on the physical consequences, and so, only serve as temporary solutions for larger scale problems. These problems also impact, not only distinct individuals, but also the economy, for example.

of the patient. Through the sick role and through being the patient – ergo the object of medical operations – the individual will still be heard and taken into account. (Zola 1973.)[10]

Now, let's turn to the individualism of inclusion. Although especially the process-like description of inclusion locates the pressure to change heavily on the society and environmental factors, it is still primarily the individual's benefit we are looking out for. We want to make the social and concrete structures better-fitted for all, but we also want to diversify and tailor curriculums to be better suited for every pupil's personal and *individual needs and skills*. Also, the ideal to regard differences as riches and as a starting point is apt to feed the individualistic trend. Helen Turnbull (2016) has argued, that true inclusion is getting to know everyone's *individual story* and the continuous aspiration towards understanding different individuals. In a way, it could even be argued, that inclusion in itself might be a natural developmental step of the overall individualization and empowerment processes of the western societies. However, inclusion, at the exact same time also emphasizes the accountability of the society and social structures as well. In case they were in contrast with the individual's rights and needs, it is the obligation of those *structures* to change to accommodate the individual.

Inclusion also raises the individual to the forefront of the discussion by emphasizing equal rights of *participation, involvement and the empowerment* of deviant individuals. By empowering marginalized people, encouraging genuine belonging and supporting participation into society, inclusion comes to *endorse autonomy*. Like already described earlier, autonomy is the ability to rightly make one's own decisions and so, to take both the responsibility and credit for them. Autonomous action requires freedom,

---

[10] See Havi Carel (2008) about the subjective experiences of the sick role and the societal attitudes towards the patient.

intentionality and understanding. Freedom here means voluntariness, or coming from one's self, ergo, freedom from coercion, manipulation or blackmail. (Lindley 1986, 5–6.) Intentionality means deliberateness and willful action, as opposed to accidents, reflexes or coincidences. Understanding is a more complex matter. It means that the agent has enough relevant information to make well-based decisions. (Beauchamp & Childress 2001, 58–59, 88–89). But what does it mean to have enough information, what things are relevant enough to take into consideration, and which are good enough reasons for some decision over another?

Theoretically there are basically two ways, how autonomy can be endorsed. When *actively supporting* autonomy, we concentrate on ensuring that the abovementioned requirements are fulfilled. This can be done, for example, by giving full exposure on the relevant facts or even physically aiding the person do the deed they have decided on. When *passively supporting* autonomy, we only concentrate on refraining from practices that directly obstruct or violate one's autonomy. This is done, for example, by refraining from coercion, manipulation or leading use of language. It can also be understood as minimizing the factors threatening one's autonomy – for example dismantling marginalizing and discriminatory social structures, or building more accessible spaces. (Beauchamp & Childress 2001, 64.)

To my understanding, inclusion encases both these ways of supporting autonomy. However, it may be harder to understand or even notice all the ways passive supporting, ergo dismantling certain social structures, for example, could and should be done. These abstract structures, cultural habits, biases and power relations also sit extremely tight in our society. For example, in the field of disabled studies, special education has been criticized for paternalism as "normal", non-disabled, non-marginalized scientists study the deviant, the marginalized, "the Other". The critics argue, that this does not help dismantling the juxtaposing or marginalization, but on the contrary, may even help to preserve and endorse it further. (see Vehmas 2005; Hallett & Hallett 2012) Also, people tend to adjust to the impact and exercise of dominance. This means that the marginalized people react and behave in ways that show their submission. For example, they may remain silent in situations where they actually would have something to say, but where those who represent the dominant culture are leading the discussion. (Turnbull 2016, 31.)

This generates two questions. Firstly, have the social structures and power relations already ripped the marginalized for their possibility to ever have a voice, by destroying or diluting their abilities to participate? (Richards 2012, 26.) Secondly, does this submission actually facilitate the abuse of power by the dominant majority as the silence actually allows the perpetrator to continue to feel innocent? At least it does not help the dominant to realize their dominance and privilege, or even the existence of differing minority views. (Turnbull 2016, 31.) These problems, to me, highlight the reciprocal and bilateral nature of the process of inclusion, as both the majority and the minorities need to be participating in the discussion.

8.2. THE DIFFERENCES BETWEEN THE TWO PARADIGMS: ACCEPTANCE VS. TREATMENT

In a way, we already started to see some differences with inclusion and medicalization concerning autonomy and the object of change in the previous chapter, although it was meant to highlight the similarities between the paradigms. This may be taken to say something about the nature of similarities and compatibilities between the two paradigms – namely, that they seem to be quite superficial. I will now briefly continue on the differences concerning autonomy and then turn to examine other apparent differences between the two paradigms.

In many bioethical texts, and also in the Finnish doctoral oath, for example, some weight is explicitly given to the autonomy of the patient, as well (see Beauchamp & Childress 2001; ten Have & Gjordijn 2013; Finnish Doctor's Oath, Lääkärinvala 2013.) This may even be an emerging trend as discussions about the rights to abortion and euthanasia proceed. However, the autonomy of the patient is often mentioned in the light of the doctor's ability to better evaluate and decide *for* the patient. In philosophy, this is called weak paternalism. The other way for doctors to relate to the autonomy of the patient is to view the patient's autonomy as a border or limit for the doctor's responsibility. So, the doctor is only responsible of the treatment, to the point that the patient does not have autonomy or does not exercise her autonomy. This is called the model of respecting autonomy. (Launis 2007, 121.)

Actually, the doctors can also make decisions *about* other people's level of autonomy. This is the case, for example, with the state of mind examinations (*suom. mielentilatutkimus*) and *non compos mentis* verdicts (*suom. lausunto syyntakeettomuudesta*). This is called the gatekeeping role (*suom. portinvartijarooli*) of the medical profession. (Beauchamp & Childress 2001, 69–70; Conrad & Schneider 1992, 244.) The power to make these decisions can be seen as a form of social control and paternalism as well as a sign of prestige the medical profession has. These in turn, have been understood as one of the consequences of medicalization, as mentioned before. (Conrad & Schneider 1992, 241–250; Mercer 1973, 34.) In any case, this power over about someone else's autonomy is in contrast with the inclusions aims of empowering people, supporting their autonomy and deconstructing paternalistic structures.

In addition to these intersections regarding the notions on autonomy, I argue that there is one even more fundamental difference between the paradigms of medicalization and inclusion. That fundamental difference is the difference between the ethos of therapeutic *cure* and the ethos of empowering *acceptance*. I will argue, that this difference may be so profound and severe that it can lead into unreconciled contradictions between the two paradigms and an impasse of cure versus acceptance.

According to medicalization *human problems are to be solved through medical treatment*. This treatment can be 1) pharmaceutical 2) other medical interventions (like surgery) 3) therapy (physical and/or psychological) 4) any combination of some or all of these. The aim of this treatment is to A) promote health, B) intervene with illnesses, C) cure sickness and D) ease suffering (Lääkärinvala 2013.) As we saw earlier, medicalization uses the concepts of healthy and normal as well as deviant (abnormal) and sick synonymously. This is also the case with mental illnesses. Like we also saw earlier, medicalization relies strongly on the statistical and biophysical conceptions of medicalization. (Mercer 1973, 2–11; Launis 2007, 117.) According to these conceptions coupled with the naturalistic and positivistic views, sickness/deviance and health/normality are real, independently existing states of affairs. However, there is also a hidden normative connotation on the concepts of health/normality and sickness/deviance in the framework of medicalization. Implicitly, it is clear that health is something desirable or good, whereas sickness is inherently bad and undesirable. Ergo, normality is desirable, deviance is bad. Hence the ethos of therapeutic cure.

Let’s see this notion in the form of a non-formal argument:

1) Medicalization uses the terms healthy and normal as well as deviant and sick synonymously.
2) Medicalization relies mainly on the statistical and bio functional conceptions of

normality.

3) Bio functional conceptions of normality have implicit normative connotation and medicalization also imposes them on statistical views on normality
4) **Thus, existence of health is something desirable and good, whereas the occurrence of sickness is something unwanted and negative.**
5) Only an individual (or a part of an individual) can be sick
6) The aim of medicine is to cure sickness and restore health
7) **Because the term "healthy" is synonymous with "normality",** ***to cure is to return to normality.***
8) **Because sickness is located in the individual,** ***the cure is focused on the individual.***
9) **Thus, the aim is to** ***return the individual to normality*****.**

According to medicalization, although deviance/sickness is bad, it is also *curable*. Through medical intervention and treatment, it is possible to restore health, and so, to *return the individual back to normality*. Actually, this is, in summary, the meaning of the so called therapeutic ethos of medicalization. The therapeutic ethos, in turn, is said to be one of the most positive sides and consequences of medicalization, bringing about, amongst others, the humane treatment of patients, also known as deviant individuals. The justification of the therapeutic ethos comes from the hidden normative meanings of normality/health and sickness/deviance. These normative connotations are smuggled in the bio functional, and even the initially neutral, statistical views of normality and deviance.

The conclusion is a straight result from 1) the synonymous and vague use of the concepts of sickness and health and deviance and normality coupled with 2) the naturalistic and positivistic views, 3) normative connotation on deviance/sickness and normality/health and 4) the therapeutic ethos or the desirability of treatment and cure. Note, that this is a logically valid argument. It means that the conclusions logically follow from the premises. The conclusion (number 10) and intermediate conclusions are marked with bold letters. The argument represents a form of *modus ponens,* the so called "if x then y" -reasoning. When an argument is logically valid, it means that it is inherently coherent and correct. (Sober 2013, 13–15.) Note that we can still oppose or disagree with the argument and its conclusion. To oppose or disagree with the conclusion, we need to abandon or refute at least one of the premises. When an argument is logically valid, we cannot hold and accept the premises, while denying the conclusion, because the conclusion follows necessarily from the premises. However, if we abandon any or all the premises, we can also abandon the conclusion,

The argument above is also contingent. *Contingent argument* means, that its truth value is dependent on its correspondence with the outside reality. Thus, this is *not* an *a priori,* but an *a posteriori* argument. The argument only holds true as long as the premises correspond with the reality. (Aspenson 1998, 34; Sober 2012, 53.) For example, we could abandon the synonymous use of the concepts of sickness and deviance. We could also deny the normative connotations of sickness/deviance and health/normality. This however, is unlikely and implausible, as it feels intuitive to regard sickness as a bad thong and health as a good thing. Refuting this premise would also eat away at the foundations of justifying medical treatment and the ethos of the act of curing. In any case, whenever one of the premises of this argument does not hold true, it does not correspond with the reality, and thus is not a sound argument, although it is still valid. (Ibid.)

Now us, who already know a little bit about the ideals of inclusion, may find something suspicious in the medicalization argument above. It may not be a faulty or wrong, let alone condemnable idea or argument in itself, but in regards of the compatibility with inclusion it seems to be a bit problematic.

Like the ethos of therapeutic treatment for medicalization, acceptance and tolerance are the primary ethos for inclusion. Like we have seen earlier in this thesis, inclusion often takes a more normative and constructionist stance on normality and deviance. Ergo, we can not necessarily see anything normal or deviant in the reality, per se, but rather, they are crude categories, that the mind imposes on the multitude of human existence. When this categorization becomes institutionalized, it becomes a device of social control. Those in control have the power to determine these categories and their boundaries, regardless of their objectivity. It is precisely to this, that the ideal of inclusion hopes to bring a change. That change, in turn, is brought about, both, by actively deconstructing the categorization and, on the other hand, by the attitude of acceptance, tolerance and anti-discrimination. This kind of profound tolerance means, that everyone is and can be different. For this, it also means that no-one has to change for the sake of others, not even for the sake of the vast majority. Actually, it might even be the other way around: The attitudes and structures of the established majority may have to change, to accommodate everyone's needs and prevent marginalization.

Now let's see this rationale as an argument:

1) Every individual is different.
2) *The aim of inclusion is to accept*, accommodate and celebrate everyone's different skills and needs.
3) **Thus, *there is no need to change or erase individual differences*.**
4) The dominant majority (and/or professions of prestige) hold the power to use social control over others, especially the deviant.

5) The *one-sided use of social control makes the society not accepting* and not attainable for all different individuals.
6) ***Thus, it is the society, that has to change*, so that everyone may feel welcome and empowered.**

This too is a valid contingent argument. Note that especially premises 4 and 5 are highly empirical. If these premises do not correspond to reality then the argument is not sound. Also, in that case we may conclude that the task of inclusion is completed. According to inclusion, difference and diversity are the starting points of society and social life. They are also to be cherished, accommodated and accepted. Sometimes with medicalization it seems to be *the other way around*: Normality is the starting point, the point of deviation. Deviant individuals are to be medicated in order to make them normal again. Medicalization wants to cut the bell curve from both extremes.

The best most salient examples of this are psychological issues:

> We want to treat both social hyperactivity and extreme shyness. There is something suspicious about both conditions. Mania is no more normal or acceptable than depression. Both are adversities of the normal scale of mood swings. A certain amount of aggression is said to be a good thing, but both extremes can be quite damaging: the excess is damaging to others and a total lack of it, is often bad for the person himself. Punctuality is a valuable trait. Yet it is pathological to be punctual to the point of compulsive obsession, just as is it is pathological to be totally negligent and oblivious, too. Normal working memory capacity is about seven digits. Yet someone may only remember 2 or 3 and another may remember 30 or more. Both

> may be quite agonizing conditions at times.

Now, I am not saying that we should let people be as manic, depressed, or anxiously obsessed as they are or want to be. Or, that we need to tolerate extreme aggression and violence, for example. I am not saying, that inclusion demands that either. The point is, rather, that there can be other additional or alternative solutions to the problems caused by these extreme versions of behavior, personality traits and reaction tendencies. The endeavor of bringing the expression of these traits closer to the population mean often is not the only option, maybe not the best one either. However, I also want to explicitly note, that there are many medical fields and issues, where the statistical mean, the bell curve or the concepts of normality and deviance do not seem to matter much, if at all. There are some almost “purely” physical traits, functions and issues, where the physical, medical treatment is clearly both the best and often also the only possibility. Such are, for example, many, if not all, surgical issues as well as the likes of mending broken limbs or treating small box, HIV or ebola. However, we have to, of course, accept and empower the ones battling with these conditions and diseases, too. The best solution is about the right combination and amount of implemented measures.

In the table on the following page I have summarized the similarities and differences of medicalization and inclusion. Next, I will turn to the compatibilities and incompatibilities of the two paradigms.

Similarities and differences between medicalization and deviance:

SIMILARITIES		**DIFFERENCES** **Medicalization** **Inclusion**	
Humane ethos		**Autonomy**	
		The sick role implies diminished autonomy (regarding or caused by the pathological state).	Support autonomy, empower the marginalized and deconstruct paternalism.
Individual to the center		**Stance on deviance**	
Medicalization: Individual is the patient. The patient is the object of medical procedures.	**Inclusion:** Everyone is an individual/has individuality. Every individual is different.	Deviance is real, objective and independently existing. Deviance is unideal or bad.	Deviance is a social construct. Any normative connotations are culture dependent and arbitrary.
		Operational measures	
		Medical treatment, the aim is to cure the sick/deviant, thus restoring health/normality.	Acceptance and toleration, aim is to accommodate all needs and skills.
		The target of measures taken	
		Individual, ergo the patient	The society, social and common physical structures and institutions

8.3. THE COMPATIBILITY AND INCOMPATIBILITY OF MEDICALIZATION AND INCLUSION

In this on-going chapter, I have established some similarities as well as some major differences between the paradigms of medicalization and inclusion. The differences, per se, do not yet conclude anything about the incompatibility of these social frameworks. On the contrary, certain amount of differences between the two philosophies may even complement each other, and so, together they may make up the most fruitful and well-fitted approach to any and all human problems. On the other hand, these differences could be so profound and intense, that the paradigms are in an irreconcilable disagreement.

8.3.1. MEDICALIZATION AS AN ENABLER OF INCLUSION

Many medical treatments, operations and aids are designed to help the individual function in their normal day-to-day life and environment. The goal is to retain *action competence* (*suom. toimintakyky).* For example, prosthetic legs, pacemakers and hearing aids are such concrete, physical, functional aids, which make it easier for people to live and act as they may have acted before their illness or accident, and as everybody else is typically able acting. Note, that also other less concrete and straight forward intervention often aim at this outcome. For example, anti-anxiety or ADHD medication can come a long way in enabling people suffering from anxiety, or living with ADHD, to behave in the same way as others do, and to maintain their quality of life. So, it seems, that in a sense medical interventions too, concentrate mainly on guaranteeing the *relational abilities*, discussed earlier in chapter 4. Instead of guaranteeing the *intrinsic abilities* (except maybe in transplant surgeries), the interventions focus more on supporting and sustaining the person's *competency* and *performance*. In this way, the question is not about what abilities the person themselves has or lacks, but what they can do and *accomplish*, regardless of the amount of help and support they need to succeed. [11]

Just like with the basic ethos of inclusion, it is not the primary goal of all medical practices to change the individual, but rather to support and enable them to function in meaningful and reasonable way. In this sense then, it seems, that the medical interventions make it possible to accomplish the sentiment of inclusion in practice. Also, it may well be the same sentiment, ergo, the will to include and accept everyone, that has, in the first place, directed the trajectory of medicine and medical treatments to help and support people's competency and natural (typical) capacities. So, at least in a sense, these social paradigms and their development seems to be not only compatible, but they seem to go hand in hand.

Furthermore, I think, that at least when it comes to the most narrow, physical level of inclusion, the medicalization paradigm is at its most compatible with the paradigm of inclusion. When the primary objective is just to bring the different individuals to the same physical space – and especially when the space is initially designed for the average, "normal" people – it becomes extremely important to adjust and modify the deviant features and skill sets to fit the ordinary environment.

Let's take two examples from the school context:

1) *ADHD medication:*

   For a child diagnosed with ADHD it can be excruciatingly hard to try and sit still and silently for 45–60 minutes at a time. It can be made easier in a special

---

[11] Notice, that many such interventions are really quite common and absolutely necessary. For example, eye glasses (and contact lenses or eye surgery) are, in a way, maybe the most common medical aid. They also make the users life, behavior, competency and quality of life totally and utterly "normal", so to say. However, without them life would be quite difficult to many, and often also painful and dangerous. Many things, like driving a car or reading and writing, could be even impossible to some. This example just goes to show, that practically every single one of us will need at least some (medical) help in some things at some point in our lives.

environment with special aids, and pedagogies and with an assistant. If, however, our only (or main) aim is to bring the child from these special settings into the "normal", ordinary setting, something else has to be done to guarantee the peace to learn for every pupil in that class. In this case the medication can help in both calming the outward behavior, thus protecting the peace and quiet, and in making it easier for the child to stay concentrated.

2) *Prosthetic limbs and remedial surgery:*

   We have a clear schema in our minds on how the human body should look like. We instinctively notice right away if someone is missing a leg or an eye, or if their hand is misshapen or malformed. And what is more, upon noticing we also instinctively feel quite uneasy, perhaps even disgusted in some extreme cases. Of course, the loss or malformation of limbs and organs also cause harm to the individual, as at least their intrinsic abilities to move, see or write, for example, can be endangered. By building and installing a realistic prosthesis to a stump or an empty eye socket, or by reconstructing a nose, for example, we can easily make the person look and appear quite "normal", so to say. This can make it less likely for other pupils to stare and point, or maybe even notice the abnormality at all. This, in turn, can also be easier for the child's self-esteem and for an integrated self-image, as well.

What is more, these normalizing, relational skill enhancing operations and treatments often make it psychologically easier both for the deviant people to come to the same space as others, and for the so called normal people to accept the deviant, "the Others", to what was earlier exclusively their space. It is undoubtedly easier to fit in when you look, act and feel like everyone else does. Similarly, it is also easier to look at and react to, let alone accept, someone who looks, acts and is basically the same way as you are. (Turnbull 2016, 5.) Turnbull (2016) points out that inclusion does not come naturally to us and we only want to include people who are like us, or at least willing to do what it takes to fit in. This will is also built-in to the sick role as the requirement to seek (medical) help and the desire to get better (Zola 1973, 678). Therefore, it feels that medicalization in a way enables and promotes at least physical inclusion. Medicalization promotes unity and brings the Others closer to Us in many ways: at least in their looks, behavior and relational skills. Then it is up to us just to let them into the common spaces, to open up our doors and gates – quite literally, not figuratively.

8.3.2. THE TWO PARADIGMS AS HINDRANCES TO EACH OTHER

In this sub chapter I will come to the two main points of this thesis. Firstly, I will argue, that there are more complications in the relationship between medicalization and inclusion, than there are similarities and supporting matters. Secondly, I will argue that these incompatibilities also regard the more profound structures and ideas of the framework, thus making the contradictions even more severe. To summarize the many nuances of differences between medicalization and inclusion, I argue, that there are mainly four basic incompatibilities between the paradigms, but these four generate a multitude of consequent dilemmas and practical problems. These four main incompatibilities are 1) the location of agency (*suom. toimijuus*), 2) the degree of tolerance, 3) attitude towards labeling and 4) the target of change. They are next explained and analyzed in this order.

Like I have examined earlier in this thesis, the proponents of medicalization regard the paradigm as a more humane form of social control than its predecessors, like the religious or moralistic frameworks, for example. The humane nature of medicalization rests mainly on the notion of the sick role. Through the sick role the deviant individual comes to be seen as a patient, and thus, becomes the object of medical intervention and treatment. The point of the sick role is twofold. Firstly, it is said to lift the stigma, blame and responsibility off the individual's back Secondly, the point is to obligate the patient to want, seek and accept treatment. (Zola 1973, 678.) Here we may start to see the problem already, but let's dig a little deeper.

Like I noted earlier in chapter 8, to erase or decrease responsibility is to decrease autonomy. Only autonomous agents can be responsible for their actions (necessary condition). Actually, responsibility over one's own actions is a product of autonomous decision making. If responsibility is decreased, it means that some or all of the conditions of autonomy have been endangered. Remember, that these conditions were freedom, intentionality and understanding. To my understanding it can be any one, or any combination, of these conditions that is regarded as endangered depending also upon the illness or handicap. For example, with different accident related and innate conditions both freedom and intentionality are clearly absent. With many complicated, multi-factor conditions like cancer or autism, it is often mainly the understanding that is regarded insufficient. What is more, these approaches and views on lowered autonomy and different conditions of autonomy are usually *implicit* – hidden in the discourse, and not explicitly expressed in the discussions between the doctor and the patient, and their family or the society at large. Moreover, the decline in the individual's autonomy or the conditions of autonomy are often represented in contrast with the doctor's autonomy and abilities. For example, the doctor should decide on the additional inspections, tests and treatments, because the doctor knows better, meaning that the doctor understands the relevant facts about the mechanisms of the illness, whereas the patient is just a ley-man, and so, should trust the professional and follow their advice.[12] (Launis 2007, 121.) Next, I will briefly problematize the sick role and the decline of autonomy a bit further, and then, examine, why it is incompatible with inclusion.

To me the main problem with the sick role is conceptual. How can the sick role, at the same time, release the person of responsibility and then obligate the person to seek, accept and prefer medical help? As far as the release of responsibility, and thus the lowered autonomy, go, they must be with respect to *medical* or *health issues* – probably even more specifically, with respect to that specific medical condition the person has at that moment, when they are diagnosed and then treated. What I mean to say is, that although the patient may have less responsibility and autonomy over their illness, only very few, and only quite rare, diagnosis' are thought to diminish their responsibility or autonomy in other fields of life. Remember, that autonomy is *not* a categorical condition. For example, people suffering from cancer, HIV, flu, tinnitus, acne or heart failure would still be regarded responsible for, say, murder, robbery, paying bills, putting on clothes and feeding their cat. Of course, there are also some (nowadays) medical conditions, like mental retardation, psychopathy and Alzheimer's decease, amongst others, that significantly lower the autonomy and responsibility in other fields too, but it is still *concerning* or *because of* their *illness*. These people too, can be autonomous in certain decisions and actions, not related or caused by their illness, like deciding what food to eat in a restaurant, which color of back bag to take to a park, or to watch TV or to play chess after supper.

Like noted earlier, autonomy is a continuum: not an on/off –state but a dynamic property.

---

[12] Controversially enough, many times the individual is also blamed for some, so called, lifestyle deceases, like liver cirrhosis for alcoholics or diabetes or coronary heart decease for obese people. The treatment of such conditions encounters a steady stream of opposition, especially related to public health care.

Thus, the decline in autonomy due to the implementation of the sick role must be a decline *regarding medical issues*. Now then, *how can the person be obligated* to certain actions and attitudes *precisely in respect of their illness* or medical condition? How can one be obligated to do something and not responsible for precisely that something? This is really quite confusing and complicated, and I believe this is also at the root of some problems regarding involuntary treatment, treatment of addicts and other social control issues of medicalization[13]. I also believe that this can be a mere semantic issue and only an ostensible problem, but the core trouble here, once again, is the lack of explicit definitions and open, full disclosure of some basic principles, premises and arguments of medicalization.

Now let's turn to the disagreement with inclusion. When understood in the broadest sense of the concept, the aim of inclusion is to increase involvement, participation and agency. These are all dependent on autonomy, and that is precisely the point: to empower the marginalized people and give them back the autonomy regarding their own issues. The point is, to give them say, at least about their own lives and issues directly concerning them. That way, and only that way (as autonomy generates responsibility), these people can be responsible of what happens to them. So, they can be both charged and praised for their actions and decisions, because these are both important sides of being a competent, independent and committed human being. Being free of blame and responsibility might be of little consolation if you are deprived of autonomy. So, the paradigms are in a clear

---

[13] Often, for example, people are reprehended over going to a spiritual healer instead of going to the hospital, when they have, say, cancer – especially if that decision later proves to be futile or harmful. Instead, the sick person has a duty to see a doctor, whereupon almost magically the patient's responsibility, as well as autonomy, over their pathological condition end, and become the responsibility of the doctor. Now, if the measures taken by the doctor prove to be futile or harmful, no one is reprehended (unless the doctor has committed malpractice or some other crime), but instead the patient is pitied and the illness is to blame.

contradiction with each other when it comes to autonomy: It is impossible to, at the same time, diminish autonomy and to support autonomy. [14]

There is another ideological contradiction and incompatibility between these two frameworks. Different ways of defining and understanding difference lead to differences in how much deviance we are ready to tolerate. The stricter the definition of normality, the less the framework tolerates difference and deviance. (Mercer 1973, 25, 32). Medicalization tries to rely on strict, objective definitions of normality, like the statistical and bio functional models of normality, where the line between the normal and the deviant is supposed to be quite clear-cut, mathematical even. Inclusion, on the other hand, admits that normality is a social construction and as such, it is changing, dynamic, culture dependent and arbitrary. For this, we have very different levels of tolerance between the paradigms: Medicalization does not tolerate difference or deviance well, whereas inclusion does – it is the whole point of inclusion. By contrast, the whole point of medicalization is to cure, as in erase or diminish, deviance and adverse differences. In the medicalization framework difference is pathology. In the inclusion framework difference is a riches. Something cannot be an undesirable pathological state and a celebrated quality at the same time. Hence, we have another contradiction.

According to previous studies, the medicalistic view of deviance hinders genuine and complete realization of the ideals of inclusion. The problem is that inclusion, a true sense of belonging and substantial participation cannot happen, while the deviant are seen as significantly different than Us, the majority, and thus, in need of treatment, betterment or

---

[14] Note, that medicalization does not explicitly and purposefully diminish autonomy. It, sort of, just happens through the sick role and through the patient-doctor -power relations. Medical professions also seem to acknowledge this problem, because their ethical codes often try to emphasize respecting the patient’s autonomy. Inclusion maybe supports autonomy more purposefully and explicitly, but many times also indirectly, for example, via dismantling oppressive social structures.

cure. (Russel 1998, 16–17.) Medicalization aims at labeling (=diagnosing) and treating deviance, and in so doing fading the multitude of difference and deviance from view, thus sustaining a narrow view of normality. I mentioned earlier that medicalization may, in some sense, facilitate physical inclusion. That is just it: Medicalization only contributes to physical *integration*, not overall inclusion. Where medicalization asks, should we normalize (=cure) this, inclusion asks, should we accept this. These are by definition almost the opposite approaches. Medicalization plays to our desire to stay within our comfort zone where remarkable deviances are not shown (Turnbull 2016, 6.) Inclusion is integration coupled with social justice and a sense of belonging. Medicalization hinders the latter conditions. It has been stated, that the social constructivist model better supports genuine inclusion than medicalization does. The social constructive model actively encourages to break and dismantle potentially harmful customary patterns of thought and social construction, and to broaden the boundaries of normality. (see Vehmas 2005). We move from medicalization to inclusion precisely when we move from managing pathologies and defects, to tolerating and supporting different skills and needs (Lappalainen & Mäkihonko 2004, 70–71.)

These two major contradictions I have presented thus far, are more theoretical and ideological incompatibilities. I will next argue that there are also at least two more practical inconsistencies, too. First of these is the procedure of labeling. Medicalization claims to reduce stigma, as it does not blame or condemn the deviant, like we used to do before. However, instead it assigns a diagnosis, which is a type of label as well. This, however, is not seen as problematic by the proponents of medicalization, as the diagnosis is regarded as a scientific, and thus a non-normative procedure. On one hand, this can be true: diagnosis is not as stigmatizing as such oppressive terms like imbecile, retard or cripple. On the other hand, labeling is always a force of social control when it comes from outside the individual. (Richards 2012, 22) In case of medicalization it comes from a distinct professional group, ergo the professionals of medical sciences (Mercer 1973, 34). This represents the dominance and supremacy of the medical profession on one hand, and on the other hand, the paternalism of the majority or of the professionals who know best, instead of the deviant being the experts of their own situation (Richards 2012, 26; Lipsky & Gartner 1996, 776). According to medicalization, we need the diagnosis, because only then we know what treatment to assign and how (Richards 2012, 29). The medical model of disability sees special education, for example, as a *symptomatic treatment* to disability. Disability diagnosis implies the need for special treatment and special treatment is best provided in special systems. This is often the well-meaning rationale behind arguments for segregation. (Lipsky & Gartner 1996, 763.)

It has been said that inclusion is the opposite of this: Inclusion is abandoning the labels. Whereas medicalization needs the diagnosis to know how to proceed and what to do. Inclusion, on the other hand, would abandon paternalism, and thus the need for others, or for the professionals, to know what to do. Instead, inclusion would encourage the dialogue between different individuals, asking them how they feel, experience and understand their deviance, and how they would want to, or need to be treated. (Richards 2012 25–26.) When special treatment leads to special systems the structure generates continuing dependence of external help and services, and so, restricts genuine participation and independence. This way we come to deprive the deviant of their equal possibilities to be heard and to belong, making them lesser citizens. (Gartner & Lipsky 1996, 764.) So, the other social framework deconstructs labels, while at the same time, the other generates a more organized system, and even a manual for labelling (diagnosing) the deviant. These are not compatible policies.

I will present and examine only one more incompatibility between medicalization and inclusion and this one is of a more practical nature, too. This incompatibility generates from the depolitization, that Conrad and Schneider (2010) pointed out. Medicalization depoliticizes human problems, as when they are understood as illnesses, or other pathological deviances, they can only be seen as individual problems. Thus, the larger perspectives on the surrounding social and societal factors, like the effects of one's socioeconomic status, gender, race, or other subcultures, are overlooked. While medically treating the problem, we are most often just applying the so called symptomatic treatment (*suom. oireenmukainen hoito*). This may not even be the cure for the pathology, and it most certainly is not the solution for the underlying problems and their initial reasons.

Zola (1973; 1966) has noticed, that sickness and health have a strong sociocultural dimension, or rather, that *they themselves are* social phenomena. According to Zola people do not primarily seek medical help because of the adverse symptoms, or the experience of being ill, or even because the illness is getting worse. Instead, people ask to be treated by a doctor, not when the symptoms are at their worst, but when the illness or the symptoms *start to collide* with their social environments and social lives. People most often go to the doctor's when the illness starts to disturb their lives, but not in the sense of symptoms coming unbearable in themselves, but because they go against other expectations, like when you should go to work, or travel, but you have the flu, or when you should have energy to take care of your children, but are too tired or in pain etc. (Zola 1973; 1966.)

This goes well together with the notions, that disability is not caused primarily by the impediment itself, but by the social and physical structures, that make the impediment problematic and harmful. What is ironic, however, is the doctor's inability to take into account the big picture of the patient social environment and other societal structures, because precisely these factors play a huge role in that the patient has come to the appointment in the first place (Zola 1966; 1973). Thus, the so called symptomatic treatment seems unfounded, or insufficient at best, because the symptoms in themselves are not the problem. The experience of illness, like the experience of inclusion, is a subjective, emotional experience, and a process as well. What symptoms the person experiences, how they experience them, and when and how they seek treatment for them, are greatly influenced by sociocultural factors. The subjective experiences, in turn, influence the way the patient talks about symptoms, and what symptoms they choose to disclose in the first place. The symptoms the patient articulates, and the way the patient talks about them, influence further examination and tests done by the doctor, and thus, ultimately, the diagnosis and treatment that patient receives. Consequently, the act of diagnosing and treatment are ultimately sociocultural processes. This is not fully recognized by the medical profession. (Ibid.)

By contrast, solving the underlying larger scale problems is just what inclusion tries to accomplish. So, it seems that the targets of medicalization and inclusion are very different, maybe even utterly opposite. For the other the target of action is the deviant individual or even his or her specific deviant or symptomatic features. For the other the targets are the structures, norms and systems of the society. While inclusion says, that the society or the institution needs to change to accommodate and accept every individual, medicalization says, that every individual has to change, to fit into the society or the institution. Inclusion aims at deconstructing the boundaries of normality, while medicalization aims at fitting every individual inside the existing boundaries of normality. The attempt of fitting everybody in only endorses the narrow and solid boundaries of normality, while simultaneously the other paradigm tries to pull the rug underneath the whole social construct of normality. Thus, it seems that the paradigms are doing conflicting or reverse work and so annihilating each other’s work reciprocally.

Below, I have summarized the incompatibilities of medicalization and inclusion in a simple chart.

Incompatibilities of medicalization and inclusion:

	Agency	**Degrees of tolerance**	**Attitude towards labeling**	**Target of change**
Inclusion	Supports agency and empowerment. Tries to increase the sense of agency for all, especially for the marginalized.	High degree of tolerance. Endeavour toward celebration of diversity and appreciation of homogeneity in the society.	Aims at deconstructing and refuting any and all labels coming from outside the individual.	The abstract and physical social structures, attitudes, biases and distorted discussions, discriminatory institutions
Medicalization	Lowers the agency of the deviant by assigning the sick role. Increases the agency of health and medical professionals, thus enforcing paternalism.	Low degree of tolerance. The boundaries of medical views on normality are strict and they are upheld and endorsed via the therapeutic ethos.	Aims at diminishing the stigma of labeling by constructing the institution of objective diagnosing. Has to assign diagnosis before the right cure can be found.	The individual or the diseased or malfunctioning parts of the individual or the symptoms of said disease.

Someone supporting the compatibility of these two paradigms may argue, that the examined differences and even some apparent contradictions do not mean that the two paradigms are mutually exclusive, but only that they have a *different scope*. Both paradigms are simultaneously present in our society, and some of their ideas and approaches are quite different, but this may not be a problem, as the two paradigms may deal with slightly different areas of human difference and diversity. Thus, it could be highly beneficial for them to influence the society together, as they could function best and most pervasively together, thereby offering something for everyone. However, there is a familiar problem with this view: Where to draw the line with these two different yet adjacent scopes of influence? Yet again we are back at the task of clarifying the concepts and definitions. If we could formulate better demarcations and definitions of medical deviances or illnesses and other non-medical deviances we could perhaps better argue for the harmonious simultaneous presence of the two paradigms with their respective scopes. No doubt, multi professionalism, pluralism and multi paradigmatic thinking are descriptive trends of our times. Nevertheless, we should be careful in how we divide these paradicmatic and professional spheres to avoid both confusion and inequality.

Next, before concluding this thesis, I will discuss and evaluete the findings of the reflective equilibrium a touch further.

9. DISCUSSION

In this thesis, I have analyzed the concepts of normality and deviance, and placed them in the core of the two social paradigms, inclusion and medicalization. I have examined the similarities and differences between these paradigms, and through reflective equilibrium expressed a few ways in which these differences can become so grave and profound, that the two paradigms start to feel incompatible with each other.

Some of the approaches of these paradigms are contrary to each other, but that does not necessarily mean that the two paradigms cannot survive and even thrive together. In the last chapter, for example, I pointed out the difference between the object of change: For inclusion, it is the surrounding society or institution, and for medicalization, it is the deviant individual. These are opposing beliefs, that much is true, but there is no reason, why these beliefs cannot survive and pertain together at the same time. That is, they do not rule each other out, as we can try to change both. Maybe that is even the way to best and most all-encompassing solution, so that everyone would do their part – the individual as well as the institution.

Helen Turnbull (2016) emphasizes the notion, that inclusion does not come naturally to us. According to her, the will to include others is not in our nature, but paradoxically the need to be included is. The need to be included and the fear of being excluded is common to all of us. To be included we strive to be like others, as we unconsciously know that we only want to include others who are like us, or who, at least, would like to be like us, and who are willing to fit in. (Turnbull 2016, 1–5.) At the same time everyone is an individual, all people are different, and there exist vast diversity among people and their races, cultures, subcultures, religions, language etc. So, to be *diversity sensitive* and inclusive at the same time, now that is the challenge (Ibid., 1). So, to sum up, to include others we want them to fit in to the dominant culture and society. Medicalization, ergo medical interventions and treatments, may help some deviant individuals to fit in better, making it easier to include them. This way, inclusion and medicalization can complement each other and make the combination the best solution. However, in this solution we fail to be diversity sensitive, as we only want to fade away the diversity and deviance. Thus, many proponents of inclusion would argue, that it would not be real, authentic inclusion.

According to Turnbull (2016) this inauthentic inclusion results from our desire to stay in our comfort zone. In other words, it stems from our fear of, or discomfort with difference and deviance. For this we would want a world where diversity is not shown and not seen. However, that is not inclusion, that is normalization, and it is more convergent with medicalization than inclusion. According to true inclusion we want a world where differences *can be* shown, seen and heard, but *without us being scared* of them. (Ibid., 32.)

Inclusion understood as diversity sensitivity allows us to be both an individual and part of the group. We cannot make sense of ourselves or our social world as totally unattached individuals, without any connections to some groups and subgroups. Diversity sensitivity also allows us to be sometimes uninclusive in the inclusive society. For example, we can spend more time with our friends from the same school or football team, or we can gather together in our religious groups and congregations, we can attend a concert for heavy metal fans or we can feel more at home with our own countrymen. This is possible also in the inclusive society, because it is not exclusion, but the celebration of our differences and diversity in the society. (Turnbull 2016, 1). It is also important to understand, that there are many other differences and deviances than medical deviances, like the differences of religion, language, socioeconomic status, race and lifestyle (see for example Graham-Matheson 2012).

The point of inclusive schools is to prepare the children for the inclusive world and inclusive society. The thought behind this aim is that inclusion contributes to the learning and well-being of every child, and creates a circle of acceptance and tolerance. When the Other is present, it is more easily accepted. So, it is thought that inclusion in schools rebuilds the whole society, by teaching us see deviance, not as abnormal or *subnormal*, but as humane diversity. This makes us realize, accept and appreciate, that there is, and always has been, great *heterogeneity* in every society and thus in our everyday life. (Lipsky & Gartner 1996, 767, 788–789.) Inclusion in schools builds more accepting attitudes toward human diversity, and attitudes influence our actions. Inclusion in schools changes the whole society, yet the changes toward more inclusive attitudes are only effective in practice, if they are in concert with other social changes. (Cornwall 2012, 135, 139.) Now the dual ethos of inclusion and medicalization can complicate this strive toward concerted social changes, as we have seen in earlier chapters.

No doubt, there is inclusion attempting to happening in our societies and school systems, but of course, there are also other, competing ideals and tension amongst these ideals. Moreover, these competing ideals are not limited to medicalization alone, but also include the pressure towards social models and mindsets, which emphasize competition, productivity and exceling along the lines of free market economy. The schools are definitely feeling this pressure, and it is shoving itself, for example, in the form of tests, competitions, prizes and stressing the desirability of academic and/or economic success and the demands of labor market. (Graham-Matheson 2012, 13; Cornwall 2012, 134–135.) So, it is also important to remember, that these two paradigms examined in this thesis are not the only possible alternatives, and their differences aside, might not be the most ill-suited pair, either.

According to Turnbull (2016), we are not an inclusive society yet. We may have not yet truly accepted all different individuals, but we have accepted *the idea*, that we *should start accepting* everyone. This change in thinking toward true inclusion, will so to speak, take us from checking the metaphorical box of inclusion, to *expanding* the box of inclusion. That is to say, it takes us from superficially recognizing and accepting differences, to seeing and understanding a multitude of differences in a way we never have before. (Turnbull 2016, 10–11.)

Like mentioned earlier, both paradigms emphasize individuality, but in their own, different ways. Medicalization focuses on treating the individual and inclusion focuses on individuality as difference and uniqueness, and aims at accommodating all differences. However, what both paradigms lack, in my opinion, is the perspective on individual, *subjective experiences* on difference, deviance and sickness, marginality, acceptance, treatment and the struggle to fit in. The focus on deviant individuals' experiences may not only shed light on how social changes are welcomed, and how they should be formulated to become better and more efficient, but it could also help us better understand the deviant and their stories. Understanding, in turn, could facilitate acceptance and approval of these individuals, and also, cultivate the diversity and diversity sensitivity of our dominant cultures.

But how could we then better take into account the subjective experiences? One of the ways could certainly be to take the critique of disabled studies seriously and question the arrangements where the non-marginalized "normal" researchers study the marginalized and the deviant. This would be another step away from paternalism and toward the realization that the disabled themselves are already the experts of their own situation, and thus they could and should be the advisors of the social changes that concern them. (Lipsky & Gartner 1996, 776.) This step should also be done on different levels, not only concerning scientific studies and research, but for example, concerning inclusive school arrangements. The view that the majority, or the teachers, or the parents, know best, sits tight. This viewpoint, however, does not support the understanding of differences or experiences of inequality – all the contrary, it just reinforces the already dominant views. Yet, there are many matters, where the pupils' own opinions, conceptions and experiences could be helpful and fruitful in improving and facilitating inclusion in practice. Like mentioned earlier, autonomy is not a categorical state, but a continuum, and there are many things which even children can decide on, or at least give their opinion on. This kind of new policy would build open discussion, which directly increases the sense of involvement. (Richards 2012, 25–26.)

On the other hand, a step away from the remains of paternalism, does not mean that the dominant need to constantly apologize for themselves either. Turnbull (2016) points out that inclusion is a reciprocal process, where all parties need to be willing to both give and take. However, the *responsibility* to try and *understand*, and then maybe make changes accordingly, rests on the shoulders of the normal majority, as the marginalized and the subdominant already know and understand the mainstream society, as it is constantly everywhere, piercing through both social diversity and individual differences. The Other already has to understand Us in order to survive at all. (Turnbull 2016, 33–38.)

Many researchers have suggested that the first step toward this understanding is the awareness or mindfulness of one's own dominance and privilege, especially with respect to the marginalized. This means reflection and self-reflection before action. (see for example Turnbull 2016, 39–45; Hallett & Hallett 2012) Then again through this process of reflection and owning responsibility, we might also notice that all of us are, at the same time, both different individuals and part of some group or groups. So, we all, or at least many of Us, may end up belonging to different subdominant groups also. They can be any groups or subgroups, like those of the sex, sexual orientation, religion or the like, as not all deviances are medical. (Graham-Matheson 2012.) Any of us can also at some point in their life end up medically (or otherwise) deviant or disabled. For all this, there is even more reason to establish a more open, broader discussion, where everyone can participate and be heard, and where we could harness the positive forces of diversity and restrain the negative outcomes as well.

10. CONCLUSIONS

In this thesis, I have analyzed the paradigms of medicalization and inclusion and their theoretical compatibility with each other. Both of these paradigms are dominant and visible in our modern western societies and their institutions, specifically in the school institution and education in general. Both of these paradigms also apply the concepts of deviance and normality as the backbones of their policy-making. However, the definitions of these conceptions vary both between, and inside the two paradigms. For this, the public discussion, as well as the practical applications of these two ideologies, are often problematic, as we seem to be lacking in common language with respect to these concepts and conceptions. Thus, one of the aims of this thesis has been to clarify the terminology, and so, to facilitate the discussion trough concept analysis. At the very least I hope to have exposed the differences and contradictions in the terminologies and the usage of language concerning these concepts and paradigms.

Trough out this thesis, I have analyzed the differences and similarities between the paradigms of medicalization and inclusion. The main aim has been to deduce, if the paradigms are compatible with each other or not. Whether they are mostly similar or not, is not relevant for the compatibility. Two paradigms can be quite different, yet compatible and complementary, one filling out the caps the other one, and vice versa. In chapters 8 and 9, however, I have argued, that with the case of inclusion and medicalization, this is not entirely the case. In some respects, the two paradigms can be seen as complementary and coherent with each other. Nevertheless, some of the differences between the paradigms are so grave and contradictory, that they do not seem to be compatible with each other. The main incompatibilities found and analyzed in this thesis have been the contradictory notions on agency, different degrees of tolerance, contradictory attitudes towards labeling and different targets of change. Moreover, these differences seem to be more profound and severe than the ostensible similarities, which are more shallow and superficial, and often seem to lean on the narrowest interpretations of the terms of deviance and normality, or of medicalization and inclusion themselves.

Someone supporting total compatibility of these paradigms may argue, that their contradictions do not reveal incompatibility, but only that the paradigms have a different *scope*. Ergo, they would apply to different types and manifestations of human diversity and deviance. Thus, some types of deviance should be handled according to the ideals of medicalization, and some others according to the ideals of inclusion. This seems plausible, and in theory, I also agree with this notion. However, along with it, we are back in the demarcation problem, as we do not seem to have any valid and common way of discerning the medical deviances from other deviances. Partly this is caused precisely by the progression and advancement of each ideal to more extensively cover all the questions of human deviance. The reasons why they both quite inevitably become more and more extensive paradigms are different. With medicalization, this is caused by a narrow and *strict conception of normality*, which puts pressure on normalizing (curing) almost all types of deviance and human diversity. The line between sickness and health is, if possible, even blurrier than the line between normal and deviant. Then again, with inclusion, this happens naturally along the notion that *everyone* is different and special, and that the structures of society should accommodate *all* people.

So, if we accept that there exist some kind of incompatibilities or contradictions between the paradigms, it seems that there are at least three ways of solving the problem. Firstly, we may set out to solve the demarcation problem between the medical deviances and the deviances best tackled with inclusion, thus assigning different domains for these paradigms, and allowing them to exist side by side, but not simultaneously within the same domains. Secondly, we can choose one paradigm over the other, thus rejecting one paradigm all together and only applying the other, so eradicating the incompatibility. And finally, we can reject both paradigms and pick or construe a new one, a third alternative.

I believe that this thesis has already been a step toward the first alternative, toward solving the contradictions and the demarcation problem, by revealing these problems in the first place. Of course, the practical reality may not concern itself with these problems at all. Some agents and institutions can follow and practice inclusion (like schools) and some others medicalization (like medical professions). However, this can be confusing, problematic and even harmful to the individuals who come across both types of institutions receiving mixed messages and contradictory attitudes and procedures. Precisely for this, a further theoretical analysis as well as more empirical analysis of the discourses concerning both paradigms and the mapping of their respective domains are needed. These studies should also be done multi-professionally, or else we risk only to re-enforce the paradigm we already represent in some way. In this study, I have not aimed at refuting either paradigm nor endorsing one over the other, but to increase the theoretical discussion over these social paradigms and their relations, and to clarify the terms and the discussion about them.

REFERENCES

Arras, JD 2009. The Way We Reason Now. In Steinbock, B. (edit.) The Oxford Handbook of Bioethics. Oxford University Press, pp. 46–71.

Aspenson, Steven Scott 1998. The Philisopher’s Tool Kit. New York: ME Sharpe Inc.

Beauchamp, Tom L. & Childress, James F. 2001. Principles of Biomedical Ethics. New York: Oxford University Press Inc.

Biklen, Douglas 2001. Inkluusion sosiaalisia konstruktioita: Käytännöstä oppimassa. In Murto, Naukkarinen & Saloviita (edit.) Inkluusion haaste koululle – Oikeus yhdessä oppimiseen. Jyväskylä: PS-kustannus.

Boorse, Cristopher 1977. Health as a Theoretical Concept. Philosophy of Science, Vol. 44, No. 4, s. 542–573.

Carel, Havi 2008. Living in the Shadow of Illness. RSA Journal, Vol. 154 No. 5535, pp. 26–29.

Conrad, Peter 1992. Medicalization and Social Control. Annual Review of Sociology, Vol. 18, pp. 209–232.

Conrad, Peter & Schneider, Joseph W. 1992. Deviance and Medicalization: From Badness to Sickness. Philadelphia: Temple University Press.

Cornwall, John 2012. Leading on inclusion: the sum of the parts is not the whole story. In John Cornwall & Lynne Graham-Matheson (edit.) Leading on Inclusion: Dilemmas, Debates and New Perspectives, Routledge.

Crockett, Jean B. & Kauffman, James M. 2001. The Concept of the Least Restrictive Environment and Learning Disabilities: Least Restrictive of What?. In James M. Kauffman & Daniel P. Hallahan (edit.) The Illusion of Full Inclusion: A Comprehensive Critique of a Current Special Education Bandwagon, PRO-ED Inc.

Daniels N 1996. Justice and Justification: Reflective Equilibrium in Theory and Practice. Cambridge UP.

Dupre, John 1998. Normal People. Social Research, Vol. 65, No. 2, pp. 221–248.

Ekins, Alison 2012. The importance of whole school culture of inclusion. In John Cornwall & Lynne Graham-Matheson (edit.), Leading on Inclusion: Dilemmas, Debates and New Perspectives, Routledge.

Graham-Matheson, Lynne 2012. How did we get here? A brief history of inclusion ad special educational needs. In John Cornwall & Lynne Graham-Matheson (edit.) Leading on Inclusion: Dilemmas, Debates and New Perspectives, Routledge.

Gräsbeck, Ralph 1995. Normaalin käsite lääketieteessä. In Pekka Louhiala (edit.) Lääketiede ja Filosofia, Yliopistopaino, Helsinki.

Hallett, Fiona & Hallett, Graham 2012. Inclusive and ethical research. In John Cornwall & Lynne Graham-Matheson (edit.) Leading on Inclusion: Dilemmas, Debates and New Perspectives, Routledge.

Hume, David 2000. A Treatise of Human Nature. David Fate Norton & Mary J. Norton (edit.), Oxford: Oxford University Press.

Jackson F 1998. From Metaphysics to Ethics: A Defence of Conceptual Analysis. Oxford: Oxford University Press.

Kahane, Guy & Savulescu, Julian 2012. The Concept of Harm and the Significance of Normality. Journal of Applied Philosophy, Vol. 29, No.4. Doi: 10.1111/j.1468-5930.2012.00574.x.

Kauffman James M. & Hallahan, Daniel P 1993. Toward a Comprehensive Delivery System for Special Education. In James M. Kauffman & Daniel P. Hallahan (edit.) The Illusion of Full Inclusion: A Comprehensive Critique of a Current Special Education Bandwagon, PRO-ED Inc.

Kuhn, Thomas 1985. The Copernican Revolution: Planetary Astronomy in the Development of Western Thought. Cambridge: Harvard University Press.

Lappalainen, Kristiina & Mäkihonko, Minna 2004. Inklusiivinen, kaikille yhteinen koulu haasteena erityisopettajan- ja opettajankoulutukselle. In Atjonen & Väisänen (edit.) Osaava opettaja – Keskustelua 2000-luvun opettajankoulutuksen ydinaineksesta, Joensuu: Joensuun yliopistopaino.

Launis, Veikko 2007. Moniarvoinen terveys. Turku: Aeropagus.

Launis, Veikko & Räikkä, Juha 1995. Kuka on sairas?. In Pekka Louhiala (edit.) Lääketiede ja filosofia, Helsinki: Yliopistopaino.

Lindley, Richard 1986. Autonomy. In series Peter Jones & Albert Weale (edit.) Issues in Political Theory, Macmillan Education Ltd.

Lipsky, Dorothy Kerzner & Gartner Alan 1996. Inclusion, School Restructuring and the Remaking of American Society. Harvard Educational Review, 1996, vol. 66, no. 4, pp. 762–796.

Lipsky, Dorothy Kerzner & Gartner, Alan 1999. Inclusion and School Reform: Transforming America’s Classrooms. Paul H. Brookes Publishing Co.

Lääkäriliitto 2013. Lääkärinvala. https://www.laakariliitto.fi/liitto/etiikka/laakarinvala/, read 22.11.2087.

Mercer, Jane R. 1973. Labelling the Mentally Retarded. University of California Press.

Middlemas, Bridget 2012. Learning and teaching in inclusive classrooms. In John Cornwall & Lynne Graham-Matheson (edit.) Leading on Inclusion: Dilemmas, Debates and New Perspectives, Routledge.

Moberg, Sakari 2001. Opettajan näkemykset inklusiivisesta opetuksesta. In Murto, Naukkarinen & Saloviita (edit.) Inkluusion haaste koululle – Oikeus yhdessä oppimiseen, Jyväskylä: PS-kustannus.

Mock, Devery R. & Kauffman James M. 2002. Preparing Teachers for Full Inclusion: Is It Possible?. In James M. Kauffman & Daniel P. Hallahan (edit.) The Illusion of Full Inclusion: A Comprehensive Critique of a Current Special Education Bandwagon, PRO-ED Inc.

Naukkarinen, Aimo & Ladonlahti, Tarja 2001. Sitoutuminen, joustavat resurssit ja yhteistyö – Välineitä kaikille yhteiseen kouluun. In Murto, Naukkarinen & Saloviita (edit.) Inkluusion haaste koululle – Oikeus yhdessä oppimiseen, Jyväskylä: PS-kustannus.

Nummenmaa, Lauri 2009. Käyttäytymistieteiden tilastolliset menetelmät. Helsinki: Kustannusosakeyhtiö Tammi.

O’Neill, Onora 2002. Autonomy and Trust in Bioethics. Cambridge: Cambridge University Press.

Oshana, Marina A. L. 1998. Personal Autonomy and Society. Journal of Social Philosophy, 29 (1), s. 81–102.

Pinola, Minna 2008. Integraatio ja inkluusio peruskoulussa: luokanopettajien asennoituminen kaikille yhteiseen kouluun. Kasvatus: Suomen kasvatustieteellinen aikakauskirja, (2008) 39:1.

Puumala, Laura 2017. Normaalius medikalisaation kontekstissa. Pro gradu- tutkielma, Turun yliopisto, Filosofian, poliittisen historian ja valtio-opin laitos.

Puusa, Anu 2008. Käsiteanalyysi tutkimusmenetelmänä. Premissi, 2008, vol.4, pp. 36–43. https://s3.amazonaws.com/academia.edu.documents/31133795/premissi.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1543318836&Signature=JB11B%2FSVMQH5C3XstYZ%2F45GpP%2Bs%3D&response-content-disposition=inline%3B%20filename%3DKasiteanalyysi_tutkimusmenetelmana.pdf, read 27.11.2018.

Rawls John 1973. A Theory of Justice. Oxford University Press.

Rawls, John 2001. Justice as Fairness: a Restatemant. Belknap Press of Harvard University Press.

Russell, Marta 1998. Beyond Ramps: Disability at the End of Social Contract. Monroe: Common Courage Press.

Salamanca Statement and Framework for Action on Special Needs education 1994. http://unesdoc.unesco.org/images/0009/000984/098427eo.pdf, read 27.11.2018.

Saloviita, Timo 1999. Kaikille avoimeen kouluun: Erilaiset oppilaat tavallisella luokalla. Jyväskylä: Atena.

SEP 2017. Necessary and Sufficient Conditions. https://plato.stanford.edu/entries/necessary-sufficient/, read 27.11.2018.

SEP 2011. Concepts. https://plato.stanford.edu/entries/concepts/, read 27.11.2018.

SEP .2013. Egalitarianism. https://plato.stanford.edu/entries/egalitarianism/, read 27.11.2018.

SEP 2016. Reflective Equilibrium. https://plato.stanford.edu/entries/reflective-equilibrium/, read 27.11.2018.

SEP 2017. Science and Pseudo-Science. https://plato.stanford.edu/entries/pseudo-science/, read 27.11.2018.

SEP 2018. Thomas Kuhn. https://plato.stanford.edu/entries/thomas-kuhn/, read 27.11.2018.

Siipi, Helena 2004. Naturalness in Biological Conservation. Journal of Agricultural and Environmental Ethics, vol. 17, no 6, pp. 457–477.

Siipi, Helena 2008. Dimensions of Naturalness. Ethics and the Environment, vol. 13, no.1 pp. 71–103.

Singer, Judith D. 1988. Should Special Education Merge with Regular Education?. In James M. Kauffman & Daniel P. Hallahan (edit.) The Illusion of Full Inclusion: A Comprehensive Critique of a Current Special Education Bandwagon, PRO-ED Inc.

Soan, Sue 2012. Multi-professional working: the way forward?. In John Cornwall & Lynne Graham-Matheson (edit.) Leading on Inclusion: Dilemmas, Debates and New

Perspectives, Routledge.

Sober, Elliot 2013. Core Questions in Philosophy: a Text with Readings. New Jersey: Pearson Education Inc.

ten Have, Henk A. M. J. & Bert Gordijn 2014. Handbook of Global Bioethics. Dordrecht: Springer Science+Business Media Dordrecht.

Thompson, David 2012. Whole school development, inclusion and special educational needs: acknowledging wider debates. In John Cornwall & Lynne Graham-Matheson (edit.) Leading on Inclusion: Dilemmas, Debates and New Perspectives, Routledge.

Tulloch, Alistair 2005. What Do We Mean by Health?. British Journal of General Practice*,* April 2005, s. 320–323.

Turnbull, Helen 2016. The Illusion of Inclusion: Global Inclusion, Unconscious Bias and the Bottom Line. https://ebookcentral.proquest.com/lib/kutu/reader.action?docID=4648713&query=, Business Expert Press, read 27.11.2018.

Opinto-opas, Turun yliopisto, Luokanopettajan tutkinto-ohjelma 2018–2020. https://opas.peppi.utu.fi/fi/tutkinto-ohjelma/7630, read 27.11.2018.

Tähtinen, Unto 1976. Ahimsa: Non-violence in Indian Tradition. London: Rider and Company.

Vehmas, Simo 2005. Vammaisuus: Johdatus historiaan, teoriaan ja etiikkaan. Helsinki: Gaudeamus Kirja.

Väyrynen, Sai 2001. Miten opitaan elämään yhdessä? – Inkluusion monet kasvot. In Inkluusion haaste koululle: Oikeus yhdessä oppimiseen. Jyväskylä: PS-kustannus.

Wachbroit, Robert 1994. Normality as a Biological Concept. Philosophy of Science, Vol.61, s. 579–591.

Wachbroit, Robert 2003. Normal Humans, Human Nature and Genetic Lessons. In Genetic Prospects: Essays on Biotechnology, Ethics and Public Policy. Rowman & Littlefield Publishers Inc., 2003, s. 51–60.

Watters, Ethan 2010. Crazy Like Us: The Globalization of the American Psyche. New York: Free Press.

Wright, Richard A. 1987. Human Values in Health Care: The Practice of Ethics. McGraw-Hill Inc.

Zola, Irving Kenneth 1966. Culture and Symptoms – An Analysis of Patient's Presenting Complaints. American Sociological Review, vol. 31, no. 5, pp 615–630.

Zola, Irving Kenneth 1972. Medicine as an Institution of Social Control. Leiden, http://onlinelibrary.wiley.com/doi/10.1111/j.1467-954X.1972.tb00220.x/pdf, read 22.11.2018.

Zola, Irving Kenneth 1973. Pathways to the Doctor – From Person to Patient. Social Science & Medicine, vol. 7, pp. 677–689.

Zsasz, Thomas S. 1974. The Myth of Mental Illness. New York: Harper Perennial.