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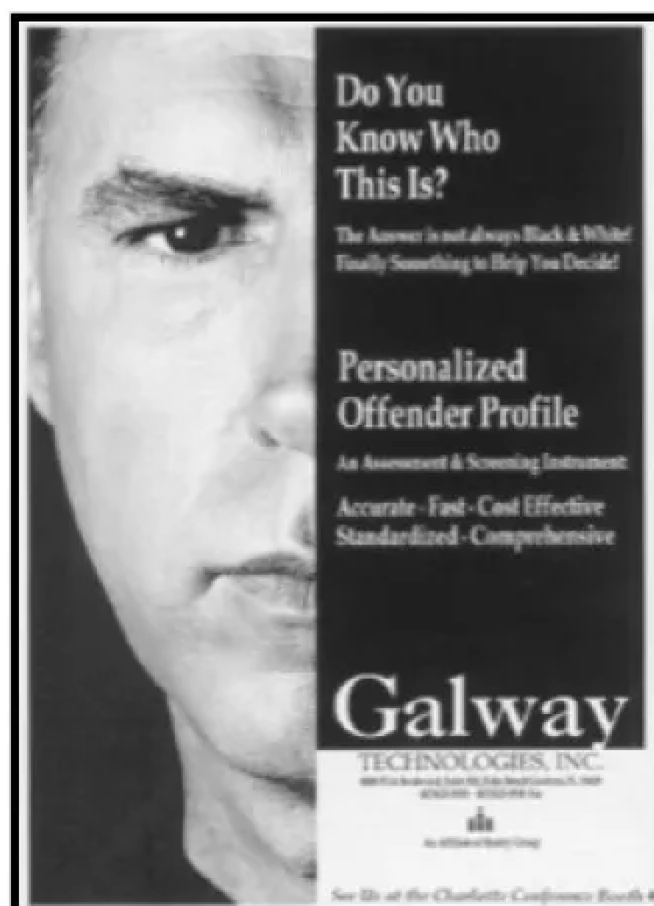
Image from Prudential Financial website, 2018.

"UNLOCK THE POWER OF THE WELLNESS EFFECT." In white lettering across a cool blue background photograph of happy workers, Prudential Financial touts the employer benefits of financial well-being for employees. The Wellness Effect™ will not only create confident, mentally healthy workers but improve the lives of workers' families and communities. Following a growing trend in financial management, programs like the "Wellness Effect" tap into a kind of therapeutic language to reframe finances in terms of individual and public health. Like new genetic companies which promise potential individualized healthcare options, financial companies offer personalized interventions for your financial health. As healthcare is increasingly reframed in economic terms–patients are now "consumers," for instance—financial systems are becoming the object of medical rhetoric. But why begin an essay on the "criminal mind" with talk of financial management?

Well, to begin, crime and the criminal mind have been "medicalized" for centuries much like financial management is today. Sociologist Peter Conrad explains medicalization is "defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it. *This is a sociocultural process that may or may not involve the medical profession*."[1] Medicalization responds to the attitudes of the society or culture in which it occurs. It responds to the economic, political, and even religious concerns of the time. The act of "medicalizing" a phenomenon not previously within

the medical domain— modes of attention or hyperactivity, financial investments, or crime—is not without consequences.

Mobilizing forms of diagnostic categorization and treatment interventions, medicalization opens the door for forms of social control. It may operate to individualize or stigmatize previously uncategorized behaviors (consider the advent of Pre-menstrual Syndrome and its frequent use to silent deviant women). In cases like crime or the "criminal mind" it has served to legitimize forms of therapeutic intervention and incarceration. While many have moved away from "medicalization" as a critical framework for understanding biomedical practice citing the simplified ways it was used to dismiss mental illness by the Anti-Psychiatry Movement Conrad continues to argue in an updated essay that attention to this phenomenon is warranted. Following the economic changes of the late 80s and 90s, Conrad argues that medicalization has taken on new valances. These changes include a shift toward consumerist ideologies of care, managed care and corporatized medicine.[2] While doctors and clinicians may still operate as "gatekeepers" to forms of treatment, medicalized practice has moved further beyond the clinical purview. Such capitalist shifts in modes of medicalization can be tracked in the ways criminal behavior is understood, analyzed, and contained. Further, we can begin to understand how crime has been unevenly medicalized such that people of color, people in poverty and people who use drugs are subject to forms of coercive therapeutic intervention while some perpetrators of violent crimes may be diagnosed with sickness like "affluenza."



Correctional trade journal advertisement: "Do You Know Who This Is?" In Rhodes. L.A. *Total Confinement: Madness and Reason in the Maximum Security Prison*. University of California Press: Berkeley. pp. 178

In Part 1 of this series, I tracked the historical development of the "criminal mind" from early social Darwinist theories of the late 1800s, to the Eugenics movements of the early 1900s and finally to its

articulation in the late 60s and 70s, following early "War on Crime" efforts by US federal administrations. Each of these phases represents a new, medicalized approach to crime. Making use of "scientific" rhetoric these attempts at medicalizing crime served to legitimize notions of racial and ethnic inferiority.[3] I concluded the essay with an examination of Stanton Samenow and Samuel Yochelson's work on the criminal mind and patterns of criminal thinking. Their theories of treatment have been adopted and implemented in carceral therapy programs across Northern America where prison officials, probation officers and even prisoners themselves become the "gatekeepers" to treatment for the criminal mind.

In Part 2, I took a closer look at the treatment of the criminal mind and criminal thinking in the prison setting. Following Jill McCorkel's work in *Breaking Women*, I looked specifically at two aspects of this treatment: typifying and identifying criminal thinking patterns and "habilitation." In Samenow's work, criminals are literally a different kind of person. They can be identified by their criminal thinking patterns and must be habilitated into a new form of thinking. This habilitation is never complete. Samenow recommends constant state surveillance for such criminal thinkers. In McCorkel's work we see how these aspects of treatment for the criminal mind place prisoners in a painful contradiction with themselves and society. This model of criminal therapeutics demands that prisoner participants take responsibility for themselves, removing responsibility of the state, while ensuring the need for constant habilitation services and state surveillance. Consequentially, this form of incarceration alongside restrictions on welfare services, displaces inmates not only from society but from active participation in the labor market. McCorkel notes that this has had particular, dramatic effect for African American women.

While crime and the criminal mind have been medicalized in forms of prison therapy described previously, Nancy Heitzig notes another form of crime medicalization. She argues that a racial frame in the US which casts whiteness as normative and deviance among white people (men in particular) as an aberration is facilitated by a medical model of criminal insanity. She notes that race is often absent from media coverage of mass shootings, instead focusing on the personhood and potential mental illness of the perpetrator. Such violence is cast as only possible through some form of mental illness. This stands in sharp contrast to media depictions of other forms of gun violence. Media coverage of Columbine asked "why are our kids becoming so violent?" while similar coverage of the death of a black child in a largely black community was concerned with "violence among black youth."[4] These accounts of violent crime as the result of a sickness serve to isolate white criminals. They do not stand as representatives of their race in the same way that members of other ethnic or racial groups do, Heitzig argues. She continues, noting that while white and wealthy perpetrators of crime are given options for medical treatment and may seek private medical care it in lieu of incarceration, people of color and in poverty are often left with mandated, state-run therapy which often operates as a form of punishment and is, according to Heitzig, therefore less effective.

We should consider other consequences of the Heitzig's noted "double standards" of social control via crime medicalization. The search for sickness in white criminality may perpetuate the notion that people with mental illnesses are more often perpetrators of violent crime. In fact, we know

they are more frequently the victims of such violence.[5] Media coverage of these spree killings may note the lack of accessible mental healthcare in the US, but do not note that the most available mental healthcare is provided in the nation's prisons and jails.[6] Indeed, the largest mental health facility in the US is the Los Angeles County jail system.[7] Psychiatric care in jails is often restricted by virtue of the fact that patients are viewed as criminals first. Medications are limited and short stays in jail mean inconsistent contact with medical professionals for the seriously mentally ill. In this way, illness has become criminalized while crime has become medicalized, perpetuating racial and economic disparities in access to healthcare and the labor market. We would do well to ask how other forms of medicalization uphold ideologies of social control.

With the consequences of medicalized crime including individualization, stigmatization, and a maintenance of racial and economic disparities still in our minds, we may briefly consider the kind of responsibility constructed in a model of financial well-being and its consequences. Here, the "wellness effect" gives employees the skills necessary to manage their own funds—individual workers are responsible. That is, the company is not responsible for raising wages if workers cannot make ends meet, further undermining union work and collective organizing. The "wellness effect" is cast as a public service, good for the "community," but also, the advertisement suggests it's good for the company's bottom-line. As consumers ourselves of a variety of forms of medicalized ideologies, we should think seriously before we "unlock the wellness effect."

[1] Peter Conrad. "Medicalization and Social Control." *Annual Review of Sociology.* 1992, Vol. 18, pp. 211.

[2] Peter Conrad. "Shifting Engines of Medicalization" *Journal of Health and Social Behavior* 2005, Vol 46, pg 4.

[3] Craig Haney, "Demonizing the 'Enemy:' The Role of 'Science" in Declaring the 'War on Prisoners'" *Connecticut Public Interest Law Journal*. 9 no. 2 (2009-2010). pp. 185-242.

[4] Nancy A. Heitzig. "'Whiteness,' Criminality and the Double Standards of Deviance/Social Control" *Contemporary Justice Review.* 2015, 18:2, pg. 201

[5] Jonathan M. Metzl and Kenneth T. MacLeish, "Mental Illness, Mass Shootings, and the Politics of American Firearms." *American Journal of Public Health*. 2015, 105:2. Pp 240-249.

[6] See for instance Frontline's "The New Asylums."

[7] See for instance: Renee Montagne, "Inside the Nation's Largest Mental Institution," *National Public Radio*. August 13, 2008.