Over the past half century, sociologists have watched a range of social and personal problems that were previously thought of as non-medical become defined as medical problems or "medicalized." A new book by historian David Herzberg explores one manifestation of this trend: the tremendous rise in the use of psychiatric drugs since the 1950s, both for serious mental disorders and for everyday psychic troubles. The widespread use of psychiatric wonder drugs like Ritalin, Prozac, and Paxil (now household names) has contributed to Americans' redefinition of what constitutes "normal mental health." But shifting definitions can occur in physical as well as psychological normalcy. What constitutes "normal height" has, as journalists Susan Cohen and Christine Cosgrove illustrate in their recent book, changed dramatically: tall girls have become more athletically valuable, while boys' shortness has been increasingly pathologized. As it happens, happiness and stature both constitute fascinating entry points for an analysis of medicalization.

Psychiatric medications have been used not only for people with well-defined mental disorders but also for minor ills, to smooth out bumps in life, to improve one's mental outlook and to enhance one's sense of well being. Happy Pills in America, an incisive cultural history of the drugs Miltown, Librium, and Valium, documents the transformation of such medications into "happy pills" for the middle class. Whether taking Valium—known to many as "mother's little helper"—or its heir Prozac (which, in Peter Kramer's words, leaves you "better than well"), it's clear that Americans have come to see pills themselves as acceptable and commonplace.

Various medical nostrums like 19th century best-sellers Lydia Pinkham's Vegetable Compound or Mrs. Winslow's Soothing Syrup have long been lauded for the promotion of well-being, but the post-World War II growth of such "medications" has been enormous. Herzberg points to a convergence between the development of commercial medicine (especially the pharmaceutical industry) and the expanding consumer culture beginning in the 1950s. To this one might add what psychiatrists Arthur Barsky and Jonathan Boros depict as Americans' decreasing tolerance for minor physical and psychic discomforts. Consumers seek a "pill for every ill," while the commercialized medical promoters search for an "ill for every pill" to create new markets for their products. This convergence of interests has led to shifts in the notions of normalcy and pathology.

In contemporary society, direct-to-consumer advertising, which barrages us with television commercials defining symptoms and ills we might have and implores us to "ask our doctors if [name of drug] is right for you," has amplified pharmaceutical promotion and disseminated it to all corners of the population. But Herzberg shows how anti-anxiety drugs like Miltown, Librium, and Valium were introduced in the 1950s to a largely white, middle class, and overwhelmingly female clientele to deal with common daily problems. "These problems—marital discord, frustration with traffic, housekeeping woes, and the inability to 'fit in'—were undoubtedly real sources of misery, but they were not always interpreted as illnesses," he writes. The "happy pills," however, would be palliative for these life discomforts. The drugs produced record-breaking profits for their pharmaceutical companies; at their peak in the 1970s, 100 million prescriptions were written for these medications. For a time they became a common aid to the middle class pursuit of happiness. But after the drugs' serious adverse effects, including addiction, became apparent, consumers made a rapid retreat from these medications.

Then, beginning the late 1970s, Herzberg writes, depression displaced anxiety as America's most common emo-
tional illness. A new class of antidepressant drugs, selective serotonin reuptake inhibitors (SSRIs), was heralded by Prozac and then followed by a laundry list of best-selling drugs. This contributed to the movement of normal sadness to a treatable disorder, as Allan V. Horwitz and Jerome Wakefield argue in *The Loss of Sadness: How Psychiatry Transformed Normal Misery into Depressive Disorder*, and to the circulation of the widely held idea that SSRIs treated an assumed (but unproven) “chemical imbalance.”

Similar to the earlier happy pills, SSRIs were disproportionately prescribed for women, not only for disorders but also as “mood brighteners.” This was brought home to me a few years ago, when I was having lunch with a very successful former student, who, in the middle of a conversation about medicalization declared, “but I love my Prozac!” While SSRIs have been a pharmaceutical blessing for some patients with serious mental disorders, for others, the “new normal” includes a proper dose of the medication that can perhaps produce the desired titration of “happiness.”

While psychiatric drugs receive significant public attention, they are by no means the only way medicine contributes to a shifting idea of “normal.” As Susan Cohen and Christine Cosgrove demonstrate in their comprehensive and well-researched book on the medical measurement, meaning, and treatment of height, physicians and the drug industry can also promote physical interventions that reflect and reinforce extant social norms. The authors tell two gendered stories here that are intriguing in what they reflect about the salience of medical treatments and social opportunities.

Physicians have for decades, perhaps centuries, developed (inexact) methods to predict how tall a child will grow. By the 1950s and 1960s simple formulas such as doubling the height at two years old were employed, soon ceding to more complex methods employed by radiologists or pediatric endocrinologists. These resulted in somewhat more accurate predictions based upon X-rays but still remained approximations.

What is most interesting and important about these calculations, however, is that they were used to offer treatment to young girls whose actual height or height predictions were that they would be “too tall” (e.g., over 6’). According to a 1953 medical endocrine reference book, for example, such too tall girls “may find it difficult to attract male companions.” More ominously, it warned, “These girls frequently develop severe somatopsychic inferiorities.” And some simply voiced concerns about how difficult it would be for tall girls to find smart clothes. In other words, tall girls would have social and emotional difficulties. But now, in a medicalized, medication-obsessed era, this height problem had a medical solution. At least for the families that could afford it, estrogen treatment could bring on menses early, closing growth plates and thus reducing the girls’ eventual height. These estrogen drugs, including DES, became the drugs of choice for girls’ height suppression. And in prescribing these “medications,” according to Cohen and Cosgrove, doctors thought they were treating a “disease” (excess height in girls) or at least preventing emotional suffering related to height.

When the dangers of excess estrogen and DES treatments became known, this medical intervention began to diminish. But the biggest change in the demand for these treatments resulted from the passage of Title IX in 1972, which ended sex discrimination in school sports. In a very short time, tall girls gained a new social value. They could become outstanding athletes, especially in basketball and volleyball; they were no longer seen as potential gender freaks, but as potential athletic standouts. What happened here was a shift in the social definition of tallness in girls, which eventually severely curtailed the

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The story of boys, as Cohen and Cosgrove show, is nearly the opposite; the concern was with boys who would be too short. Anecdotal and systematic evidence accumulated that extreme shortness in men (e.g., below 5’4”) can be a social disability: shorter men earn less money, get promoted less often, win fewer elections, are often stigmatized (“hey shorty”) and are just less manly in traditional ways. While a few individuals are short due to a specific growth hormone deficiency, most short men have what might be called “idiopathic short stature.” In other words, they are just short. In 1985 synthetic human growth hormone (hGH) was available for the first time, and the drug company Genentech got a version of hGH approved by the U.S. Food and Drug Administration (FDA) for treatment of individuals with growth hormone deficiency. This was a relatively small market (so to speak!), so Genentech
surreptitiously also promoted it to physicians as a treatment for any problems of potential short stature. While Genentech was eventually fined for its unapproved promotion of HGH, physicians were still free to use it to treat young boys whose parents were concerned that their son would have a social disability. The

of HGH, for the treatment of children in the 1.2 percentile who were predicted to be short but had no growth hormone deficiency. This enables the pharmaceutical company to promote the drug for idiopathic short stature and reinforce the belief that all men need to be of a certain height to achieve normalcy. Physi-

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drug needed to be taken over a number of years and at a total cost of about $100,000 it might add a couple of inches to a child’s full grown height. HGH doesn’t make short people tall, just less short. A few years ago, Eli Lilly got the FDA to approve Humatrope, its version

of the books can then begin to expand their offerings in what might be called cosmetic endocrinology. Together, these books remind us how the medical profession and pharmaceutical industry stand ready to provide vehicles for aiding our individual pursuits of happiness and good fortune. But while such medical interventions can change psyches, behaviors, and bodies, these are not accomplished without new medical and social risks, especially in how they reconstruct what is considered normal in our culture and turn normal conditions into pathologies. As we enter the genetic age, whether we will show any caution before embracing medical interventions that promise greater happiness or produce new versions of normalcy— but could, in fact, deliver the opposite—is an open question.

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happiness and the social sciences

by Robert Stebbins

Happiness: A Revolution in Economics
By Bruno S. Frey
MIT Press, 2008
240 pages

The Psychology of Happiness: A Good Human Life
By Samuel S. Franklin
Cambridge University Press, 2010
179 pages

Happiness is an age-old philosophical concern, dating at least to Aristotle. It’s also a popular idea, easily understood in common sense terms, yet as elusive in practice as it is cherished in the abstract. Perhaps because of these complexities, recent years have brought a virtual deluge of scholarly books and articles on the subject. “Happiness” is now a lively subject of teaching and research in psychology, and a concern of sociology, especially in the areas of social psychology, mental health, and emotions. Some economists, including one reviewed here, have even taken an interest in the subject. This new or renewed social scientific attention to happiness is, in my