

those claims fell by the wayside—their frames did not attract adherents. Activists who framed the issue in terms of income inequality and the 1 percent were more successful in rallying supporters to their cause, and particular issues, such as raising the minimum wage, became the focus for public attention.

### QUESTIONS

1. Opportunity is a cultural resource that is available to claimsmakers. Does the word mean different things to different claimsmakers?
2. Economies have cycles—relatively prosperous times, and relatively hard times. It might be possible to address economic issues during good times (when more money is available). Why does economic claimsmaking tend to be more vigorous during hard times?
3. Imagine that, instead of the 1 percent and income inequality, attention had concentrated on some other topic related to the Great Recession. How might the social problems process have changed?

## 4

### Experts as Claimsmakers

Colonial Massachusetts was established by Puritans, and ministers were key figures in that society. They saw evidence of God's hand everywhere in the world, and their sermons sometimes commented on current events, interpreting them in religious terms. A bad harvest might be evidence of God's wrath, and problems among people were caused by sin, by individuals breaking God's commandments. Virtually any event could be interpreted within this religious framework. Ministers, then, were colonial New England's principal experts; their theological training qualified them to explain and evaluate most aspects of life. Their religious frame was seen as authoritative because it was promoted by professionals representing the society's leading institution.

The ministers' religious perspective seems less authoritative today. In at least public discussions of social problems, modern Americans rarely speak of *sin* (and when politicians or even religious leaders do invoke such language, they often come under criticism). Rather, contemporary Americans are more comfortable with a kind of medical vocabulary; when talking about social problems, we are more likely to speak of *diseases*, *syndromes*, *disorders*, or *addictions*—words that seem grounded in medical, scientific

classifications. Consider how contemporary discussions of Aquinas's classical list of the seven deadly sins often redefine these behaviors as medical problems; for example, lust might be characterized as *sex addiction*, gluttony as *food addiction* or *compulsive eating*, anger as an *anger management* problem, and sloth as *chronic fatigue syndrome*. (At the same time, modern medicine sometimes seems to promote those same deadly sins by treating their absence as medical problems that also may require treatment; consider drugs to enhance sexual performance [lust], cosmetic surgery [pride, envy], liposuction [gluttony], or concerns about workaholism and type A personalities [sloth] or low self-esteem [pride].) At least when they talk about social issues, contemporary Americans are less likely to accept the judgments of religious leaders, and more likely to defer to doctors.

The declining influence of ministers and growing clout of doctors illustrate how constructions of social problems reflect shifting patterns of institutional influence. In societies where religious authorities hold sway, social problems often are discussed in religious language; where medical authorities are more influential, social problems tend to be understood in medical terms. At different times and in different places, ideas about which people with which sorts of knowledge ought to be considered experts vary. *Experts* are presumed to possess especially authoritative knowledge, and other people—including activists, the media, and policymakers—may defer to this expertise.

In short, experts rank among the most influential claimsmakers because they are thought to have special knowledge that qualifies them to interpret social problems. Some experts are what Chapter 3 referred to as *insider claimsmakers*; their status as experts can give them easier access to policymakers so that they are part of the polity. This chapter examines the role of experts as claimsmakers in the contemporary social problems process. It begins by exploring the central place of medical authorities in constructing social problems, then turns to other sorts of experts.

## MEDICALIZATION

Sociologists who have noted the increased use of medical language to characterize social problems speak of **medicalization** (Conrad, 2007), the process of defining troubling conditions as medical problems. A century ago, it was generally recognized that some people drank too much; that is, their drinking was blamed for causing problems at work, in their homes, and so on. The common label for these people was *drunkards* (Gusfield, 1967). Being a drunkard was seen as, if not a sin, at least a moral failing; drunkards were doing something they shouldn't do, and they needed to reform (the solution to being a drunkard often involved making a pledge to practice temperance; that is, the drunkard would promise to stop drinking).

Today, the term *drunkard* has virtually disappeared from our vocabulary. Of course, there are still people who drink too much, and whose drinking is thought to cause job problems, family problems, and so on. But we call these people *alcoholics*, and we speak of the *disease of alcoholism*. Alcoholics may receive *treatment*, often at *clinics*, where some of the costs are reimbursed by health insurance. In short, alcoholism has been medicalized, in that we now view it as a medical problem that should be addressed through medical solutions.

Consider another example: some students do not do well in school. Traditionally, those students were blamed for their poor performance: perhaps they were of lower intelligence, or perhaps they weren't trying hard enough. Today, claims suggest that poor performance at school may be caused by medicalized conditions, that these students have *learning disabilities* or *attention deficit hyperactivity disorder* (ADHD) (Conrad, 2007). Medical language—words such as *diagnosis*, *symptom*, or *therapy*—increasingly frames discussions of students' difficulties, and doctors now prescribe drugs to large numbers of children to help them become more attentive.

Why is medicalization important? There are two obvious ways it makes a difference. The first is that medicalization seems to



shift responsibility away from the individual. In our culture, we routinely hold individuals responsible for what we view as deliberate behavior—acts that people choose to perform. Drunkards were once seen as weak because they gave in to drink, and poor students used to be viewed as lazy; in both cases, the individuals were held responsible for their own problems. In contrast, we generally do not hold people responsible for their illnesses; we don't blame them for becoming sick. Therefore, saying that people have the disease of alcoholism or a learning disability means that they shouldn't be blamed for their problems, that they merit sympathy and support, rather than criticism.

A second consequence of medicalizing a problem is that it provides a familiar frame—sometimes called the **medical model**—for thinking about the issue. Medical problems are described as diseases, disorders, syndromes, or disabilities. The people with these problems are ill; they display symptoms. They need to become patients, who can receive treatment from medical personnel—doctors, nurses, therapists—who often work in hospitals or clinics, and who can be reimbursed through the patient's health insurance. In other words, medicalization is a claim arguing that some problem should be owned and controlled by medical experts and organizations.

Medicalization, then, frames troubling conditions in particular ways (see Box 4.1). At first glance, our culture seems to construct sins or crimes differently from illness: sinners and criminals are held responsible, blamed for their actions, and punished; people who are ill are not blamed and receive treatment instead. However, the medical model also focuses on the individual rather than the larger society. In a medicalized view, people have diseases or syndromes that lead them to drink too much, to eat too much, and so on; and they must confront and overcome these problems through healthy behavior. By focusing on individuals' choices, medicalization shifts attention away from the ways in which larger social arrangements, such as poverty, shape these troubling conditions.

Medicalization grew markedly during the twentieth century. In part, this shift reflected dramatic changes in the practice of medicine:

#### Box 4.1 LEGITIMIZING MIGRAINE

Migraine headaches are a familiar, common problem that affects about 12 percent of adults. Medical analyses of the disorder date back centuries. Yet both the physicians who study and treat migraine and their patients are frustrated that the diagnosis is not taken more seriously.

Kempner (2014) argues that migraine suffers from a "legitimacy deficit." People who don't have migraine often dismiss them as "just another headache" and suspect that migraine is just a psychosomatic disorder, perhaps best treated with lifestyle changes, like stress reduction. The debilitating nature of migraine is not widely appreciated.

As a result, the physicians who deal with migraine and their patients biomedicalize the condition. They point to evidence: brain scans showing that migraine has a physiological basis; disease classifications that categorize it as a disease of the brain; and pharmaceuticals that help reduce the number and intensity of migraine episodes for some patients. They hope that this evidence will give migraine more legitimacy as a "real" disease so that people will be more willing to acknowledge that migraine headaches are debilitating, rather than suspecting that sufferers are exaggerating the severity of the sort of headache everyone experiences from time to time.

Migraine reminds us that experts are not all-powerful. Although there is a good deal of evidence to support—and medical authorities who actively advance—claims that migraine is a physiological disorder, people who experience migraine, which can be chronic and totally disabling, still do not receive the sort of widespread sympathy and understanding that, say, a broken leg elicits.

doctors and hospitals became subject to tighter professional standards, so the quality of care rose; at the same time, advances in medical science led to new medications and treatments. All this meant that the chances of medical care actually helping patients

rose sharply; people began to expect more of medical authorities, and the prestige and authority of physicians rose.

The rising stature of medicine encouraged the expansion of medical authority into a broader domain of social problems. In particular, psychiatrists (who are trained as physicians) began to claim that many troubling behaviors—including juvenile delinquency, unconventional sexual activity, drug addiction, and crime—should be recognized as symptoms of psychiatric problems. After World War II, the American Psychiatric Association began developing its *Diagnostic and Statistical Manual of Mental Disorders* (the so-called *DSM*), a huge catalog of all recognized mental disorders, which has continued to expand with each new edition (Kirk & Kutchins, 1992). The growing number of available diagnoses means that more and more behaviors can be understood in medical terms (see Box 4.2).

In addition to psychiatrists, whose medical training clearly placed them within medicine, practitioners in a variety of other quasi-medical professions adopted the language of *disease*, *symptom*, and *treatment*. Among these were clinical psychologists, licensed clinical social workers, and many others, including some with little or no professional training. Drug treatment, for instance, increasingly was provided by “professional ex-s [sic]”—recovered drug users who did not necessarily have professional credentials, but who were employed by drug treatment centers to lead therapeutic groups and who used medical language to describe what they did (J. D. Brown, 1991).

Often medicalization consists of little more than adopting a medical vocabulary. Take what is called the disease of *alcoholism*: its symptoms include drinking and getting into trouble at work, at home, and so on; there are no clear biological symptoms that distinguish alcoholics from nonalcoholic drinkers (Appleton, 1995). Similarly, treatment for alcoholism is to get people with drinking problems to choose to drink less (most often, total abstinence is recommended). The leading program for dealing with

#### Box 4.2 DISPUTING AUTISM CLASSIFICATIONS

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* is the authoritative catalog of psychiatric problems. It is periodically revised—new disorders are added, and older diagnoses are redefined. Barker and Galardi (2015) describe reactions to a 2012 *New York Times* report that the next revision (*DSM-5*) would adopt a set of diagnoses that would redefine autism in ways that might narrow the disease's definition (making it harder for a patient to receive an autism diagnosis).

While nonexperts might feel ill-qualified to comment on a news story about psychiatric experts defining their principal reference work's categories, the *Times* piece actually inspired considerable online commentary. (It is important to understand that no one—in either the news reports or the online commentary—challenged how severe cases of autism were diagnosed; the focus was on where to draw the line for people displaying less severe symptoms.) Some people argued that autism was being overdiagnosed, that what were once considered normal personality differences were being medicalized. These commentators were pleased to think that the domain of autism—the range of symptoms that might lead to a diagnosis—might contract. However, other comments—often from parents whose children had been diagnosed under the diagnostic standards set in the current *DSM*—opposed altering the diagnostic criteria in any way that might make it more difficult for them to receive a diagnosis that might let them qualify for help.

This example reveals that experts do not operate in a vacuum; nonexperts may dispute experts' knowledge, weighing in on such apparently technical issues as what should or should not be considered autistic.

alcoholism, Alcoholics Anonymous (AA), is a resolutely amateur operation. There are no professionals; all of AA's members are people who identify themselves as recovering alcoholics. Individuals attend meetings with fellow alcoholics and discuss AA's twelve-step program for achieving sobriety.



AA insists that alcoholism is a disease, but that the cure is to stop drinking, continue attending AA meetings, and follow the Twelve Steps. Note that AA's solution for alcoholism—that is, helping the individual with a drinking problem to make a commitment to stop drinking—is not all that different from the way drunkards were expected to reform by taking a pledge of sobriety, although the language of medicine seems to impart special authority to treatment as a solution. The twelve-step model has been adapted to help people deal with a variety of troubling behaviors—including drug abuse, overeating, and gambling—that have also been characterized as addictions or diseases.

In short, various medical authorities, with very different sorts of credentials, claim ownership of many contemporary social problems. As noted in Chapter 3, ownership can bring important benefits. Experts who gain ownership of a social problem usually gain a good deal: their social visibility and prestige rise, they become more powerful, and typically they stand to benefit financially from the increased business that people afflicted with the problem bring to them. This means that experts often have a vested interest in promoting claims that depict social problems from their perspective.

In a classic constructionist case study, for example, Stephen Pfohl (1977) argued that pediatric radiologists played a leading role in bringing attention to battered child syndrome—what would later be called *child abuse*. Initially this problem was typified in terms of physical injuries to children too young to explain how they had been hurt. Pediatric radiologists—specialists in interpreting children's X-rays—argued that they could distinguish fractures caused by accidents from those caused by abuse. These claims not only promised to improve the protection of vulnerable children, but also gave pediatric radiologists—who represented a small, relatively low-prestige medical specialty—ownership of a life-threatening disease, so the specialty's status rose. Expert claimsmakers often experience such gains, and thus wind up doing well by doing good.

Experts often seek to defend their professional turf and even expand their domain of ownership. The process may be gradual. Consider the changing scope of pediatrics (Pawluch, 1996). When this medical specialty emerged in the early twentieth century, pediatricians focused their efforts on problems associated with infant feeding; the milk supply was often tainted, causing many infants to become seriously ill. However, improved techniques for managing the purity of the milk supply soon made infant feeding much safer, so the major service that pediatricians had been providing was becoming less needed. In response, pediatricians began to expand their domain to emphasize the treatment of, first, other childhood diseases, and then normal, healthy childhood development. As birth rates fell, of course, there were fewer children for pediatricians to treat, but the specialists began to extend their services to treating patients in adolescence and even early adulthood (see Box 4.3).

These efforts need not be seen as cynical and self-serving. Experts generally believe that they have valuable knowledge and offer useful services, and they are continually looking for new opportunities to apply their expertise. In periods when their services are already in high demand, they have less time to extend their domain, but when business is slack, the prospect of attacking new problems becomes much more attractive. In this way, professional domains expand and the professionals' interests are advanced.

Ideally, experts' gains can be consolidated into institutionalized ownership. For instance, rising health care costs increasingly require patients to have medical insurance. But what sorts of treatments should health insurance cover? Professionals who provide different treatments want medical insurance to cover their services so that more patients will seek those services. Thus, the federal government's decision to define alcohol and drug problems as medical problems, and to require health insurance programs to cover some of the costs of their treatment, institutionalized these experts as owners of the alcohol problem (Weisner & Room, 1984). As

### Box 4.3 WHEN EXPERTS SUCCEED TOO WELL

At the beginning of the twentieth century, childbirth was dangerous; for every 100,000 births in the United States, 850 mothers died within a month of giving birth. By 1980, this figure had fallen more than 99 percent—to 7.5 maternal deaths per 100,000 births.

This might seem to be wonderful news—a serious social problem had been essentially eliminated. However, it posed a problem for those experts who had devoted their careers to studying the problem of maternal mortality, and they began to expand the domain of the problem, which allowed them to argue that their research topic remained important. They accomplished this by arguing that a death could be considered an instance of maternal mortality, not just if it was caused by an infection or some other complication of childbirth within the first month after the birth, but if death occurred from any cause within a year of being pregnant. This meant that the death of a woman who died, say, in a traffic accident eleven months after giving birth could be counted as a case of maternal mortality; indeed, a woman who died in an accident within a year of choosing to terminate a pregnancy could also be counted.

Such redefinitions allowed maternal mortality experts to argue that maternal deaths might be as high as 20 deaths per 100,000 live births, and to call for campaigns to do more to address this problem. Their claims could be made even more alarming by focusing on particular causes of death, such as homicide; such deaths might be very rare, but they could be typified as evidence of a neglected problem. It is important to remember that experts have a vested interest in the importance of their problems.

Source: K. Johnson, 2013.

Chapter 3 noted, owners have advantages in promoting their constructions of social problems; when ownership is coupled with such experts' institutionalized arrangements, experts' authority becomes entrenched.

In recent years, medicalization has taken new directions, with troubling conditions becoming subjects of **biomedicalization** (Clarke, Shim, Mamo, Fosket, & Fishman, 2003). Experts argue that biological processes are the root cause of many troubling conditions, which means that effective solutions must then address biology. For instance, the scientific revolution in genetics has led to claims that it will soon be possible to identify particular genes that cause various troubling conditions. Clearly, genetic anomalies cause some medical disorders, such as Down syndrome. But biomedical proponents argue that it will soon be possible to identify the genetic roots of all manner of behaviors, such as homosexuality or alcoholism, and research funding increasingly supports biomedical studies. This assumption that biology is at the root of many troubling conditions also fosters **pharmaceuticalization**, the process of defining prescription drugs as the solution (Abraham, 2010). Some of these claims may be borne out; others may prove false. At least for the foreseeable future, however, medicalization is likely to remain our society's leading form of expert claimsmaking.

### THE ROLE OF SCIENCE

Medical authority may be seen as a subcategory of a broader form of expertise: science. As with medicine, the advances made possible by the expansion of science, particularly during the past two centuries, have given scientists considerable authority in our culture. Society has been transformed by the growth in scientific knowledge; think of the Industrial Revolution, the exploitation of new forms of energy (steam, electricity, petroleum), faster transportation, speedier communication, and so on. Increased scientific knowledge made these changes possible.

Science depends on an appreciation of evidence. A scientific theory must generate falsifiable predictions; that is, those predictions must be able to be tested, and if they are proved wrong, the theory



is rejected. Scientists do research to produce evidence that can support or challenge their theories' predictions; the more supportive evidence they find, the more confidence scientists have in their theories. This system of reasoning has proved very powerful and has provided the foundation for all sorts of technological and medical advances, and in our society scientists are considered to have considerable authority when speaking about matters for which they have gathered evidence.

This is not to say that scientific evidence is infallible. Science is socially constructed; it is one of the ways people make sense of the world. To be sure, we have considerable confidence in well-established scientific findings, but it takes time for findings to become well established. Research can be flawed, and evidence can be incomplete or incorrectly interpreted. Scientists may debate issues among themselves, questioning one another's reasoning and evidence. Scientific progress can be a slow process; such debates can continue for years, even decades, until the evidence compiled becomes sufficiently compelling for a consensus to emerge among scientists.

Unfortunately, the deliberate pace of science is not well suited to news media eager to report on dramatic scientific breakthroughs. For instance, the media may publicize reports of the initial study on a particular topic, even though that research may eventually prove to have been flawed. A dramatic example was the media's reaction to a 1989 report by two researchers who said that they had observed a cold-fusion reaction in their laboratory. The implications were staggering—harnessing cold fusion would provide limitless, inexpensive energy—and the media began to speculate about the social changes this discovery would bring. Alas, other scientists soon concluded that the researchers had misinterpreted their results—that they had not found a way to produce cold fusion—and the media quickly dropped the topic.

Scientific experts' claims derive much of their rhetorical power from the understanding that scientists have special knowledge and access to particularly strong evidence, so their views deserve respect.

The media's tendency to treat the results of a single piece of research as definitive leads to confusion in the case of ongoing scientific debates. Until sufficient evidence becomes available, scientists—like other experts—do not necessarily agree. Their evidence and interpretations may differ, even conflict. The press, the general public, and policymakers often find such disagreements frustrating, because they tend to look to scientists for not just authoritative, but correct, information. Apparent contradictions call scientists' authority into question.

For example, one week the media might report that a medical journal has published a research report concluding that drinking alcohol increases the risk of contracting a particular disease. The following week the media might announce that another group of researchers has concluded that moderate drinking improves one's health. What should people think? It is possible that both reports are correct—that is, that drinking raises the risk of contracting a particular disease but generally improves health. Or perhaps one of the studies is flawed (or even both are flawed). Over time, additional research is likely to lead to an eventual scientific consensus, but it is important to recognize that disagreements are normal within science and many other expert communities. Experts may disagree about which are the important questions to ask, about the best way to arrive at answers to those questions, about how to interpret the available evidence, and so on.

In general, research questions and answers are most clear-cut in the physical sciences (such as physics and chemistry), less so in the biological sciences (such as medicine), and the least so in the social sciences. The physical sciences have fewer disagreements about what constitutes compelling evidence, and debates among physical scientists often can be settled decisively; in contrast, social scientists often cannot agree about what constitutes convincing evidence. In addition, it is important to appreciate that disagreements among scientists can center on very different sorts of questions, and that the authority of science depends on the sort of question being asked.

Consider, for instance, the debate over climate change. At the most basic level is the question of whether the planet's temperature is indeed rising. Scientists have devised various ways of measuring temperatures going back through time. Although there may be some disputes about the accuracy of particular measurements, or about which methods of measuring temperature changes are most accurate, these are relatively technical matters, and there is considerable scientific consensus that cycles of global warming and global cooling have occurred in the past and that temperatures have risen about  $0.74^{\circ}\text{C}$  over the past one hundred years or so. Accurately measuring changes in temperature presents a relatively clear-cut research challenge—the sort of question that scientists are clearly qualified to answer. It is, of course, more difficult to predict what will happen in the future, although again there is fairly widespread consensus that temperatures are likely to continue to rise over the next century (but considerable disagreement about how much they are likely to rise, with estimates ranging from  $1.8^{\circ}\text{C}$  to  $4.0^{\circ}\text{C}$ ).

A second issue—over which there is more debate—concerns the causes of climate change. Although some argue that the current global warming may be a natural process—just part of the long-term cycle of planetary heating and cooling—most scientists agree that at least some of the warming is due to humans' impact on the planet. Most commonly these claims focus on the role of greenhouse gases (for instance, emissions of carbon dioxide from vehicles and smokestacks) in retaining heat in the atmosphere. Note that these explanations are not mutually exclusive; perhaps the planet would be warming naturally in any case, but human activities are exacerbating the trend. At this level, the scientific issues are not as straightforward, and even experts who agree that global warming is occurring may disagree over the extent to which people's activities contribute to this process.

The debate's third level is far more contentious. Even if we assume for the moment that everyone agrees that human activity plays a substantial role in causing climate change, what should be done?

Here, debates can address many different issues, including what the consequences of global warming might be, what sorts of policies might reduce climate change, what the costs of those policies might be, whether the prospective benefits justify those costs, who should bear the costs, and so on. At this stage, purely scientific issues are less central; science may offer fairly compelling evidence about the extent and causes of climate change, but scientific knowledge cannot specify the correct course of policy. Consider nuclear weapons, for example: scientists were able to design and build nuclear weapons, but the decisions to use—or not use—those weapons were made by political leaders, not scientists. Scientific knowledge ordinarily is not sufficient to set social policy.

In short, we need to understand that when scientists participate in debates over social issues, the relevance of their expertise varies, depending on the particular questions being considered. While people—including some scientists—may like to imagine that scientific findings are sufficient to guide policy, in practice policymaking is shaped by other considerations, especially values (Pielke, 2007). In addressing a question such as how much the planet's temperature has increased during the past century, scientific expertise is likely to play the central role. However, many commentators would argue that science cannot provide authoritative answers to questions such as whether the prospective benefits of implementing a particular policy to reduce greenhouse gases will justify the policy's costs, or how the costs of controlling emissions should be distributed among richer and poorer countries. The willingness of audiences to grant authority to scientists is likely to depend on how relevant they believe the experts' knowledge to be (see Box 4.4).

Contemporary debates over scientific authority often focus on constructions of risk. The modern fascination with risk can be dated to the 1960s, when the surgeon general announced that smoking was hazardous to health, activist Ralph Nader drew attention to unsafe automobiles, and author Rachel Carson warned that pesticides were causing significant environmental damage (Meyer & Rohlinger,



#### Box 4.4 CONSERVATIVES LOSING CONFIDENCE IN SCIENCE

Expertise confers social status, for it is not enough that experts claim to have special knowledge; it is also necessary that other people ratify that expertise, and defer to the experts' judgments. For decades, surveys have asked the public to rate the amount of confidence ("a great deal," "only some," and so on) they have in various institutions. These data make it possible to track changes in the level of confidence of both the public overall, and in various subgroups of the population, such as people who describe their political orientation as conservative, moderate, or liberal.

In 1974, there were only modest differences in how people with different political orientations rated their confidence in science; if anything, conservatives expressed slightly more confidence in science than the other two groups. However, in the intervening years, the levels of confidence expressed by liberals and moderates remained essentially stable, while conservatives' confidence in science fell until they were the group least likely to say they had a great deal of confidence in science.

Such shifts have consequences for the social problems process. To the degree that there is general agreement about the authority of some type of expert, claims from such experts need not be divisive. However, if views of experts become politicized—as when conservatives have less confidence in scientific authority—then experts' claims have less power. In particular, conservatives' skepticism about the scientific findings regarding climate change have made policy debates much more contentious.

Source: Gauchat, 2012; McCright & Dunlap, 2011.

2012). These highly visible claims led to concerns about other risks, which in turn produced all manner of warnings—about the dangers of cholesterol, secondhand smoke, toxic waste, and so on. Such claims often couple scientific evidence (suggesting, for example, that a particular chemical may be carcinogenic) with warnings that the

danger is widespread and the issue urgent. Increasingly, the media cover scientists' warnings that this or that condition poses risks to individuals' health, to environmental safety, and so on. Although the evidence regarding some risks—such as the link between smoking and lung cancer—is overwhelming, scientists disagree about the extent and significance of other risks.

It can take time for scientists to agree on assessments of risk. The most compelling scientific evidence comes from experiments, but it is usually impossible to design experiments to study risk. We cannot take identical groups of infants and make sure that they have identical experiences going through life—except that we can expose the experimental group to a particular risk and keep the control group from being exposed to that risk. Such a study might produce very strong evidence, but it would be time-consuming, expensive, and unethical. In practice, researchers must settle for much weaker evidence; they might, for example, identify people exposed to a particular risk, try to match them with similar folks who have not been exposed to that risk, and then study whether the two groups have different rates of particular diseases. It is always possible to challenge the results of such studies—for instance, were the two groups matched on every relevant variable?—and it takes a great deal of evidence (such as the countless studies on smokers' health) to make a convincing case.

It is difficult for nonscientists—a category that includes most activists, members of the media, the general public, and policymakers—to assess claims about risk that refer to scientific evidence. Debates over social problems often ignore such issues as comparative risks (for instance, the number of people at risk, the number of people likely to be harmed, and so on). All kinds of activities (for example, driving to work) carry risks. Often we take these risks for granted and ignore them, even though they may be far greater than are the heavily publicized dangers of, say, exposure to secondhand smoke. Scientific evidence—particularly calculations of risk—is not well understood, and such issues often lead to confusion in the face of what is thought to be expert claimsmaking.

## EVIDENCE, INTERESTS, AND ADVOCACY

A major reason why people defer to experts is their presumption that experts command knowledge that other people don't have. Although all knowledge is socially constructed, we consider experts' knowledge to be more likely to be accurate than gossip, rumor, or other less authoritative sorts of knowledge that, we know from experience, often prove to be wrong. Thus, we tend to consider expert knowledge to be relatively correct. We defer to medical authorities because we assume that they know how to diagnose diseases, are able to understand the causes and workings of those diseases, and can recommend the best possible treatments. Similarly, we presume that scientists have done careful research and compiled evidence that offers the best available information about how the world works.

In other words, we turn to experts for sound information based on high-quality evidence, and experts' status as relatively authoritative claimsmakers depends on such understanding. Experts are commonly assumed to be impartial judges—their medical diagnoses or scientific findings grounded in facts rather than opinions. Yet experts often have an interest in promoting claims, and when they become advocates for particular positions or policies, they are not necessarily guided solely by their expert knowledge (see Box 4.5).

We have already noted that experts stand to benefit from the ownership of social problems; recall how the status of pediatric radiologists rose after they drew attention to battered child syndrome. Experts also may have social ties to parties with interests in social issues. Scientific research can be extremely expensive, and many scientists derive funding from corporations, government agencies, and so on. These funders may have an interest in the researchers' findings. For example, both medical researchers and their pharmaceutical company sponsors may have financial stakes in a new drug, and they may hope that the drug proves safe and effective, just as scientists employed by a corporation may be under pressure to affirm that the firm's waste disposal practices are safe. Other

### Box 4.5 MAKING HAPPINESS AN EXPERT PROBLEM

Obviously, happiness is a very old idea. But happiness has recently emerged as a social problem under the ownership of experts. As the twentieth century came to a close, there were claims that increases in income did not correspond to increases in measures of happiness (these measures typically asked people to rate how happy they were). The notion that happiness could be measured objectively made it a subject for expert assessment, with psychiatrists, psychologists, and economists becoming the principal owners of the happiness problem.

The experts' claims that prosperity and programs to promote social welfare through improving material conditions do little to enhance happiness invite a romantic critique: materialism will not lead to happiness; the roots of true happiness lie within the individual. In their view, public policies should worry less about emphasizing the importance of economic growth, and more about enhancing mental health; educators should teach "happiness skills"; and individuals should be encouraged to pay more attention to nonmaterial values and to take care of their health. Thus, inner welfare should be more important than social welfare in ensuring what really matters—happiness.

Experts play active roles in constructing many social problems. We assume that doctors know what ails us, that economists know how to improve prosperity, and so on. The construction of happiness—traditionally viewed as a personal emotion—as a social problem best understood by experts reveals our increasing readiness to allow experts to intrude into and offer guidance for our private lives.

Source: Frawley, 2015.

scientists may be closely associated with particular social movements, such as environmentalism.

Even though we tend to idealize scientists as objective, impartial observers, they may have allegiances that help shape their conclusions.



Some legal trials feature psychiatrists hired as expert witnesses by the prosecution and the defense, who testify, respectively, that the defendant's mental state was such that the trials should or should not proceed. The point is not that experts' social ties make science illegitimate—a very large share of scientists have such commitments—but that scientific knowledge is not produced or disseminated in a social vacuum.

In some cases, scientists' allegiances may be to the particular perspectives or approaches that characterize their disciplines. For instance, sociologists and other social scientists also act as expert claimsmakers. Just as medical authorities bring their professional training to bear when they medicalize troubling conditions by characterizing them using the language of diseases, symptoms, and other medical concepts, social scientists have their own orientations and conceptual tools. Economists, for example, argue that people can be understood as rational actors who make choices to maximize their own satisfaction. This proves to be a powerful underlying assumption, in that it can be extended to analyze all manner of choices. Thus, economists tend to see social problems as the products of people's choices, and to promote policies that will encourage people to make particular choices. For example, one way to discourage smoking is to raise tobacco taxes; if tobacco is more expensive, at least some people may choose to stop smoking.

Sociologists, too, apply their discipline's perspective to the analysis of social problems in their works (including this book). Sociologists argue that people shape one another's actions, and that social problems are products of particular social arrangements. Thus, where a psychiatrist may approach a social problem in terms of individuals whose thinking is disordered because they suffer from a syndrome of some sort, or an economist may see it in terms of arrangements that reward some choices more than others, sociologists are more likely to point to the way culture and social structure constrain and shape people's activities. C. Wright Mills (1959) called this mode of thinking the *sociological imagination* (discussed

further in Chapter 5). This book, for instance, emphasizes understanding the social problems process through which actors socially construct social problems.

In other cases, experts may have allegiances to particular ideological positions. Liberal and conservative experts can approach social problems in very different ways: they focus on different causes, and they recommend different solutions. So-called think tanks—private nonprofit organizations dedicated to policy analysis and advocacy—often have an ideology that shapes their experts' recommendations (see Box 4.6). These experts maintain connections with media outlets and politicians who share their ideological orientations, so advocates from different positions have access to expert knowledge that can be used to buttress their claims.

Although we might like to imagine that experts are completely independent, impartial authorities, without interests or ideological commitments, this perfect objectivity is, in practice, impossible to achieve. Experts are part of the larger social order. At a minimum, they believe in the value of their professions: psychiatrists consider psychiatry a valuable perspective, just as sociologists promote the value of the sociological imagination. Experts can further be expected to believe that the problems they have chosen to study are important and worthy of their attention and that the solutions they have been working on are promising. They may also have more obvious interests (such as a financial stake in the outcome of their research) or ideological preferences. Such social connections do not necessarily mean that the experts are wrong, but they do suggest that experts may be less than perfectly objective, and may think less critically when they confront ideas that fit their prejudices, so their claims should not be automatically accepted.

Expert knowledge is imperfect because it is produced by scientists, physicians, and other experts who are themselves actors in the larger society. It should be no surprise that experts' ideas evolve as new information becomes available. But it takes time for novel ideas

#### Box 4.6 CONSTRAINTS ON WHAT THINK TANKS THINK

Think tanks are organizations of experts designed to promote claims and policy responses. Typically, they represent particular ideological positions; thus, the Brookings Institution often adopts liberal stands, the American Enterprise Institute and the Heritage Foundation promote conservative positions, and the Cato Institute presents libertarian views.

Claimsmaking is a central purpose of think tanks. Their experts try to identify troubling conditions, construct them as particular sorts of social problems, and devise proposals for policies that might solve those problems. Think tank experts operate as insider claimsmakers, trying to bring their concerns to the attention of legislators and officials in government agencies, so as to directly influence the policy process.

To maintain their influence, think tanks' experts are dependent on their connections to others (Medvetz, 2012). To get members of Congress and other government officials to pay attention to their claims, people at think tanks need to consider what concerns those officials; think-tank proposals are more likely to receive officials' attention when they address problems those officials already consider important. Think tanks are largely funded by substantial gifts from corporations and foundations; those donors have their own ideas about which issues deserve the think tanks' attention, and they may withhold funding if they sense that think tanks don't share their concerns. It also is important to maintain contacts with members of the media who can choose to cover or ignore the claims think tanks produce; a well-connected think tank can get more coverage for its claims. Think tanks, then, do not operate in a refined intellectual vacuum.

to emerge and gain acceptance. As evidence accumulates, consensus is likely to develop, but this process cannot occur overnight. This is why expert knowledge is best understood as a special type of claim, part of the larger social problems process.

#### OFFICIALS AS EXPERT CLAIMSMAKERS

Another important category of expert claimsmakers consists of officials, particularly those employed by government agencies, such as the Centers for Disease Control and Prevention (CDC) or the Environmental Protection Agency (EPA). Such agencies have various responsibilities: they may compile information (collecting data to measure the crime rate, the unemployment rate, and so on); they may administer regulations (regarding workplace safety, pollution, or other issues); they may fund research through grants to experts outside the government; they may disseminate information to the citizenry; and so on. The work of many agencies bears on one or more social problems. Because the federal government spends billions on the budgets of its various agencies, these officials can draw on substantial resources. Usually they are able to compile more and better information about troubling conditions than unofficial claimsmakers can, giving officials' claims special authority in many social problems debates. Official agencies often achieve a level of ownership for social problems.

Agencies compete with one another for budget allocations and other scarce resources. Often multiple agencies have an interest in the same social problem. For instance, alcohol issues are the concern of several federal agencies: the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF); the National Institute on Alcohol Abuse and Alcoholism (NIAAA); the National Highway Traffic Safety Administration (NHTSA), which is concerned with alcohol-related traffic fatalities; and on and on. Imagine how many federal agencies must be concerned with a particular aspect of racial inequality. Just as social movement organizations find themselves competing with one another, officials—at least some of the time—view other agencies as competitors, both for resources and for ownership of particular social issues.

Protecting and, if possible, expanding an agency's turf becomes a central concern for officials, and claimsmaking provides one weapon



for bureaucratic infighting. That is, drawing attention to a particular troubling condition, devising a program to deal with the problem, and then administering that program can serve two ends. On the one hand, it is easy to imagine that most officials are sincere, that they have joined an agency because they believe that it does important, valuable work. Like other claimsmakers, officials probably believe their own rhetoric and adopt the frames they promote. At the same time, officials have instrumental reasons to promote claims: successful claimsmaking is likely to serve the agency's interests, to increase its power, influence, and budget. Whatever their convictions, officials often have an interest in the claims they promote. For example, officials of the U.S. Bureau of Narcotics undoubtedly saw marijuana as a dangerous drug when they first called for a federal law against it in the 1930s, but that law also helped protect the bureau from further budget cuts (Dickson, 1968).

Officials may recognize that their agencies could address certain additional troubling conditions if they could help launch the social problems process. Indeed, agencies often control significant, flexible resources that can be used to jump-start the claimsmaking process. In the 1960s, for instance, the U.S. Children's Bureau (CB) was under fire from critics and losing control of some programs that were being shifted to other agencies (Nelson, 1984). At the same time, CB officials had long been in contact with the American Humane Association, an organization that had historically been concerned with the physical abuse of children. The CB began funding the research that drew national attention to what was initially called *battered child syndrome*, soon to be renamed *child abuse* (Pfohl, 1977). Child abuse became a visible, dramatic subject of considerable public concern, and in the process helped restore the CB as an important agency of the federal government. As an owner of the child abuse problem, the CB could extend its programs—funding further research, helping develop legislation requiring doctors and other professionals to report child abuse, and so on.

Although the expert claimsmakers in these examples were federal officials, analogous processes can occur in state or local governments, wherever officials become involved in drawing attention to troubling conditions. In some cases, national attention on a problem may lead local officials to call for action in their communities; in other locales, officials may be slower to acknowledge that the problem exists in—and requires action in—their jurisdictions. The policies of different cities toward homelessness, for instance, depend on how local officials respond to the issue (Bogard, 2003). In other cases, claimsmaking by officials may focus on purely local issues—such as whether an old building should be demolished to permit new development, or be preserved as part of the community's historical heritage (Lofland, 2003).

Officials working in government agencies usually have special knowledge or expertise that justifies their participation in claimsmaking. They are insiders, and their activities often occur behind the scenes, out of the public view. In sharp contrast are the claimsmaking activities of elected officials—presidents, senators, and the like—who may seize on an issue and become active claimsmakers. These officials may lack special expertise, but their visible positions make it much easier for them to attract media attention and help publicize a cause.

### EXPERT CLAIMSMAKERS IN THE SOCIAL PROBLEMS PROCESS

Chapter 3 explored the role of activists and social movements in claimsmaking; this chapter has concentrated on the claimsmaking of experts—particularly medical authorities, scientists, and public officials. In many cases, claimsmaking campaigns feature alliances between activists and experts. Activists often contribute enthusiasm, passion, and whatever organizational resources their movements may control, whereas experts provide authoritative knowledge.

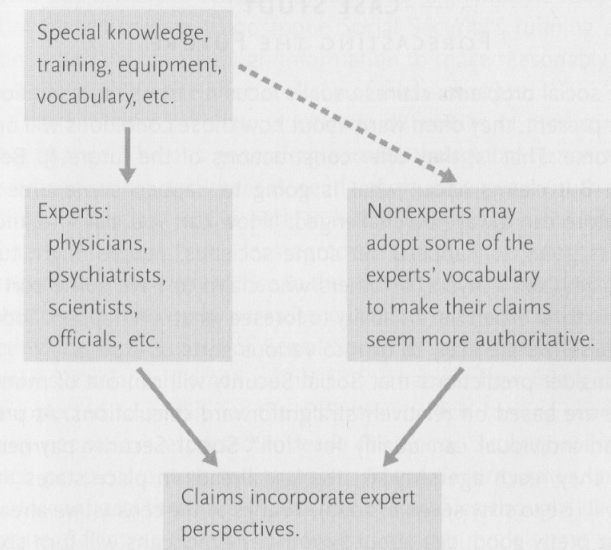
(This is obviously an oversimplification: many activists become quite knowledgeable, and experts can become highly dedicated to claimsmaking campaigns.)

Knowledge is an important commodity in claimsmaking. Remember that social problems claims begin with grounds statements—that is, statements about the facts concerning the troubling condition. When claimsmakers are trying to draw attention to a neglected condition—one that hasn't attracted much attention—often they discover that little information is available and no experts are studying the problem yet. One solution is for activists to begin to collect their own information. For instance, it was only after gay and lesbian activists in some cities tried to gather reports of homosexuals who had been assaulted that official efforts to collect hate crime statistics started (Jenness & Grattet, 2001). Similarly, residents living near toxic waste sites may begin to collect their own evidence of health problems as a way of arousing concern about the risks they face (P. Brown, 1992). In such cases, amateurs try to generate the sort of knowledge that experts have failed to collect, in order to fill what would otherwise be a gap in their claims. Figure 4.1 illustrates how both trained professionals and those without formal training as experts can make use of professional knowledge when making claims.

Just as activist claimsmakers must be alert to the responses of others—particularly the media, the public, and policymakers—so, too, must experts be concerned with feedback from other actors in the social problems process. Because experts are likely to consider the knowledge that they contribute to the social problems process especially valuable, they may be disappointed that their statements are not more influential. Audiences may have trouble interpreting what experts have to say, particularly when the experts present their findings using a professional, technical vocabulary. To bridge the gap, experts may discover that they need to popularize their work, to translate their findings into lay language.

Another problem is that audiences may have impossibly high expectations for experts' contributions; as we have suggested, experts

Figure 4.1 EXPERTS' ROLE IN THE SOCIAL PROBLEMS PROCESS



may add to our understanding of a troubling social condition, but their knowledge usually is not sufficient to identify policies that can make the problem disappear. Ultimately, whether experts' claims—or, for that matter, the claims of activists—are widely understood depends on the treatment they receive in the media.

#### MAKING CONNECTIONS

- The role of experts in the policymaking process is discussed further in Chapter 7.
- The media rely on experts to make claims about social problems. In the next chapter you will learn how experts and the media collaborate in the social problems process.
- In Chapter 9, the role of experts in evaluating the outcomes of social problems and making new claims about problems will be discussed.



### CASE STUDY FORECASTING THE FUTURE

While social problems claims usually focus on troubling conditions in the present, they often warn about how those conditions will only get worse. That is, they offer constructions of the future (J. Best, 2011). But claims about what is going to happen some time in the future can always be challenged: "How can you claim to know what is going to happen?" In some societies, people might turn to oracles, soothsayers, or others who claim to have some sort of supernatural expertise, an ability to foresee what will happen. Today, of course, we are likely to turn to various sorts of experts.

Consider predictions that Social Security will run out of money. These are based on relatively straightforward calculations. At present, an individual can qualify for "full" Social Security payments when they reach age sixty-six (the law already in place states that this will rise to sixty-seven in 2027). Thanks to the census, we already have a pretty good idea about how many Americans will turn sixty-six and qualify for Social Security in, say, 2018. Population records also let us predict the percentage of seventy-year-olds who will die before they reach their seventy-first birthday, and so on. So it is a fairly simple matter to add the people entering the Social Security rolls and subtract those who are expected to die, which lets us predict with considerable accuracy how many Americans will be receiving Social Security in any particular year and, based on current arrangements, we can figure out how much money will be needed to pay them. These figures are not really in dispute; there aren't many Social Security skeptics.

We can also imagine ways in which the laws regarding Social Security might be changed: for example, we could raise the age at which individuals become eligible, alter the formula used to calculate cost-of-living increases, raise Social Security taxes by raising the tax rate (which would mean that everyone would pay more on the first \$118,500 of their income [the figure when this book was written]) or by increasing the amount of income subject to Social Security taxes (which would mean only those earning more than \$118,500

would pay more), or reduce payments for high-income recipients. All of these are ways to postpone Social Security's running out of money, and we have enough information to make reasonably good predictions about the effects of any of these changes.

Contrast these predictions with the difficulties of predicting climate change. There is general agreement that global temperatures have been rising, and there is nearly as much agreement that this change is due, at least in part, to humans' effects on the environment, but there is much less agreement about how much further temperatures are likely to rise in the next fifty or one hundred years. Predicting temperature increases is much more difficult than predicting the future costs of Social Security. Social Security's future involves a relatively small number of variables: how many people are expected to qualify for the program in each coming year; how many people are expected to leave the Social Security rolls; how much people are expected to pay in Social Security taxes, and so on. In contrast, there are thousands of variables thought to affect climate. Scientists develop elaborate computer models that specify the effects these variables are thought to have on one another. These models change over time as experts incorporate more knowledge about climate processes.

The result is that climate change predictions vary; some models predict larger and faster temperature increases than others, so there are a range of estimates—some higher, some lower—for how much temperatures will increase by, say, the year 2100. Scientists may disagree about which models they prefer. This is not unusual in debates among scientists and other experts; science advances by proposing hypotheses, testing them, and gradually accepting some ideas while dropping others. Scientific knowledge is constantly changing in the face of new evidence; we should not be surprised when scientists disagree.

Still, it is possible for claimsmakers to point to such disagreements as a means of raising doubts. A notorious example is the decades-long campaign waged by the tobacco industry against antismoking activists. For decades, scientists had argued that smoking increased the risk of lung cancer and a host of other medical problems; thousands

of studies supporting this conclusion accumulated. In response, the tobacco industry mounted a public relations campaign and hired scientists as spokespeople to question the generally accepted conclusion that smoking was dangerous. In effect, they argued that the evidence was not all in, and therefore policymakers should not take action.

A somewhat similar campaign questions the scientific consensus about climate change. Because the most promising way to slow climate change involves reducing the emission of greenhouse gases, industries that generate those gases (such as the petroleum industry) have resisted climate-change claims. In the United States, Republicans have been more allied with these businesses, and they have argued that policies should not be changed until the science is settled. This campaign has reshaped public opinion: where once Republicans and Democrats, and liberals and conservatives, were about equally likely to report that they respected scientific authority, in recent years Republicans and conservatives have been more likely to express skepticism about predictions of climate change, even though there is widespread scientific agreement that temperatures are rising (Gauchat, 2012; McCright & Dunlap, 2011).

Notice some differences between expert claims about Social Security and climate change. First, predictions about Social Security are more precise because the relevant factors are well understood and easily measured, so there is less disagreement about what is likely to happen. With climate change, scientists generally agree that the planet is warming, but their models disagree about how fast this is occurring and what the effects are likely to be. Second, it is relatively easy to “fix” Social Security by some combination of raising taxes and/or reducing benefits; while none of these options is painless, it is easy to imagine that some compromise solution could be crafted. In fact, the history of the Social Security program is a series of these compromises, generally agreements that put off the crisis for a few decades. In contrast, proposals to address the global problem of climate change are likely to be extremely costly, so that the stakes are higher, making it harder for the many different nations involved to agree on a solution that they all find reasonable.

Society depends on expert claimsmakers to make knowledgeable recommendations about social problems, but experts' claims are only one element in the social problems process, and experts' recommendations do not automatically overcome all objections. Patients can challenge doctors' diagnoses and prescriptions, and so on. This is particularly true when experts make claims about the future. A prediction is not a certainty, and uncertainty invites doubts and resistance.

## QUESTIONS

1. Identify another current prediction about a future social problem. Who makes the claim, and how much confidence should we have in the prediction?
2. Can you think of predictions about the future that were made in the past? What was the societal reaction to those predictions? Were those predictions accurate?
3. Predictions vary in how far they peer into the future—a year, a decade, even a century. Does this time span make a difference in how people respond to future claims?