

Moral Engineering & Neuropsychiatry — Recasting a Culture of Intervention in Sweden

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Abstract: The purpose of this paper is to problematize neuropsychiatry as public claims maker within a Swedish context. This will be done by applying what I conceptualize as a *culture of intervention*. Additionally, the paper also will show how neuropsychiatry's public position interacts with a governance that works as a moral engineering. Governing is in the study understood as structuring the field of possible actions — what can be done or not is that which needs to be controlled. Neuropsychiatry seems to be the “essence” of the conduct of conduct — it is a knowledge-production that produces self-regulated subjects. The object is to analyse the conditions that make certain practises acceptable at a certain moment. I use it as a way of problematizing the generally accepted idea of *scientific progress* that underwrites the history of the neuropsychiatric diagnoses as an *uncovering journey towards completion*. The paper looks at how these neuropsychiatric diagnoses have become naturalized and given, an unquestionable regulatory knowledge that explain as well as prescribe what to do. This is further related to how the Swedish welfare state has gone from a social engineering rational to a moral engineering rational that builds on individuals taking responsibility over their own life.

Key words: governing, social engineering, moral engineering, Foucault, bio-politics, advanced liberalism, culture of intervention

1. Introduction

Looking neuropsychiatry up on the English Wikipedia one gets briefly introduced to the question of mind versus brain. Looking neuropsychiatry up on the Swedish Wikipedia one gets to know that the concept of neuropsychiatry in Sweden primarily refers to a psychiatric practice focused round a group of diagnoses usually set during childhood such as adhd, autism, Asperger and Tourette's syndrome. Diagnoses that in Sweden are seen as neuropsychiatric impairments. However brief, the English Wikipedia heading still contains some of the original conflict, whereas the Swedish show no trace of any academic quarrel at all. Public information, such as Wikipedia, might be seen as displaying relevant aspects concerning the struggle to control a discourse. Still an unanswered empirical question, my impression is that controlling the information given concerning neuropsychiatry, the diagnoses, prevalence, and consequences and alike is something that seems to be actively done. The information-consensus one meets concerning neuropsychiatric diagnoses such as adhd is staggering considering how little is actually known when it comes to the major questions of aetiology and prevalence. What

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gets visualized in the neuropsychiatric-discourse, or rather practice, is the structuring of a field of possible actions. In Sweden, what has been waged is a battle over the right to produce the truth concerning problem-behaviours such as unruly children and recidivism in crime. At stake has been the right to formulate a problem in terms of its causes, prevalence and solution. Neuropsychiatry seems to have won that battle in Sweden.

2. Purpose

The purpose of this paper is to problematize neuropsychiatry as public claims maker within a Swedish context. I will do this by applying what I conceptualize as a *culture of intervention* (Andersson, 2012). Furthermore, I will try to show how neuropsychiatry's public position interacts with a governance that works as a moral engineering.

3. Governing Life Producing Subjects

To govern is to structure the field of possible actions — what can be done or not is that which needs to be controlled. Neuropsychiatry seems to be the “essence” of the conduct of conduct — it is a knowledge-production that produces self-regulated subjects.

What I will try to analyse is the establishing of *practices* in the term intended by Foucault (1991, p. 75), i.e., my objective is to try to expose the conditions that make certain practises acceptable at a certain moment. I use it as a way of problematizing the generally accepted idea of *scientific progress* that underwrites the history of the neuropsychiatric diagnoses as an *uncovering journey towards completion*, where science *uncover the actual and inherent* meaning of these neuropsychiatric diagnoses. I thus use practices as: “... a question of analysing a ‘regime of practices’— practices being understood here as places where what is said and what is done, rules imposed and reasons given, that the planned and the taken for granted meet and interconnect” (Foucault, 1991, p. 75). What I want to get a hold of is how these neuropsychiatric diagnoses have become naturalized and given, an unquestionable regulatory knowledge that explain as well as prescribe what to do with those diagnosed, this then “... means to analyse programmes of conduct which have both prescriptive effects regarding what is to be done (effects of ‘jurisdiction’), and codifying effects regarding what is to be known (effects of ‘veridiction’)” (Foucault, 1991, p. 75).

The practices of neuropsychiatry are part of a *bio-politics*. Bio-politics then is a way of managing people as a group or a population that emerged alongside of the establishing of the modern nation state. In an era where power must be warranted rationally, bio-politics builds on utilizing an emphasis on the maintenance and protection of life rather than the right to end life. Through the regulation of the body, and the production of a power-formation that has the enhancement of life as its primary focus, bio-politics frames itself as a politics of life. By regulating customs, habits, health, reproductive practices, family, and well-being bio-politics conceptualise the state as a “body” and the use of state power as essential to life of the social-body.

My analysis will also build on asserting that what we are witnessing is a governing that is part of advanced liberalism, i.e. a governing where power is de-centred and where the population is expected as well as required to play a most active role through self-government. Due to the more active part, what is required is a subject able to regulate himself from within. Advanced liberalism is based on giving predominance to market mechanisms and of the restriction of the action of the state, thus acquiring a knowledge-production that enables the assembling of self-regulated and self-correcting subjects.

These self-regulated and self-correcting subjects needs technologies — technologies of self. The regulation

of conduct depends on technologies produced by that of expertise. Expertise produced technologies turn governing into something that is grounded in the authority of science and objectivity creating a distance between self-regulation and the state (Rose, 1996, p. 156). The technologies of self-functions by a logic of choice, by transforming individuals construction of themselves, thus “[...] inculcating desires for self-development that expertise itself can guide and through claims to be able to allay the anxieties generated when the actuality of life fails to live up to its image (Rose, 1999, p. 88). Advanced liberalism also contains a claim to reduce the scope of government. A central means to do this is through responsabilization. Responsibilization amounts to making the populace conceive of risks such as illness, unemployment, poverty, not as the responsibility of the state, but as part of a domain for which the individual is responsible, thus transforming what used to be welfare state problems into a problem of self-care (Lemke, 2001, p. 201).

4. Culture of Intervention

I have previously drawn on a conceptualization that I termed *The Culture of intervention* (Andersson, 2012). As I see it the culture of intervention was the major factor in installing the Swedish welfare state — a state that in the name of public good took upon itself to enhance its citizenry through social engineering and what made the Swedish welfare state stand out was its ability to intervene into lives. Where other nations might have had similar policies — in Sweden, these policies were actually enforced. With laws like the sterilization law (1934–1976) and Institutes like the *National institute for racial biology* the Swedish welfare state has a pedigree consisting of eugenics as well as evolutionism.

The will to knowledge and the care of the population that underpinned the Swedish welfare state was primarily a medical knowledge that placed itself above individual considerations. Deviation in any way was an indicator of something being wrong, and if something was wrong, it was up to the state and its officials and civil servants to find a cure or remedy, preferably through expert led interventions. It was a culture where the civil servant, the administrator and the physician “made up the rules”, where the rights of individuals and the rule of law was overridden by administrative decision (Qvarsell, 1993, p. 303). It was a governance, based on social engineering, that intervened in the name of public good. However, the downfall of the rehabilitative ideal in the 1960–70s, may partly be understood as, at least, partial abandonment of the culture of invention.

One could say that the culture of intervention reached a zenith with the proposal for a new penal code in 1956 (SOU1956: 59). The proposal was for a protective code where the criminals as far as possible should be turned over to different forms of care. The proposal was egalitarian in the sense that the sane or insane was to be treated the same before the law and sanctions were to be adapted to suit the ailment of the offender (Qvarsell, 1993, p. 330). Even though the entire proposal was not enacted it is a telling example of the culture of intervention, a culture that has also fashioned ideas like turning a middle size Swedish town into a laboratory for crime prevention, prevention based on mental hygiene and individual prevention (SOU 1964:59). The overly interventionist fosterage-mission assigned to the Swedish school during the 20th century has been coined as “a nationalization of the soul of the children” (Broady, p. 131).

5. From Social to Moral Engineering

The Swedish welfare state with its culture of intervention was driven by a conception of politics as applied science (Andersson & Nilsson, 2009). Strong beliefs in the possibilities of science and its potential use in making

a better society gave scientific experts a central position in governing the Swedish welfare state (Andersson & Nilsson, 2009). The blurring of science and politics is a central factor for understanding the positions given to especially the medical sciences in Sweden.

If social engineering was about improving society through sciences, moral engineering is about improving the individual in terms of its ability to adjust to a governance built on framing the market as the primary organiser of social interaction. By producing technologies of the self, compatible to the demands raised by a responsabilizations — process, moral engineering facilitates in the assembly of subjects that adopt to a governance based on the supremacy of free market. Looking for example at cognitive behavioural therapy programmes within the Swedish prison and probations services it becomes obvious how an ability to make rational choices, curbing ones affections, and applying the faculty of reason are the central part of being rehabilitated (se for example Petersson, 2003; Andersson, 2004).

5.1 Advanced Liberalism Swedish Style — The Decentralisation of the Nationalized School

The late 1980s and early 1990s was the period when neoliberal political economy became the political solution in Sweden. Adjusting to Milton Friedmans monetarism meant that the social democrats in the 1990s abandoned full-employment as primary political goal in favour of a policy of restraining inflation. Transforming the public sector, thus framed as non-productive and debilitating, became a central political aspiration and downscaling public spending became, along with providing freedom of choice by deregulating so-called welfare services, the most central task of government.

The advancement of neuropsychiatric diagnoses depended on these changes in the political economy in such a way that a changed fiscal system opened up the need for diagnosing school-failure. The mandatory nationalised school-system became decentralised and came under municipal control in 1992 (Lindensjö & Lundgren, 2000). The reform also incorporated a new financing-system, a system that would play into the hands of neuropsychiatry. Replacing a system based on standardised amounts, means for special education now had to be applied for specifically (Lindensjö & Lundgren, 2000). And it was this applications-process, tying a successful application to having a diagnosis, which opened up for the need for neuropsychiatric diagnoses and expertise. The economic re-structuring of Swedish schooling thus made way for neuropsychiatric diagnosing of children during the 1990s. During the 21s century this roll has been taken over by pre-school and special education and support within pre-schools seem to have become the major field for neuropsychiatric diagnosing. Fiscal restraints have led to municipals demanding a diagnosis to render any extra means for pre-schooling special education.

5.2 MBD-DAMP-ADHD the Swedish Neuropsychiatric Scene

As I pointed to in the introduction, looking up neuropsychiatry on the Swedish Wikipedia one get to know, after a very short general introduction, that neuropsychiatry is a psychiatric practice that target diagnoses, established in childhood, such as adhd, autism, Aspergers and Tourette's syndrome.¹ These diagnoses then make up what in Sweden is termed neuropsychiatric impairment (NPI). Looking up NPI on Wikipedia one is told that: "The branch of psychiatry that set these diagnoses and treats these conditions is in Sweden called neuropsychiatry". However, "(i)n a more general sense, neuropsychiatry study all of the somatic ills that have consequences for the psyche, but this conception of the term has become less common in Sweden".²

¹ <http://sv.wikipedia.org/wiki/Neuropsykiatri> (111207).

² http://sv.wikipedia.org/wiki/Neuropsykiatriska_funktionsnedsättningar (111207) my translation and my emphasis. In Swedish: Den del av psykiatrin som diagnostiserar och behandlar dessa tillstånd kallas i Sverige för neuropsykiatri. I allmänare bemärkelse är

Considering that neuropsychiatry defined in these terms is an extremely small research field in Sweden, and emanating mainly from one person, Christopher Gillberg, the achievement in terms of claims-making is notable. Interestingly enough, this claims-making seems always to be done in what is framed as fierce opposition, a framing probably necessary due to the fact the claims of neuropsychiatry is more than extensive. Promoting a messianic and always contested knowledge, based on weak empirical grounds³, (but promising salvation and cure, freeing parents as well as inflicted from any personal accountability over “failed lives”) seems more easily promoted if a fierce opposition can be made to exist. An opposition that brings credence to the seriousness of the problem neuropsychiatry is about to solve. Intriguingly, the trajectory of neuropsychiatry in Sweden runs parallel to its criticism.

At the heart of this trajectory is the so-called Gothenburg study⁴. In origin a prevalence and screening study concerning *minimal brain dysfunction* (MBD) the study has, alongside the international death of MBD and promotion of ADHD, been transformed: firstly to a study of *deficits in attention, motor control and perception* (DAMP), becoming finally a study of ADHD. (I will shortly return to the diagnosis DAMP — which is the product of Gillberg) The study, making up Gillberg’s (1981) PhD-dissertation, has come to serve as the empirical material in several PhD-theses produced by the research group that Gillberg headed. The trajectory of neuropsychiatry in Sweden can be seen as brought forth by three waves of criticism. The first wave is the international criticism of MBD during 1960s, 70s and 80s. The second wave consists of internal medical criticism towards the DAMP-diagnosis, emanating from a professor in child and adolescence psychiatry, P-A Rydelius and a child physician, Leif Elinder. This subsequently transformed into a third wave headed by a sociologist, Eva Kärfve, who wrote a book on the DAMP-diagnosis. Kärfve was joined by Elinder in her criticism and they demanded to, according to the principal of public access to documents⁵, see and review the empirical material that the so-called Gothenburg study consisted of.

The first wave of criticism was an international criticism directed at the MBD-diagnosis. It came to play in a Swedish setting in such way that Gillberg during the 1980s and 1990s had to defend the Gothenburg study from accusations of being a MBD-study and thus from being disqualified alongside the rest of the MBD-research. This fending of the critique took on a self-reflexive stance and here the critique is sort of self-applied. It is Gillberg who raised doubts and defended his standpoint as valid. The international critique against MBD, finalising in Schmidt et al. (1987), was the death of an aetiology that built on claiming that brain damages caused hyperactivity and inattention. Gillberg’s defence drew on claiming that his Gothenburg study used MBD as a chart of symptoms rather than as a claim to aetiology. In defence of the study Gillberg coined the diagnosis DAMP to replace MBD

neuropsykiatri studiet av alla somatiska sjukdomar som har konsekvenser för psyket, men denna uppfattning av begreppet har blivit mindre vanlig i Sverige.

³ One central empirical problem that permeates most neuropsychiatric research is the question of prevalence. The studies that address the question of prevalence are often cross-sectional studies — a type of study that cannot answer such question. These studies also often claim to be total populations studies, but the response rates are often extremely small in comparison. Gillbergs Gothenburg study is framed as a total populations study concerning all children born 1971 in Gothenburg. However, of the 5114 children born that year in Gothenburg only 119 made up the study, 59 making up the control group and 60 making up the studied group. From this Gillberg produce the claim that 7.1 percent of all Swedish children have DAMP, thus making DAMP into the most frequent health problem amongst children (Kärfve, 2001, pp. 45–53).

⁴ See previous footnote.

⁵ “In order to guarantee an open society with access to information about the work of the Riksdag (Swedish parliament), Government and government agencies, the principle of public access to official documents has been incorporated into one of the fundamental laws, the Freedom of the Press Act. This openness gives the Swedish people the right to study public documents, a right which may be exercised when they so wish” (<http://www.regeringen.se/sb/d/2853/a/18096>). In Sweden universities are public authorities and thus have to adhere to the principal.

and claimed that “DAMP is a better term than MBD. DAMP *describes* the child’s difficulties. It is a diagnostic concept that does not *leave room* for questions in the same way that MBD did” (Gillberg, 1991/95). DAMP is thus a Swedish diagnosis that has been in use mainly in the Nordic countries. Up until the height of the second and third wave of critic the common way amongst adheres to the neuropsychiatric stand was to write DAMP/MBD together — thus making up the needed correlation and cumulative aspect of DAMP.

The second wave of criticism evolved out of the use of the DAMP-diagnosis as well as its ancestry in MBD. As pointed to previously, the municipalisation of the school and the new system for financing schooling opened up for neuropsychiatric diagnoses due to the need for a diagnose when applying for special educations means. Mid- to late 1990s a medical and psychiatric criticism emerged that questioned the soundness of diagnosing children with neuropsychiatric diagnoses since this also meant making the diagnosed children’s problems into neurological and biological defects. This criticism evolved as a reaction to an article in one of Sweden’s biggest morning papers in 1997 where the authors claimed that 120000 children in Sweden suffered from neuropsychiatric impairments. The major argument behind the article being that these impairments, as long as they remained untreated, ran the risk of causing great personal suffering in terms of bullying, suicides and crime (Börjesson, 1997, p. 6).⁶ The second wave of criticism can also be read as a reaction to a campaign promoting a neuropsychiatric understanding of school difficulties. Utilizing a Swedish welfare-tradition of focusing on public health, the colonializing ambitions became obvious in that the authors of the debate-article wanted to frame neuropsychiatric impairment as “probably the biggest threat to public health” (Börjesson, 1997, p. 6). Making use of the concept of public health was thus a way of legitimizing as well as making claims to the medical tradition of the Swedish welfare state. However, it was these claims, underpinned with assertions that every Swedish school class had a minimum of one pupil with NPI (Gillberg, 1996), that provoked the second along with the third wave of criticism. Rydelius (1999), professor in child and adolescents psychiatry highlighted the historical roots of biological claims to children’s psychological problem and their successive failures over time, pointing to the fact that what Gillberg et al. wanted to frame as neurological faults in the brain was better understood as school problems.

The neuropsychiatric claims-making of the period also built on establishing an understanding of neuropsychiatric diagnoses as something similar to and comparable with physical conditions such as diabetes, blindness, hearing impairments and being confined to a wheelchair (Börjesson, 1997, p. 7). Today it seems to be a generally accepted notion in Sweden that DAMP, adhd and autism are *impairments*, not physical but neuropsychiatric impairment, but all the same very real impairments.

Another feature of the debate in the mid- and late 1990s was the economic argument based on the potential risk untreated neuropsychiatric impairments constituted to society. Untreated, these conditions could lead to criminality, teenage pregnancies, divorces, unemployment, substance abuse and chronic mental suffering, thus costing society dearly (Börjesson, 1997, p. 12). It is thus both economically sound and morally prudent to screen for and as soon as possible find these poor suffering children and relieve them of their misery. Needless to say, those heading the supposedly needed screening-process would be the same researcher making the claims.

When the debate was at its high point at the turn of the century, Rydelius opposed the claims made by the neuropsychiatry. Pointing to the failures of the MBD-diagnoses and other explanations trying to tie hyperactivity

⁶ The societal economic gains of diagnosing and treating NPI:s is the ever re-occurring argument giving it all a economic rationale as well.

to brain damages, Rydelius (1999) highlighted the historical inability to give a clear cut neurological explanation of what he saw as primarily school problems and not problems of individual pathology. Present day debate on neurological diagnoses in Sweden see almost no scientific resistance at all. Professor Rydelius still hold firm in his conviction that hyperactivity is a school problem that the child, with the right assessment as well special educations means, can grow out of. However, in the public debate these opinions are rare and the main arena for Rydelius to voice his views have become a teachers and educators magazine.⁷

That the criticism emanated from within the medical profession is interesting in that disclaimers against it take on the form of disqualifying the competence of the ones voicing the criticism. Subsequently, this helps to promote neuropsychiatry as cutting-edge science, known to a few initiated researchers, thus only someone more or less ignorant and incompetent dare criticize such a precise knowledge (Gillberg et al., 2001). When one of the critics is a professor in child and adolescences psychiatry the claims concerning ignorance of the critics seem rather less viable, but still it gets voiced.

An important aspect that gets promoted during the 1990s polemics is the identity politics that builds on assigning rights to an identity, the neuropsychiatrically impaired. The right to the diagnosis is framed as an empowering strategy that helps both parents and children. Thus denying those inflicted what is rightfully theirs, i.e., the diagnosis, is both inhuman and downright cruel. Turning to the third wave of criticism, this becomes the primary argument against the criticism.

The third wave⁸ was a continuation of the second, but what happened was that a sociologist took the lead in in what the neuropsychiatry community then framed as a “witch-hunt”⁹ on neuropsychiatry. Kärfe’s “witch-hunt” consisted in writing a critical book about the Gothenburg study, the DAMP-diagnosis, and the claim that DAMP and other neuropsychiatric conditions actually consisted of a public health problem (Kärfe, 2001). This polemics ended up in court where court ruled in favour of Kärfe, who had requested to review the empirical material that the Gothenburg study consisted of. Due to very low drop-out rates in a follow up study on the Gothenburg study, Kärfe suspected fraud and wanted to review the empirical material. The major claim made in the follow-up study is that 58% of the 60 making up the study, developed serious problems in terms of drug abuse, criminality and other social deviations.¹⁰ The reaction from the Gillberg group was to destroy their empirical material.¹¹ The destruction in itself led to the conviction of Gillberg for breach of duty as university professor, a verdict against

⁷ <http://www.lararnasnyheter.se/pedagogiska-magasinet/2010/05/07/larande-handlar-ocksa-mognad> (111125).

⁸ Gillberg et al even took the polemics to the British Medical Journal (BMJ) where an article was published which received great approval of Gillberg’s followers and supporter, while at the same time provoking responses from neutral scientific evaluators that had been quoted, as they saw it, wrongly in the article. (<http://www.bmj.com/content/335/7616/370>) (111210). That this, according to Gillberg’s followers, well researched article provoked different expert, not part of the polemics but either quoted by Kärfe or Elinder in their criticism, or set to evaluate the accusations of research fraud raised against Kärfe by Gillberg, to respond is in itself a telling aspect of how neutral the article might have been (<http://www.bmj.com/content/335/7616/370?tab=responses>) (111210).

⁹ Kärfe wrote her PhD-thesis on witch-trials in 17th century France. A fact that has been used as an argument that what Kärfe actually is doing, when she empirically takes Swedish DAMP-research apart, is conducting a witch-hunt.

¹⁰ Sociologically it stands to reason that, if as Gillberg claims, that such a high percentage developed serious problems, many of them would not be answering calls to participate in a follow-up study. None of the 58% had received any (amphetamine) medication. (Rasmussen P & Gillberg C. (2000) “Natural outcome of ADHD with developmental co-ordination disorder at age 22 years: a controlled, longitudinal, community-based study”, *J Am Acad Child Adolesc Psychiatry*, Vol. 39, pp. 1424–1431).

¹¹ At the heart of the problem is the very Swedish principal of public access to documents. See footnote nr 8. Gillberg clings to his promise of anonymity and secrecy given as a (treating?) physician, but since the material in the study has been used in PhD-thesis’s it becomes public and should be have been anonymized. As research material it has to be accessible to all (since it a PhD-thesis is publicly defended) and any means of identifying participant in the study should have been rendered impossible. But Gillberg, and the once who destroyed the material, his co-workers, amongst which one is his wife, claim that it was impossible to anonymize the material.

which Gillberg lodged grievances and finally lost at the European Court of Human Rights.¹²

The major disclaimer, apart from accusations of being part of the scientology church¹³ and pursuing a witch-hunt, is the fact that Kärfe is a sociologist and thus unqualified to understand medical research. Promoting the claim that medical research and sociological research is two essentially different enterprises has been a major part of the defence against Kärfe's criticism.¹⁴ As a sociologist Kärfe is a social constructivist and hence a relativist and ergo unable to assess the highly empirical claims made by neuropsychiatry since she does not believe in objective knowledge, or rather, that's how the argument goes. Reading Kärfe's book one hardly finds the ironic, post modernistic, knowledge relativist that distrust empirical research. On the contrary, one finds a statistically inclined sociologist that on good grounds questions, amongst other things, the prevalence claims made in the Gothenburg study pointing to unrealistic assumptions as well as research ethically questionable procedures. Amongst other things, Kärfe (2001, p. 45) demonstrates how Gillberg, by adding two persons from the control group increase the prevalence of DAMP from 4 per cent to 7.1 percent, a prevalence number that then becomes an undisputed fact in the debates where DAMP is claimed to be a public health problem. The ethically questionable in adding two persons from the control group, two persons that no other than Gillberg and his associate found to have DAMP, must be rather gross. That these two children get to represent some 50000 children and 44 percent of the response rate make the prevalence claims nonsensical (Kärfe, 2000, p. 49).

The cumulative description of the development of neuropsychiatric research is the major factor keeping it all together. One would think that the criticism raised against the DAMP-diagnosis would be the end. But as with the case of MBD, these diagnoses cannot be refuted, instead they evolve. So, as MBD hung on by writing MBD/DAMP, DAMP is still hanging on due to the habit of writing DAMP/ADHD. The given question is: why cling to the DAMP-concept at all? But giving it up would be, as in the case of MBD, giving in to defeat. Neuropsychiatry as cutting edge knowledge does not make mistakes, it progresses. So by introducing a further diagnosis, DCD (developmental coordination disorder), DAMP is rewritten as a more severe form of adhd since it incorporates perceptual as well as motoric problems, thus DAMP is adhd plus DCD.¹⁵ Comorbidity, a central part of neuropsychiatry's hegemony, makes it possible to reinvent and rewrite problems, those inflicted by NPI:s seldom have one infliction, they have several.¹⁶ A central part of the launching of NPI as the biggest public health problem builds on adding together the prevalence numbers (Börjesson, 1997, p. 46). The counting then done is rather creative since the assumed prevalence numbers for adhd is added to the (by the Gothenburg study) counted

¹² <http://www.dagensjuridik.se/2012/04/sverige-frias-av-europadomstolens-grand-chamber-i-gillberg-malet> (2015-03-17).

¹³ The most extensive accusations raised against Kärfe's supposed connection to the Scientology church is made in *The British Medical Journal* (<http://www.bmj.com/content/335/7616/370>) (111210). Kärfe is supposed to have given a lecture at scientology conference on adhd. According to Kärfe this is an age old accusation originating from Gillberg et al., however previously uncorroborated the claim gets corroborated in the BMJ article since the British journalist, who claims to have gotten the information from a woman within the scientology organization, hence corroborates it. Kärfe's reply to this then is to acknowledge her attendance, but with reference to programmes and the like, point to the fact that she did not talk there, and if she would have, she wonders if this then with necessity would have meant that she is a follower of the church? She also make a point of the fact that the journalist, by accepting information from the scientology church, make the mistake that Kärfe is accused of, namely relying on the church for his criticism (<http://www.journalisten.se/debatt/14033/eva-kaerfe-haeglund-aer-ute-och-flyger>) (111210).

¹⁴ In answering the criticism voiced by Rydelius et al. (2001), Gillberg et al. (2001) implicitly show how they do not consider Kärfe's criticism as real criticism when it is claimed that it is *only* Rydelius that is criticizing Gillbergs research group.

¹⁵ That these perceptual and motoric problems are residues from the MBD-diagnosis is not mentioned, but Gillberg loves to cling on to and refer to these aspects when he discusses NPI:s (Gillberg, 2005).

¹⁶ As an example of the extent of cormorbidity we can take a study on prisoners in Sweden. This section of the Swedish prison-population appears to have rather heavy problems since 75% had personality disorders and drug abuse, 25% were psychopaths, 33% hade live-long-prevalence diagnosis in anxiety disorders and 25% had adhd. The study was made up by some 40 inmates (Dalteg et al., 1998, p. 3079).

prevalence of DAMP. Since DAMP is a stricter form of adhd, it seems rather dishonest to count them twice.

How then is neuropsychiatry fairing in Sweden today? One would guess that being accused of research fraud and unethical research, even though not convicted, destroying the documentation that make up ones empirical material as well as having large parts of the research team sentenced for the destruction of the material, would marginalize any research team. But nothing could be further from the truth when it comes to neuropsychiatry. Gillberg has in 2011 been awarded the second most prestige's prize in medicine that one can be awarded in Sweden.¹⁷ He even had a research centre named after him, which he of course is head of.¹⁸ The Swedish queen attended the opening.

5.3 Other Players in the Game: The Internet and Social Media

Laypeople on the Internet managing webpages, blogs and alike all seem to side with neuropsychiatry. It is a forceful voice that has sided with neuropsychiatry. The argument that decide in favour of neuropsychiatry seem to be that, in getting the diagnosis; the inflicted person gets the answers to all the questions and an explanation to all the problems that have weighed heavy on that person trough their entire life. Exposing as well as explaining personal difficulties without putting the blame on the individual seem to relieve individuals from the sense of failure and guilt that is the core workings of the disciplinary project of the school. One way of understanding this is that this “seeing the real me” make the subjectifications — process much easier — replacing the subjects school-produced failure-identity with an identity that give scientific credence to your failures must be easy to embrace, thus the diagnosis is not in itself a sign of sickness and failure — but rather the opposite. Accordingly, the responsabilisation — process that is at the core of moral engineering is not seen as a burden — correspondingly the diagnoses could thus be seen as some sort of empowerment.

The rage that Kärffve's sociological criticism of DAMP rears in Sweden is remarkable. Feelings of aggravation and animosity are more than present in the different blogs.¹⁹ The framing of the diagnoses as impairment helps turning the blame from the individual and towards a society that do not endorse the individual needs of the impaired. Having impairments is no ones fault and a just society, like the Swedish, should do everything in its power to counter injustices brought about due to these deficiencies. So, criticising the scientific status of neuropsychiatric diagnoses seem to be interpreted by “the public” as being a renunciation of the relief felt due to having been diagnosed. One might compare the willingness to accept the neuropsychiatric diagnoses with the so-called sexual revolt of the 1960s and 70s. The sexual revolt built on the idea of oppression and the need to be free from an oppressive society that hindered, through unscientific prejudices, the uncovering of the true self. But, as Foucault point out, the politics of identity meant the transformation of sex into a discourse and turning for example the homosexual into a specific kind with a certain way of life (Nilsson, 2008, p. 158). But since these identities are the key to official recognition people readily embrace them.

Central intermediaries here are the so-called patient interest groups. In Sweden this group is named *Attention*. As producers of webpages, blogs, pamphlets and brochures to inform the public, Attention acts as mediators of a generalised “knowledge” supporting the scientific claims made by neuropsychiatry. The closeness between the so-called patient interest groups, medical companies, clinical practitioners and researcher is in itself more than

¹⁷ Part of the motivation reads; that Gillberg gets the Söderberg award for his ground-breaking research concerning the aetiology of autismspectra syndrome, especially by clarifying the relation between heritage and environment (<http://www.torstensoderbergssiftelse.se/priser/det-soderbergska-priset/index1,15.htm?id=563>) (111218).

¹⁸ <http://www.gillbergcentre.gu.se/> (111218).

¹⁹ See for example <http://adhd-npf.com/eva-karfve-svarar> (111125).

interesting.²⁰ There are even indications that patient interest groups were originally founded by leading researchers through charitable foundations money available to them as heads of these foundations (Conrad, 2007). The fortified relief given by a diagnosis seem to be strengthened by an identity politics that alleviate from blame.

Another aspect here is a media unwilling to pass judgement on neuropsychiatry.²¹ Medicine is in itself inherently good — that is beyond questioning. Trying in any way to question the intrinsic goodness of medicine is a sort of modern blasphemy. Medicine might make mistakes — but it always have the best of intentions. This becomes obvious when media looks at neuropsychiatry's truth claims. The Neuro of neuropsychiatry means that everything in the psyche and the person has its causes in the brain, this basic insight is however constantly overlooked by Swedish media who persistently stress that: "When it comes to adhd all serious researchers are in agreement that both environmental factors and the specific conditions of the individual²² play a part"²³.²⁴ One might thus conclude that a basic structure of the discourse on medicine is that medicine is always inherently good, at least its intentions. There are no structural problems with medicine neither as profession nor as research. Wrongdoing is thus caused by momentarily lapses, individual misjudgement, mistakes and temporary slips. So when Sweden's biggest broadsheet, DN, wanted to summarise the polemics between Kärfe and Gillberg they let a science reporter write the article.²⁵ The fact that the journalist had a higher degree in medicine shines through in the article since it implicitly calls into question both Kärfe's ability to assess medical research as well as her intention with her research. All the while Gillberg gets portrayed as an empathic researcher and physician who have the best interest of his patients at heart. The media's willingness to accept the (mis)conception that neuropsychiatric research is neither *comprehensible* nor *assessable* if you are not a trained neuropsychiatric is a central structuring factor when it comes to establishing neuropsychiatry as practice.

5.4 Self-reference and Control over the System

What Kärfe did was to challenge an entire system, medicine, and the system reacted. Even those in the medical-profession that agreed with Kärfe highlighted the fact that she is a sociologist (Rydellius&Zetterström, 2001). To counter Kärfe's claims the concept of *sociologism* was used. Kärfe wanted to highlight the biological aspects of DAMP as an explanation and thus talked of biologism. Her critics however claimed that Kärfe did not fare any better since she, implicitly, proposed a sociologism instead, thus replacing one totalizing ideology with another (Beckman, 2007).²⁶

One central aspect of what happened can be understood in terms of what Hacking (2001) calls *internal*

²⁰ On the relation between the medical companies and medical researchers see for example Brante (2006), and on the importance of patients interest groups and adhd see Conrad (2007).

²¹ The biggest Swedish tabloid had a critical enquiry concerning Swedish psychiatric care during the fall of 2011. <http://pillerpengarpsykvard.aftonbladet.se/> (160114). Considering the scopes done in the article series, the silence that has met the enquiry is interesting.

²² A biological line of reasoning, traceable back to studies like Henry Goddard's The Kallikals or Richard Dugdale's The Jukes, builds on claiming that bad breads bad (Rafter, 2009). This kind of reasoning permeates Gillberg's analysis when he asserts that the overrepresentation of DAMP among boys from the lower classes of society, is due to the fact that their parents had DAMP, and the grandparents as well, making their class-position into something caused by biological inferiority (Kärfe, 2001).

²³ "Men när det gäller adhd är alla seriösa forskare överens om att både miljön och individens specifika förutsättningar spelar in" (<http://www.dn.se/nyheter/vetenskap/hjarnkampen> (160114)).

²⁴ If this had any "truth" to it the entirety of neuropsychiatric research into NPI:s would be disqualified. The only environmental factors that might contribute are the behaviours of the mother during pregnancy in terms of smoking and drinking – the rest is just genetics and epigenetics (Andersson, 2012).

²⁵ See footnote 23 for reference.

²⁶ That Kärfe never made any claims to aetiology or tried to give alternative explanations to DAMP makes it even more absurd to talk about a sociologism.

explanations of scientific progress. Even though Kärfe (2001) works within an empiricist scientific tradition scrutinising the empirical claims made by Gillberg and his followers, her criticism is still treated as foreign — as an alien attack on medicine in its entirety.

Historical arguments, based on showing how external factors contribute to our understanding of things, become exceptionally problematic since they point to factors that an internal explanation of scientific progress must disqualify. Medical science is conducted in a scientific vacuum and does not depend on historical factors; hence the internal and cumulative explanation of scientific progress becomes extremely visible in the trajectory of hyperactivity as a disorder. Looking at standard works or websites the history given is that the first recordings of ADHD was made during late 19th century. Then however the history-writing jumps to MBD and the 1950s, a failure in some ways, but nevertheless neuropsychiatric knowledge still progressed. Then comes the 1980s and the ADD-diagnosis, hardly mentioned, since it was soon to be followed by *adhd* in a cumulative scientific process uncovering the true facts concerning *adhd*. Internationally MBD is thus presented as the forerunner to *adhd*, and as more or less equivalent to this diagnosis. This cumulative framing of the trajectory of the condition seems to have become the generally accepted history of the disorder thus turning the history of it into an empirical knowledge-progress internal to the scientific progress of neuropsychiatry. The conceptual move from the MBD diagnosis was brought on by knowledge enhancement; hence the *adhd* diagnosis is based on more knowledge than the MBD diagnosis. Accordingly we now know more about the condition.

Central here is the question of aetiology. The problem with MBD was that it had an aetiology that made it open to falsification. However, giving up the search for causation would mean giving up the scientific status of neuropsychiatric inflictions. Also, it is in the question of aetiology that the supremacy of *neuropsychiatry* rests — it is through its material ontology that neuropsychiatry becomes *neuro-psychiatry*. Ontologically blocking out nonmaterial things like concepts, feelings, culture and the like — makes it given that, what we must be observing, when we observe behaviour is brain/mental reactions to stimuli. The failure to sit still is consequently not a cultural understanding of behaviour, but a brain-body reaction to stimuli. The latest aetiology stand is that *adhd* has an epigenetic causation (Smith et al., 2009). Epigenetic is the study of inherited changes in gene expression caused by mechanisms other than changes in the underlying DNA sequence, hence the prefix *epi-*, meaning over, above-*genetics*.²⁷ Thus, non-genetic factors cause the organism's genes to behave differently, hence facilitating the reappearance of several classical “causes”, causes that all correspond to the behaviour of mothers during pregnancy, such as smoking, drinking or taking drugs.²⁸ Opening up for external factors causing genetic-changes as well as protecting the claim that *adhd* is a neurological condition the epigenetic stand appears to be the ideal aetiology for neuropsychiatry for a while to come.

The self-reference aspect of neuropsychiatry as science is interesting. When Rydelius and Zetterström (2001), following Kärfe, criticised the research done by Gillberg and his research-team, Gillberg et al (2001) answer builds on the self-referential system that medicine has become through the peer-review system. The argument from Rydelius and Zetterström against Gillberg et al was untenable since the work done by Gillberg et al had been approved by peer-reviewers and boards of examiners, approving their PhD-thesis. This kind of reasoning also

²⁷ There is, however, no change in the underlying DNA sequence of the organism.

²⁸ The epigenetic standpoint carries a potential solving of another recurring problem; the 5 to 1 overrepresentation of boys over girls being diagnosed with the condition (Smith et al 2009: 146). Overrepresentation as a problem arose when launching the genetic aetiology. When hyperactivity was caused by brain damage overrepresentation caused no problem since it could be claimed to be due to chance. With the epigenetic turn overrepresentation can once again be explained in terms of chance and the behaviour of the mother during pregnancy.

draws on an internal explanation of scientific stability. Even though there are few alternatives open in terms of argumentation, the conjecture that internal consistency is a good science-criterion is more than questionable. Nonetheless, the question arises whether it is possible to raise any criticism at all that does not build on the same assumptions? Even though I do not want to use the concept of paradigm, it becomes obvious that criticism that do not fit into the overall understanding of neuropsychiatry as it is defined, for example in the works concerning adhd, has no legitimate claim. “Scientific progresses” within neuropsychiatry thus seem possible only in that earlier claims are proven entirely untenable within in the paradigm (I thus use paradigm defined as *basic adherence to the basic assumptions that define neuropsychiatry as neuropsychiatry*). It is a rather disturbing circumstance that neuropsychiatry research does not seem to be willing to live up to Popper’s (1963) demarcation criteria on knowledge, i.e. that scientific statements should be open to falsification. To the best of my knowledge — the only falsified “knowledge” within in adhd-research is the claims made concerning MBD. However, turning to an epigenetic aetiology concerning adhd seem to restore some basic assumptions made concerning MBD, namely that the behaviour of the mother during pregnancy is an all important factor (Andersson, 2012).

Medicine as a self-referential system has more implications concerning what gets believed or not. The National board of Health and Welfare is the central public authority when it comes to medicine in Sweden. As an authority it evaluates, it recommends and: “We collect, compile, analyse and pass on information. We develop standards based on legislation and the information collected. We exercise supervision to ensure that the standards are observed, and to minimize risk and improve patient safety. We also undertake other official duties such as maintaining health data registers and official statistics”.²⁹ This is a public authority with immense powers. The fact that the experts recruited to or used for evaluations, writing experts report and the like, at The National board of Health and Welfare are recruited from within the research group that is built around Gillberg makes criticism of any sort rather unlikely. The so-called state of the art document on adhd, which is to be the documentation clinicians and others turn to when they need information on the subject, is written by researchers from Gillberg’s research group.

5.5 Social vs. Morale Engineering

The school is the major setting when it comes to many aspects of prevention, intervention, dreams and hopes of the welfare as well as the neoliberal state. Bio-politically, the school is at the core of a governing that draws on and aims for the enhancement of the population. The school has been and still is an arena for interventions as well as screening, but that which differentiates social engineering from moral engineering is special education and the question whether “the problematic child” should or should not attended “normal” classes.

The development of the child was at the heart of the social engineering of the welfare state. Any divergences or deviation from a normal growth and development process was interpreted as a sign that something could be wrong. And if something was wrong, which only the expert could know, an expert-led adjustment-process was initiated targeting the subjects reintegration into society. The reintegrative aspect, present in the prison as well as the school, drew on the fact that adjustment presupposed differentiation and separation for the expert-led intervention to work. In special education, this meant that those deemed having a non-normal learning-process were to be separated from the regular classes and placed in so-called observations classes where their development could be monitored and adjusted.

Special education at the highpoint of the Swedish welfare state was thus an expert led intervention based on

²⁹ <http://www.socialstyrelsen.se/english/aboutus> (111203).

differentiation and exclusion aiming at inclusion. This is the position on children with hyperactivity and attention problems still held by Rydelius to day. He sees hyperactivity and inattention as school problems, and not necessarily as a sign of neurological deficiencies, and promotes a return to a special education perspective built on exclusion and monitoring of those showing signs of learning disabilities. This is a social engineering that is highly dependent on a welfare state willing to afford the means necessary. Moral engineering on the other hand, builds on making the individual assume moral responsibility over his or her life. Moral engineering builds on the same assumptions of normal vs. non-normal growth and development, reading non-normal activity as pathology. But moral engineering also builds on disclaiming societal causes, instead giving primacy to aetiological claims that highlight individual responsibility, not for the problem as such, but for the solution to the problem.

The neuropsychiatric framing of so-called neuropsychiatric impairments makes them into something treatable. It becomes an individual deficiency that, treated appropriately, should be no hindrance to living a normal life. This also fits with the ambitions of an inclusive special education paradigm. The inclusive paradigm in special education builds on assuming that all and everyone shall attend regular class — this is now enabled in Sweden through medicating those deemed in need with amphetamine. This nonetheless, seem to build on an *excluding inclusion*. A pathologising exclusion that separates the subject from the normal in such way that it can only belong in that the subject embrace his or her diagnosis making it into the subjects primary identity. Thus the identity as having a NPI make the subject excluded from the normal, while at the same time, as an accepted deviation, the impairment in itself is an argument for inclusion since a society that actively excludes subjects with a legitimate impairment is a bigot society. The moral engineering of neuropsychiatry consequently is a process of making the impaired and his or her family take responsibility for the impairment. It is a responsabilization process wherein the diagnosis relieves the impaired and his/herparents from blame as long as they through medication assume their responsibilities mitigating society from any responsibilities concerning societal factors in the process. Adhd might be a neurological deficiency caused by genetic or rather epigenetic factors but, correctly treated, there is no reason why the impaired should not be able to adjust to the market society's demands, i.e., if treated the impairment does not infringe on the faculty of reason.

In terms of governing, what becomes important here is the question of responsibility. Social engineering built on an including exclusion — the deviating subject was to be excluded from normal society during the course of his or her rehabilitation, only to be re-included when “cured”. Here the solution to the problem was the responsibility of the state, whereas the responsibility for the problem, at least in part, was the individuals. The governmental rationale here thus became an expanding state that by way of expert-led interventions made claims to the just and good society. As rationalization this enabled the expansion of the state, since the state, through the workings of its experts, actually *knew what the good life of its citizens consisted in*.

Today the Swedish state lays no claim to knowing what the good life is. Instead it lays claim to *knowing the path to a good life* — freedom of choice. Replacing the steering of its citizenry toward the good life with a gentle guidance, the Swedish state has reformed itself in relation to much of the criticism made against the welfare state in terms of being invasive, paternalistic and authoritarian. The excluding inclusion of moral engineering is about making the populace shoulder the responsibility that the state wants to place on them. This is a responsabilisation-process that is about making the subjects responsible for the solutions of problems, but not necessarily responsible for the problem as such. This is why NPI:s becomes interesting. It is not the individual's fault that she/he has an impairment, nor is any wrongdoing while being un-treated or und-diagnosed the fault of said individual. But, once you are diagnosed and once the identity is assumed — you become responsible for the

solution of the problem. Exempting you from blame for your problems — governing is applied by making you assume responsibility over your own life, whatever the circumstance might be. It is thus not your fault that you failed school, got drug-problems or failed in some other way. But once the veil of incompetence is lifted by way of a diagnosis it becomes your responsibility, as long as receiving the correct treatment, to solve the problems facing you by way of rationale choice on an open and free market.

Theoretically what emerge are thus two different forms of governmental rationalities: the welfare state rationale and an advanced liberal rationale. In themselves these rationalities incorporate conceptualizations of the good society, what that is, what it should be and how we reach it. But the rationalities also framed what means are “possible” and thus also desirable. As a problematization facilitating governing, adhd clearly disclose what solutions are desirable, and which are not. Compared to the welfare state rationality, the advanced liberal enables and empowers the individual, while at the same time excluding and thus also disqualifying macro level and state interventions that in any way question the supposed autonomy of individual choice. Eradicating all forms of structural claims to problem, apart from maybe accentuating the problem, what is left to know and order is the actions of individuals — and adhd becomes a factor that can, untreated and unrecognized, be hazards.

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