

DIAGNOSTICS AND IDEOLOGY

By Eva Palmblad

Abstract: The purpose of this article is to examine current theories and concepts concerning children with concentration difficulties and hyper-activity from a perspective of the sociology of knowledge. The material on which the study is based is popular science writing on the subject. The examination reveals theories and concepts, which carry definite traits of socio-pathological thought. The danger of social pathology becoming an ideology furthering conformity is discussed. Finally a sketch of a model of understanding, which has as its starting point deviant behavior as a carrier of social meaning, is drawn.

Background and Problem

The medical perspectives on deviation appear to arise out of a deep resonance from values which dominate in contemporary Swedish society. The diagnostic culture is gaining ground, something which is evident in the approach to a variety of problems in education. The dominant framework of understanding with regard to children's and young people's reading and writing difficulties is a medical framework (Zetterqvist Nelson 1999). This is increasingly the case also with regard to problems of concentration difficulties and hyper-activity. Diagnosis has become a condition for access to special help and support in an educational system struggling to cope with constant shortages of resources. Diagnostics, nowadays, is afforded the sanctions of the state. The Disability Ombudsman -

a state authority set up in 1994 to safeguard the rights and interests of disabled people - has unequivocally come down in favour of the use of diagnoses such as Dyslexia and DAMP. The Disability Ombudsman refers to medical research in support of this approach. Diagnostics is claimed to be a necessary condition for the application of correct measures (The Disability Ombudsman 1995, 36f).

Swedish public discourse on disturbances of concentration and related problems is characterised by uniformity and consensus (Börjesson 1999). This is remarkable considering the lack of agreement on whether the conditions - labelled as MBD/DAMP, ADHD, Asperger's and Tourette's Syndromes - are as scientifically robust and unequivocal as the diagnostics would have us believe. There is a lot to

be said in favour of the view that these conditions are not strictly speaking medical. The conditions have a socio-cultural dimension which is probably of great significance for the attention afforded them in the first place. This dimension makes the phenomenon interesting from a sociological point of view. The fact that diagnostics is heralded as a promise, not only a medical promise, but a moral and social one, contributes to this. Diagnostics is described not only as a condition for an improved state of health. Those affected and their families see in diagnostics the promise of freedom from blame and shame. Diagnostics also carries a subtext implying that the absence of disturbing behaviours will make life easier and more pleasant — for all concerned.

Purpose and Implementation

The purpose of this study is to examine the moral and social slant which characterises the discourse, dominated by neuro-psychiatry. The intention is an attempt to lay bare the social and moral presumptions that characterise dominant perspectives, theories and concepts regarding children and young people with said conditions. The literature studied is popular science material.

In the last five-ten years, a number of popularised books on MBD/DAMP and related diagnoses have been published. They address themselves to groups of

professionals who come into contact with the problems, to those affected and their families as well as to interested members of the public. In connection with the launch of the campaign 'Year of the Brain' in 1999 a list of references was issued: 'Books for the approaching Year of the Brain'. The selection of books used for this article have been selected from this list (www.umu.se/hjarnaret). In addition to this, conference reports from the first three Nordic Symposia on MBD/ DAMP have been used.

Common for this type of literature — in many cases written by our country's leading experts on the subject — is that it combines factual information with advice, guidance and recommendations on what to do. Characteristic for these productions is, in other words, that they relate the state of knowledge as well as prescriptive advice. The material can, therefore, be considered useful for the purpose of reconstructing an intellectual framework. The reconstruction will be arranged around the following themes: definitions; background factors; consequences; remedies; obstacles. With the examination as a starting point I will attempt to distill a more basic model of thought with which the discourse on problem children is connected.

The Social and Moral Orientation of Popular Science

Definitions

The fact that diagnoses have become necessary for access to the medical and social support systems of society is a given starting point in the literature examined. The medical jurisdiction on the subject is clearly and unambiguously stated. It is a question of "medical diagnoses. They cannot be arrived at without the contribution of a doctor" (Gillberg 1996, 122, my translation).

Formally the conditions discussed are defined as deviations of behaviour and development (Gillberg 1993, 4). It is a question of symptom diagnosis, the establishment of which is based on diagnostics of function, that is "a detailed analysis of the child's abilities and difficulties" (Duvner 1994, 43). As regards prevalence, fifteen to twenty per cent of all Swedish children are said to be suffering from some form of neuro-psychiatric disorder (Gillberg 1993, 3). "Underdiagnosis" is described as a problem, especially when an underrepresentation of girls is being discussed. Worth noting is that the term "overdiagnosis" is never used, let alone being discussed as a problem.

Let me briefly relate what it is that children belonging to the diagnostic group generally are said to have difficulties with: generalisation; abstraction; automaticity; routines; stamina; flexibility. This means problems for the

children to function in social interaction, act on instructions, keep to instructions, change activity, choose from alternative actions, control body movements. Much attention is given to another couple of peculiarities considered characteristic of the affected children: their self-centeredness and their lacking adaptability (Duvner 1994, 85; Duvner, 1997 54, 59; Gillberg 1996, 37; Gillberg 1997, 48; Hove Thomsen 1997, 58; Kadesjö 1992, 22-23, 43).

The concentration difficulties and hyperactivity claim the foreground. If we were to examine the definitions of concentration difficulties with a little stronger focus on detail, we would discover that they cannot be said to be general. One insightful passage states:

"If, in a learning situation, there is no agreement between the motivation of the child and the intentions of the adult, the child is perhaps perceived as lacking in concentration. But the child could be very concentrated on other aspects of the situation, on the other children, on other sounds, on not failing, and so on. The child is just not motivated for what the adult wants. Motivation for the task is of great significance for the concentration of the child" (Kadesjö 1992, 7-8, my translation).

And a little later in the same text: "That all goes well, providing they want to, is something you often observe

when you are with children who have concentration difficulties. Even children with great difficulties of concentration are able to concentrate when they are motivated. As an adult it is easy to feel provoked by seeing the child in a certain situation, but not being able to get it to concentrate on tasks you want it to do" (Kadesjö 1992, 32-33, my translation).

These narrower definitions (see also Gillberg 1997, 86; Duvner 1997, 59-60) suggest that the problem of concentration is not genetically determined, but rather conditioned by factors in the environment. These definitions are very important, something which, strangely enough, does not appear to attract any greater attention.

The main point of the presentations is the classification, sorting and systematisation of diagnoses. The focus on the diagnostic system is placed in the 'context of justification' rather than 'the context of discovery'. It is about collecting and systematising facts under classifiable concepts which have already been defined. The research undertaken is often of the character: more definitions, more classification (RBU 1987, 79-81). We are dealing with a pronounced science optimism, where the inexorable progress of scientific knowledge is viewed as a given fact.

The link between diagnosis and resources is, however, today far from

self evident. But those children and parents who are not the winners in the play for benefits have to console themselves with the words of the experts that diagnostics in itself has a therapeutic effect (Gillberg 1996, 132; see also Gillberg 1997, 124). The diagnosis is said to lead to "liberation and relief" for those affected and for their families (Hellström 1995, 52, my translation).

The assessments of the conditions are, as we can see, not medical in the sense that they exclusively have their starting point in the polarity of health-illness. The assessments take place under strong influence of prevailing societal value systems. The descriptions and definitions of the disturbances center on the phenomenon — failure to fit in — to a significant degree, that is, on behavioural and attitudinal deviations which appear socially disintegrating. It is about deviations from norms; what these norms more concretely are, is rarely made explicit. Apparently, it is simply about institutional, taken for granted, expectations about how children and young people of a certain age ought to behave. As pointed out by a doctor, the "prerequisite for knowing what deviation really is, is that one knows in detail what the normal pattern of development of children is" (Michelsson 1987, 21, my translation). It is precisely this that we do not know: Studies enabling us to establish what a child's 'normal development' as regards social behaviour is, do not

exist. The fact that our knowledge — and thereby the standards by which we measure — suffer from a significant degree of uncertainty is a matter ignored.

Background Factors

The explanatory model most commonly employed is usually described as neurological and multifactorial. The underlying cause is said to be organic. The disturbance can be of a genetic/hereditary nature. It could have to do with damage of the brain. The background could be a combination of these factors. The dysfunction could be made worse by environmental factors.

To judge by a considerable number of texts, it would appear as if research had convincingly shown a biological basis for the problems (see for example Duvner 1994, 11-15; Duvner 1997, 88; Frith 1989, 80-94; Kadesjö 1992, 49-54). It is not difficult to arrive at the conclusion that what remains to be done are final touches, minor changes of definition of terms. Only in the odd case it is hinted that the question of the biological causes could be a matter of any serious controversy among the experts (Kadesjö 1992, 55). The reference is made in order to reject psycho-dynamically oriented interpretations of the causes of disturbed family relationships, interpretations that are considered burdening families unjustly with guilt. Throughout, any explanation which speaks in terms of patterns of social interaction, is

criticised, often with reference to the apportioning of blame and the consequences of this (Hellström 1995, 42). In this, there is a duality, as the social interaction is said to risk worsening the child's condition. People in the child's environment could, through relating incorrectly to it, add a social problem complex to its biological inheritance:

"Social deprivation and lacking parental abilities do not lead to ADHD. But the attitudes of the parents and of other adults towards the child affect the extent of the problems, how longlasting they will be and, above all, what further deviations of behaviour this will lead to" (Duvner 1997, 24, my translation).

Explanations which take their starting point in socio-structural conditions are also being rejected. Social factors such as class and socio-economic conditions "have very limited significance for the way in which the expression of basic symptoms is formed" (Gillberg 1996, 115, my translation, see also 151). The rejections are sometimes even more emphatically expressed. In one case a clear line is drawn in relation to the "simplified" explanations sometimes offered by staff in nurseries and schools, and which refer to the conditions under which children in our society grow up. Such explanations risk "concealing a complex reality". Genuine insight into the children's problem will lead to the conclusion that it is biologically conditioned (Kadesjö 1992, foreword; see also Hellström, 1993, 2).

The factors which are sometimes termed genetic and sometimes hereditary are apportioned a decisive role in this context. No one doubts that the future, before long, will bring solutions to the remaining mysteries. In 1993 a scientist expressed his conviction that we, within five to seven years, would have an answer to the question of the genetic background of these conditions (Barkley 1993, 2). The conviction that heredity is the significant factor is manifested through the frequent use of percentages. Some examples:

“ADHD has a pronounced element of heredity, even if it is not yet possible to relate this propensity to a certain chromosome or gene or to a specific physiological/biochemical deviation from the norm. Eighty percent of children with ADHD have close relatives with similar problems. If a child — of either sex — has ADHD, the risk of a future sibling developing the condition is approximately fifteen percent for a sister and twenty five for a brother” (Duvner 1997, 23, my translation).

“If one were to attempt to sort different background factors in cases of DAMP into percentages, there would be something like fifty percent heredity and thirty percent brain damage, with a relatively significant number in both groups who have elements of both kinds, but where one of the factors dominate, and twenty percent are

unclear as to cause” (Gillberg 1996, 134, my translation).

“Half of the variance with regard to hyperactivity and short attention span could be explained by genetic factors. A tenth of the variance could be explained by disturbances in family relationships” (Rasmussen 1990, 43, my translation).

In one text the supporting evidence is made concrete through a description of a case. Anders, ten years, attends the child habilitation clinic for investigation having been referred by the school health services. Anders has considerable problems with the concentration required for his studies; his achievements are poor. The investigation shows that Anders is a typical case of ADHD. His family shows signs of a hereditary propensity for developing the condition:

“When we asked the parents about heredity, the father recounted that he himself had had similar difficulties during his entire time in education. He was an energetic and a restless person who had accomplished much at work, but he had also suffered a period of depression. His father was a farmer, known for his ability and his intensive and impulsive manner but also for being a despot with a hot temper. He lost the farm through excessive business speculation” (Duvner 1997, 13, my translation).

No answer is given to the question of how meaningful the claim that say fifty percent of the background to a child's characteristics is 'hereditary'. The distinction between hereditary and genetic is disposed of. Characteristics, attitudes and behaviours, like life styles, can very well be inherited without the need to presume that genetic components are at work in this context. There is for instance a tendency for children of doctors to become doctors more often than others. The medical profession, like the acting profession, the profession of sports journalists etcetera, thus show a degree of heredity. There is nothing to suggest that we are dealing with a genetically determined matter. We can imagine a heredity of a hundred percent — as in a monarchy — without assumptions of a 'royal gene' being at work in the background. We are never made aware, in other words, of the two constituent parts of heredity: the biological and the social. Even less is there any debate as to whether we are dealing with a biological or a social reproduction. Neither is there a distinction being made between co-variation and causal links.

The concept of heredity is used to stop a more serious discussion about possible effects of social factors on the problems from taking place. As regards DAMP-children there is information which indicates that they "on average come...from a lower socio-economic background than children in general". The reasons behind this state of affairs

are said to be unknown. Of a number of imaginable factors behind this, the authors dwell on the following:

"Parents to children with DAMP have quite frequently had similar problems, themselves, and have therefore faced obstacles to the development of their full potential, or to advance in their chosen careers due to, among other things, difficulties of concentration. Having a child with difficulties could also in itself contribute to a lack of time and energy to devote to education or the development of a career" (Gillberg 1996, 151, my translation).

The social position of a person changes, through reference to a hereditary component, from being a potential cause to becoming a consequence of a biological problem complex. The same turn-around is applied to a piece of reasoning which takes its starting point in the statement that children with primary concentration difficulties "very often" come from psycho-socially disadvantaged backgrounds.

"An explanation to this link could be that the parents' style of bringing up their children and their life style are expressions of a problem of concentration difficulties also in themselves. This could have contributed to their experiencing difficulties in creating psychological stability and a sense of social security for themselves and their children. It is not implausible that this could be the case against the

background of our current knowledge that heredity is one of the most important background factors behind lacking ability to concentrate" (Kadesjö 1992, 12, my translation).

This overrepresentation can thus, in the final analysis, be brought back to biological conditions, that is, to the so called hereditary equipment and its effects.

Sorting in the arguments about the backgrounds of these conditions, and attempting to discern where the frontiers of research lie, has not been an entirely simple matter. It is difficult to fend off the conclusion that we, in reality, know very little about the genetic factors that may be involved. What a genetic component means exactly is, furthermore, not entirely clear within the discipline of biology. It similarly appears that little is known about how possible genetic components interact with factors in the environment.

Consequences

One text emphasises the consequences of the conditions already in its opening lines: This is a book about lively, impulsive children and youngsters, who

"in its moderate and charming variation resembles...Emil in Lönneberga [a fictional character in Swedish children's literature, author Astrid Lindgren]. Others develop into the biggest troublemakers of their school, who get suspended from school and maybe

embark on a career of deviancy such as a criminality, drug or alcohol abuse and mental illness" (Duvner 1997, 9, my translation).

The following is a pronouncement on the same fateful theme: "Many [adults with DAMP] are to be found in prisons, in psychiatric wards and in unemployment" (Stovner 1987, 62, my translation).

At least two thirds of all children with DAMP are said to develop marked psychiatric symptoms during childhood. Depression and socially deviant behaviour are among the most common additional psychiatric diagnoses. Approximately sixty per cent of the children afflicted by DAMP have developed one or both of these additional diagnoses by the time they have reached the age of seventeen (Gillberg 1996, 86).

Depression — which could be seen as an expression of the existence of a super ego — is not uncommonly accompanied by suicidal thoughts (Gillberg 1996, 88 91-92). By socially deviant behaviour is meant aggressiveness, destructiveness (against property or people), truancy, running away, arson, abuse, sexually provocative behaviour.

"At an estimate half of all children with DAMP must be said to suffer from depression at the age of ten. Approximately the same number are showing socially unacceptable behaviours, i.e. they fight, destroy property and break the norms of social

behaviour for their age group. A considerable number of them smoke, get drunk and partake in destructive gang activities. The overlap between depression and socially deviant behaviour is significant” (Gillberg 1996, 79, my translation).

The definition of a poor prognosis is “not functioning well in society” (Gillberg 1996, 156, my translation). The prognosis is more favourable if the disturbed social behaviour is linked to depression, which thus is an indication of an awareness of the shortcomings of the self (Gillberg 1996, 90-92). In some of the individuals showing disturbed social behaviour there are strong features of manipulateness, which means that they could be described as psychopaths (Gillberg 1997, 33). As regards individuals with Asperger’s Syndrome, they are “probably overrepresented” within forensic psychiatry; so also among those who commit crimes of violence (Gillberg 1997, 36, 80, my translation).

“One group of individuals with Asperger are drawn to theoretical philosophy, religion, sects and cults around the theme of death, for instance. This can become very problematic, as they may find it significantly more difficult to keep the subject in perspective...The same applies to interests which touch on, or directly involve violence. Weapons, toxins, explosives, sports with elements of violence, for example boxing and

karate, could all exert a strong attraction on individuals with Asperger’s Syndrome. There are practically always reasons for attempting to distract attention from such potentially dangerous areas” (Gillberg 1997, 122-123, my translation).

These types of formulations promote the view that the difference between obstinacy — disorderliness — aggression — anti-sociality — criminality is only a matter of degree. The descriptions of the potential consequences of these conditions repeatedly slide from one type to another. The use of a figurative spiral, described as starting with “restlessness, impulsive actions, forgetfulness” and ending with “running away, truancy, anti-social behaviour” is illustrative of this view; it describes a negative problem escalation, where the behaviours of the children and the parents lead to increased conflicts and violence (Duvner 1997, 66, my translation).

The risk of a negative development is said to be impending unless attention is paid and measures taken to deal with the problem at an early stage. Early diagnosis, an understanding of the problem, and early intervention can prevent children and youngsters from being excluded and from choosing a career of deviancy (Duvner 1994, 86). Attempts at playing down the problems — said to be done by some “people in general” and by the “educational and caring professions” — are forcefully

rejected. Viewing problems of hyperactivity and lack of concentration as indications of a lack of maturity, expected to subside as the years go by, is to trivialise the problems (Gillberg 1996, 72-73; Kadesjö 1992, 96, my translation).

It would appear that the idea of pre-destination, so deeply rooted in our culture, is at work here.

Remedies

Throughout the presentations, the unlikelihood of a cure for the disturbances is being underlined. Proposed remedies focus instead on helping the child and family to live with, and handle the difficulties and to prevent serious damage from occurring (Gillberg 1996, 161; Gillberg 1997, 119; Hellström 1995, 108).

One expressed aim of the interventions is about personal insight and adjustment to reality. The child, as well as the family, must learn to live with their difficulties (Duvner 1994, 60). An improvement in the situation becomes possible first "through insight about the difficulties and a change of attitude along the lines that it is possible to live with functional impairment without too much of a psycho-social disability" (Gillberg 1996, 161, my translation). The child must be made aware of its own diagnosis (Gillberg 1997, 50). Interventions aimed at creating an awareness of the disability is to be applied, by preference, in conjunction

with the completion of the investigation. "Pre-arranged information" is given, which "should serve the purpose of making the child more aware of how it will function, its strengths as well as its difficulties and limitations" (Hellström 1995, 168, my translation). The idea of disability is, so to speak, fed into the child gradually:

"The information...must be given repeatedly, be worked on and reinforced by significant adults in the child's environment. This is with the aim of making the child gradually more aware of its behaviour and its difficulties and also of how these can be overcome...it is about helping children to take responsibility for their actions, not withstanding their difficulties" (Kadesjö 1992, 103, my translation).

Despite repeated reminders of the importance of acknowledging and working on strengths as well as weaknesses; assets as well as limitations; resources as well as shortcomings, the emphasis is essentially placed on the latter in each of the word pairs. As a rule the texts give only a slight hint of the special resources that the children possess, such as originality, creativity, energy and curiosity (Duvner 1994, 122; Duvner 1997, 93-94; Frith 1989, 21; Kadesjö 1992, 215-216). In one case an attempt at a more detailed description is made (Gillberg 1997, 87-92). When it comes to taking steps to safeguard these characteristics, we find very little. Nowhere is concrete

guidance provided as to how to develop these positive traits. This stands in sharp contrast with the advice and directions dealing with negative characteristics; here the amount of practical advice is extensive and the inventiveness great.

Worth noting is the strong emphasis being placed on the need for liaison, co-operation and co-ordination between different professions and services, where also parents and other members of networks should be included in order to draw in all those involved into a shared understanding of the child. The shared sense of understanding is necessary to enable the child and its parents to manage the impairment correctly (Kadesjö 1992, 102). The correct management approach is a necessary condition if the child is going to have a chance to function and develop optimally. In the talk of co-operation, no mention is ever made of the fact that professions and occupational groups are organised hierarchically. No hint of the fact that the medical profession has served as the deliverer of premises in relation to a number of occupational groups in the caring professions during the entirety of the twentieth century is given.

The strategy that carries the day takes its starting point in the principle of behaviour modification. This principle is based on the idea that individuals are entirely governed by factors in their surroundings. Their behaviour can be

controlled by applying a system of reinforcements. In this context, it becomes important to identify consequences that decide the behaviour. Each individual gets reinforcement — in a differentiated manner — in accordance with his or her ability to interpret the rules which apply. Here, the arrangement of stimuli for drilling in desirable behaviour, all according to the classic principle of conditioning, comes into use. Systematic and considered use of disciplining and rewarding — with the emphasis on the former — is made for the purpose of influencing the behaviour of the individual, all according to Skinner's model.

The children need "direct and immediate reactions on their actions, both positive and negative" (Hellström 1995, 117, my translation, see also 114). The ability to concentrate is improved by "different types of reward, as well as (by) carrying out tasks with an inherent element of reward" (Duvner 1994, 80). Praising the child when it lives up to the desired behaviour is better than "blaming for failure... Rewards need to be given in connection with the desired behaviour to which reinforcement is being given" (Duvner 1994, 88, my translation; see also Kadesjö 1992, 106-108). Agreements should contain rewards (Duvner 1997, 95). These children have difficulties learning from experience; their actions are not controlled by what has gone before, or what will happen in the future. The principle of behaviour

modification, which states that their choice of action is based on “weighing the consequences of possible alternative actions and trying to predict what possible experience or ‘reward’ each might lead to” (Kadesjö 1992, 42, my translation), is imprinted on them.

In the discussion on adapting the child’s surroundings, methods of behaviour modification are made concrete. The systematic arrangements of reinforcements include pre-arranged environments, or maybe rather, pre-arranged environments functioning as support of the arrangements of reinforcement. What is demanded of these settings is that everything has to be arranged within a set framework, that rules are constantly repeated, that everything is done at set times and places. In these settings adults function as so called ego supports.

Children with concentration difficulties are said to be in need of a clear external structure, clear rules, and familiar ways of doing things (Cederblad 1996, 271; Duvner 1994, 61, 79; Kadesjö 1992, 108-110). Unstructured situations lead to excessive demands on the child’s ability to cope and result in chaos. Daily and weekly activities should follow a similar time pattern; detailed schedules making clear what is to be done, with whom and how. Time should be made visible through the use of time schedules (Duvner 1884, 110).

It is often necessary to provide the child with an ego-support function (Duvner 1994, 61), which should consist of “close but firm adult support” (Hellström 1995, 117, my translation). The adult should function as a person “who kindly but firmly brings him back to order” (Duvner 1997, 115; my translation, see also Hellström 1995, 130). An external structure is viewed as a prerequisite to the child’s ability to build an internal structure. “These internal structures are necessary for the child’s ability to understand, plan, and take responsibility for its actions” (Kadesjö 1992, 114, my translation). The child needs an adult who is one step ahead, who can intervene and check when necessary, and help the child see his or her own part in what happens (Hellström 1995, 114). The function of ego-support is largely to set limits; “to put a stop before the child goes off the rails, at the right moment” (Kadesjö 1992, 111, my translation).

The restrictive view on medical drugs in Sweden is the subject of recurrent criticism. Many would benefit from drug treatment (Duvner 1997, 106). The concern about prescribing drugs has no basis in science, but has to do with our “historical fear” of abuse and addiction to drugs affecting the central nervous system (Duvner 1997, 128, my translation). One of the biggest obstacles to increasing the use of pharmacological treatment is thus said to be of a “psychological nature” (Gillberg 1996, 175, my translation).

This resistance has found support in the fact that "certain active opinion makers sometimes unfortunately have been allowed to stand completely unchallenged" (Hellström 1995, 176, my translation). Approximately seventy percent of MBD/DAMP-children who have had drug treatment are reported to have experienced an improvement in their ability to concentrate, a diminished impulsiveness and better control of their emotions (Duvner 1994, 81). Doctors urge parents' organisations to exert pressure in order to gain greater access to central nervous system stimulants (RBU 1987, 67).

There are marked expectations about being able to solve the problems of these children and young people: "We possess a great deal of knowledge of what are the important steps to take in order to further adjustment and a positive personal development" (Duvner 1997, 128, my translation). More research is seen as necessary, however, to ascertain to what extent drug treatment of children and young people can prevent social maladjustment (Gillberg 1996, 173).

The problems are, as previously seen, being located within the individual and defined in individual, not structural terms. The behaviours and characteristics are considered to be conditioned by constitutional or organic factors, not ascribed ones. The interest focuses on the socially disintegrating consequences of the deviancies. Also the discussion

on remedies is characterised by a focus on the individual and on solutions which further individual adjustment. The direction throughout is towards changing the attitude and behaviour of the individual to converge with societal norms of that which is acceptable.

The logic regarding the relationship between problem definition and remedies is rather impenetrable. What is the relationship between behaviour modification and its assumption about the malleable human being, and the biologically determined conditions? It is not obvious to all that the solution to basically biological problems lie in a systematic and firm upbringing.

Something which is never touched upon is the risk that interventions could lead, not to a reduction in, but to making the deviant behaviour permanent. The risk that the efforts involved in experts tracing, defining, classifying and remedying the deviant behaviour could lead to such consequences, is something, which is usually pointed out by theoreticians on stigmatisation. The discourse seems to rest on the presumption that the contributions made by the experts are, always have been, and always will be of benefit to the clients and their development.

Obstacles to Diagnostics

Within the framework of the presentations, what could be called a campaign for diagnostics and in favour

of a biomedical view of the problem children is being carried out. Part of it is about identifying forces of resistance against the development or the 'correct' way of looking at the problem. The resistance has been located to groups of professionals in the teaching profession and also in certain parents and their way of viewing the problem.

The prevalence of an "anti-diagnostic culture or ideology" — by which also child psychiatry has been afflicted — is said not only to have hindered the application of adequate diagnostics, but also the provision of proper care (Hellström 1995, 262, my translation). The main target for criticism is staff in the educational system. Many school and pre-school teachers show "a lack of knowledge on the subject" (Kadesjö 1992, 96). These occupational groups are not infrequently characterised by "unrealistic hopes" that the problems will be outgrown, and of an exaggerated fear that children and families will be stigmatised by the contact with psychiatry and social services (Kadesjö 1992, 96 and 188). But it may also be a case of "an inflated view of their own ability, of their own competence, or that they are unaware of the limits of their own abilities" (Kadesjö 1992, 187, my translation). It is important for school and pre-school teachers neither to take over the responsibilities of the parents nor the responsibility for assessment and remedies that demand professional expertise (Kadesjö 1992, 184).

Teachers' difficulties in accepting their own limits and with identifying where the limit of their own authority lies may result in the contributions of others being viewed as a threat.

It is thus said that there prevails within the teaching profession a tendency, which obstructs a necessary "shared experience of the problem" (Kadesjö 1992, 187-189, my translation). A special problem is said to be the lagging development of specialist competence needed to meet the needs of children with concentration difficulties (Duvner 1994, 61). "Many special needs teachers make the children endlessly repeat basic skills tasks in an unsystematic fashion, unconnected with the child's school work in general and without information about other difficulties that the child might be experiencing" (Kadesjö 1992, 149, my translation).

Teacher training courses, at basic as well as advanced level, are said to be characterised by a disproportionate emphasis on psycho-social factors of causation. The fact that teacher training does not include basic information about the normal development, neither of abnormal development of children and young people, is seen as regrettable. Despite the fact that problems such as DAMP and ADHD are prevalent in at least one child in each class, "the majority of all teachers have no idea what these diagnoses mean", and "it is unacceptable that

teachers also in the future are going to remain the only child experts in our society without any education about children” (Gillberg 1996, 197, my translation).

The discussion of the problems that teachers are said to have with realising where the limits of their competence lie in relation to those of the medical profession, never touches on the case that doctors who have problems with realising where the competence in the area of medicine ends and the area of pedagogics begins. The marked silence of the teaching profession in response to the pronouncements of their medical colleagues may be due to habit or to pragmatism, possibly a combination of both. The enduring historical conflict between medicine and pedagogics around certain groups of disabled people, those with learning difficulties for example, are not touched upon.

Another cause of the difficulties with reaching a “shared understanding of the problem” is identified in the parent group. For many parents the process of digesting and processing the information and coming to insight into the disability of their child is long and drawn out (Hellström 1995, 161). Parents “who do not appear to see or acknowledge the difficulty of their child” pose a special problem (Hellström 1995, 135, my translation). The image of the denying father, who believes that everything will be alright

in the long run, and the aware mother recurs in different places (Nordgren 1990, 8-9). Certain fathers, who have themselves shown “symptoms”, hold the view that the experts tend to exaggerate the problem. They are often happy to point out that they have managed to do well in life without having been given a diagnosis (Gillberg 1997, 124). But, the implication is that with the right approach and a little perseverance — through dialogue, to use current terminology — the family will be convinced of the importance of a diagnosis.

The following is a description from a case of a child with DAMP. The mother of the boy understands that the boy has a problem, while the “father, who himself may have had DAMP as a boy — and who is perhaps still ‘immature’ — believes that the mother is only coddling the child”. The father “needs to change his attitude” and support his wife “in stead of, as is the case, denying that there is a problem” (Gillberg 1996, 187, my translation, see also 192-196). A “shared understanding of the problem” in the family would not make the problem go away, but it would mean that “certain of the secondary complications (for example depression and social behaviour problems) could perhaps be prevented altogether” (Gillberg 1996, 188, my translation). The apportioning of blame apparently sneaks in through the back door.

The problem of the medical profession's claim to the privilege of stating what is the truth is characteristically never touched upon. On whose premises does the "shared problem formulation" take place? What room is there for an alternative problem formulation, that is, of a kind that is based on an entirely different experience of the problem and of the problem formulation to the dominating medical ones? It could actually be the case that some cases of "problem denial" by certain parents and teachers, when considered in greater detail, are not due to an unwillingness to "confess" that the child is in difficulty. It could simply be the expression of a protest against the prevailing frameworks of understanding. The categorisation of all critical stances as "denial" is undoubtedly an effective strategy; this type of psychologising is, furthermore, difficult to fend off. Contrasting definitions of the situation could very simply be slipped into either the idea of illness or into the theories about defence mechanisms.

The Return of Social Pathology

Let me now attempt to define the sphere of thought, within which we are currently moving. Social pathology, which experienced its initial heyday at the end of the nineteenth century, implies the application of a biological or a medical model to social problems. The idea is that anomalies occurring in

the institutions of society can be "diagnosed" in the light of general and universal criteria for normality and health. The thinking of social pathology is permeated by ideas of individual maladjustment and the effects thereof in the form of social disintegration (Lemert 1972, 9-10; Mills 1943).

From a historical perspective, the discussions have to a high degree centered on the consequences of madness, intellectual disability, alcoholism, sexual deviancy and criminality. These states are considered morbidity-generating conditions, which threaten the moral order on which society, or parts thereof, rest. There is a strong tendency within social pathology to define acts, which are contrary to prevailing cultural ideals and norms, as anomalies. Normative guarding of the defining line — using a register ranging from interventions characterised by force to those of guidance — becomes very important.

Social pathology is orientated towards individuals rather than towards structural conditions. Interventions are focused on bringing the individual's way of functioning — preferably also desires — in harmony with goals accepted by society. Certainly, psychosocial factors are at times mentioned as being significant to the creation and development of these anomalies. But the deeper problem is placed at the level of the individual, through the construction of a detailed picture of the

displayed symptoms, the phases the career of deviancy are undergoing, and the consequences for the social order. We are dealing with an individualising analysis.

Social pathology fails, within its framework of thought, to incorporate questions that deal with structures at a higher level, such as power, institutional arrangements, ideologies, questions of class, etcetera. It is not structural conditions that cause the anomalies, but inadequate people. Some citizens are considered to be in 'need of remedies'. The 'needs' are considered expressions of deficiency and shortcomings in the individual — not expressions of poor social and economic conditions (Squires 1990, 157-158, 169). The kinds of remedies, applied by specially authorised persons, are to be given in the form of stimulation to self help: the aim is to get the individual to work to correct him or herself in a desired direction. The condition for a successful process is that the individual internalises the image of him or herself as inadequate in some respect or other.

The thinking of social pathology has strongly influenced the political as well as the professional debate on social problems during the entire twentieth century. We can see how this puts an unmistakable imprint on the debate on the problem children. Characteristic for the texts included in this study is that 'culture' or 'society' are viewed as

undifferentiated entities. The view of society is one which could be described as organic or functionalistic.

The absence of a differentiated analysis of society is perhaps most clearly revealed in the discussion about remedies. Certainly, there is talk of the pre-arrangement of school and home environments in order to meet the needs of the child and create optimal conditions for the child's development. But given the interest for reform of the organisation of school and family, a silent acceptance and a sanctioning of the prevailing system of norms and values is taking place. The purpose of the pre-arrangement is to get the existing organisation, and the normative values on which it rests, to run more smoothly. It is primarily to do with oiling the wheels of the existing machinery. The starting point is clear:

"These children and young people must, like everybody else, fit in to the social system that makes up a school; a social system which has a number of more or less explicit rules and expectations on the behaviour of the children. If the school has, say, ten written rules, it will have hundreds of unwritten rules; silent pedagogics which relates 'this is what you do in school' (Kadesjö 1993, 4-5, my translation).

Nowhere is the child's behaviour being explained with the norms themselves as the starting point. No attention is paid

to the fact that social change or “pre-arrangements” could lead to fundamental changes in the normative and organisational framework.

In some cases the texts rise above the level of the individual, and we see attempts at a critique of culture and society, but they remain formal and diffuse. Life in our modern society is described as increasingly complex; the flow of information increases and the work pace is fast. People are exposed to a great number of impressions and the demands on our ability to handle and sort the information are increasing. In this climate, children with the kind of problems we are discussing will find life increasingly difficult (Hellström 1995, 17; Kadesjö 1992, 4-5). These examples of culture critique can be discovered in the observation that we live in times of increasing demands for co-operation (Gillberg 1997, 95) and of lengthy academic study (Gillberg 1996, 82). People, who in the old days were able to exist as eccentrics or as local characters, perhaps under the protection of some academy (the university world has long functioned as a sheltered workshop for deviant intellectuals), can no longer count on being able to escape discovery and diagnosis (Gillberg 1997, 95 and 148).

But the final answer to the question why deviances occur is simply that it is to do with biological impulses which breaks through social restrictions. The

panacea offered for the anomalies is: more socialisation.

A risk in using the social pathology model is that it tends to function as propaganda for conformity to the norms which characterise the prevailing social system. We are dealing with the kinds of message which promote dispositions and ways of relating to the world, viewed as necessary for the preservation of our society: submission to authority, acceptance of existing social hierarchies and contentment with one’s lot. Moral, social and political elements of the discussion about problem children tend to be made invisible with the aid of quasi- biological concepts such as adjustment. The tendency is reinforced by the texts appearing to be apolitical. Proponents of diagnostic thinking could — willingly or unwillingly — come to be the proponents of the status quo.

Deviancy as the bearer of social meaning

As a subtext in the dominating discourse runs the assumption that a world without disturbing behaviours becomes easier to inhabit, for all of us, but first and foremost for those affected. Children and youngsters are said to suffer from not being able to live up to the demands and norms of adults, which is a condition for being able to reach important goals such as

'fitting into the group' (Kadesjö 1992, 28).

Let us, in an attempt to break out of the framework of the discourse, assume that the problem children are young people with strong individual interests and a strong sense of integrity. From the standpoint of this assumption, the sufferings would not be conditioned by the young being unable to live up to the expectations of others. The suffering is caused, instead, by the intuitive insight into the deeper social meaning of the structure of demands and expectations. The suffering arises in conjunction with a growing insight into the basic conditions of existence. The problems are brought to the fore when the child enters school, which is the first meeting with society's organisation and the norms upon which it rests.

Let us further assume that people, contrary to the basic assumptions of behaviour modification, are not controlled by their surroundings, but that they have strong inherent forces, such as striving for meaningfulness, creativity and morality. Let us assume that people, even small people, feel 'reinforced' by doing things based on individual choice (Chomsky 1974, 37f). As we have seen, it has been observed that children and young people, when offered the opportunity, are very well able to concentrate and to work long and hard — on condition that they find it interesting. Under such conditions, the young do not need reinforcement in

the form of rewards to carry out their tasks. On the contrary, children grasp, as we can all witness, every opportunity to express their creative abilities and their imagination. In this their effort to realise their individually chosen work, they place all their efforts on fending off interventions from teachers, psychologists, doctors and others who attempt to get them to adjust to the prevailing order. This is the situation — the moment — in which the "problem child" is created.

Seen from this perspective, the aim of our efforts should be the construction of a culture in which the creativity of children and young people are given free play. The measures should be directed towards making arrangements which would enable every individual to chose meaningful work. But educational arrangements like this would not be compatible with the prevailing societal order. The work life of our society is not arranged in this way and therefore neither is our education system, as it prepares for life at work. Society, and thereby school, can only allow a very small number of people free development. The vast majority must do what is prescribed them, they must learn to submit to authority, and they must learn to have limited expectations of life. Many people will end up in hierarchical organisations. They will end up in jobs where they do what others decide they must do. For quite a lot of people, it will not be realistic to expect a higher degree of job satisfaction. One group of

citizens will not be able to expect any work at all. They have been apportioned the task of being unemployed with all that this means in terms of expectations and ability to know their place in society.

Our educational system is characterised and has been characterised “by a strong tendency to filter out independent thinking, creativity and imagination, and instead to encourage obedience and submission” (Chomsky 1999, 82, my translation). Non-acceptance means problems one way or another. In the school of times past, characterised by considerably more authoritarian conditions, the children’s room for manouvre was considerably more restricted than is the case today. In the more permissive educational climate of today, the opportunities for children and young people to live out their attitudes and and behaviours have increased. A more permissive climate should, however, not be viewed as an indicator of changes in the normative framework. It is rather to do with — as one researcher expressed it — the playing field having changed. In the past, the patterns were clearer and the rules of the system simpler to understand and were underpinned by more concrete, physical sanctions. Today the playing field is hazy. The patterns have become fuzzy and require a measure of skill to decipher the many hidden messages. This, especially, has come to disadvantage children from backgrounds which are not familiar with the

middle class codes according to which schools are run (Frykman 1998, 89).

It is not difficult for an individual, who is resourceful and comes from a background which has taught him or her how to reach success in the world, to accept him or herself. In this situation you are not likely to have problems of adjusting to existing reality. For those who lack resourcefulness and are defined as deficient, insight about self and adjustment to reality is a considerably more painful process. The insight into the injustices of our society may not be accepted and internalised by all children without protest, a protest which could take the form of attack or defense, be diffuse or obvious. It is possible that life becomes easier and more pleasant for an individual who is accepting rather than kicking up a fuss. But the question is whether the concessions — which touch upon experience of meaning, motivation, justice — stand in proportion to the ‘rewards’.

We exist in a society increasingly characterised by the categorisation of individuals in terms of winners or losers. The fear of ending up among the number of bullied is probably considerable among children and young people in the education system. The reactions of children and youngsters could, against this background, be viewed as a response to the current condition of society and the way in which this may affect adults around

them. In times when increasing class divisions, unemployment, segregation, exclusion and loneliness is the stark reality for an increasing number of people in our society, it does not appear unreasonable to view the “symptoms” under discussion as quite a natural way to react. We may find one of the explanations to the problem in the historical change of the playing field of education and society.

With starting points like these — which do not deny neurological differences in people — the social meaning of deviancy becomes clear. The behaviour of children and young people become a kind of seismograph on our societal condition. The attitudes and behaviours of the young can, as a critical examiner of diagnostics has pointed out, be considered a running commentary on the conditions in our society. Deviancy does not have to be seen mainly as a clinical entity and as something which necessarily needs to be treated on an individual basis. The behaviour could, on the contrary, be viewed as a response to a situation of deep conflict (Conrad 1976, 80) From this perspective, children’s behaviours change from pathologically conditioned disturbances to demands and urgent requests directed to the world of adults. Instead of considering the “symptoms” as bearers of information about the constitutionally conditioned deficiencies of individuals, they become indications of socio-institutional shortcomings.

The debate about problem children has taken place within the framework of a view of the world characterised, partly by the idea of organisational rationality, partly by the idea of human pathology (Skrtic 1995, 66ff). This framework has shown itself to be very difficult to penetrate. By opening up the thinking around the problem children to structural factors; by raising questions about organisational rationality and around pathology, we can achieve a considerably broader, more complex, and thereby balanced picture of the phenomenon. We learn at the same time to view the deviancy as relative; to see it as culturally and historically conditioned, and as varying with time and space. In this relativisation lies a condition for achieving radical changes of the situation. Ambitions for increased democracy and social change are not lacking in the prevailing discourse. But the lack of a balanced structural analysis combined with the tendency to focus on the individual, makes breaking out of the framework of the prevailing system difficult.

Conclusion

The jurisdiction of medicine in relation to school children’s deviant behaviour is underlined by the fact that diagnostics nowadays seems to have science as well as humanity on its side. Seen in a longer historical perspective, medical definitions of deviations — such as alcoholism, madness, intellectual

impairments, homosexuality — have been forwarded in the name of humanity and science. With these claims, the demands on the legitimacy of medical definitions have been strengthened and the legitimacy of alternative definitions — religious, legal, pedagogic — weakened (Schneider & Conrad 1980, 8). From this framework it is difficult to hold a discussion with a reasonable degree of openness. Anyone with the intention of putting forward alternative perspectives and frameworks for interpretation risk being accused of being an opponent, not only to research and progress, but also to goodness and good intentions.

Doctors in alliance with parent's organisations have, not least through obvious media successes, contributed to directing the search light to a problem, that is a painful reality for many children (Börjesson 1999). Diagnostics has for many of the affected and their families become something considerably more than a medical promise. As such it has to be opened to examination. Not to deprive those affected and their families of hope, but to improve the conditions for a liberation from oppressive institutions, ideologies and value systems. A critical examination of society and its institutions, such as education and the family, is set to further more radical social changes.

The consequences of diagnostics for the opportunities of young people regarding, for example, future studies and

choice of career, are yet to be investigated. Some are possible to foresee against the background of current developments within the educational system. A strong expansion in the number of independent schools is currently taking place around the country, schools, which receive significant subsidies. This development, where public resources are being transferred to private concerns, will inevitably affect the standards of local authority schools. To take the sixth form colleges as an example, these have the choice of selection of their prospective pupils. The Education Act, ch. 9, 8§2, enables the independent sixth form colleges to reject candidates, namely "candidates, the acceptance of whom would lead to significant organisational or financial difficulties for the college" (SOS 1999, 57). If the acceptance of a prospective pupil with special needs brings about significant difficulties, the college can deny the pupil admission. However, at this stage of life, the disability awareness of the young person may have reached such a degree that the young person is capable of viewing his or her situation "realistically". The question whether we see it as acceptable that the structures of opportunity for the young are circumscribed in this manner is not a matter for science, but has to do with values.

In the discussion about these children and young people as a resource in our society, which has hitherto been

characterised by a lack of ideas, suggestions that they could probably find a niche in life where their special talents and characteristics can find expression, for example, as entrepreneurs or sportsmen, also needed in the world, have been put forward (Kadesjö 1992, 215-216). But is it not also possible to imagine that among the young — unconventional, defying of authority, energetic — dwell the future union leaders, social reporters, critical debaters of society, advocates of citizen's rights and welfare — which our world may today be in an even greater need of?

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