ADAPTATION

IN THE CLUTCHES OF A DISCOURSE

Paraphrasing Charcot´s female hysteria. Viktoria Kindstrand

Essay
Art in the Public Realm
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Abstract

"Adaptation – in the clutches of a discourse" is a project that investigates a discursive power and knowledge production. The project uses perspectives from philosophy, phenomenology, sociology, social constructivism and discourse theory in order to get a multilayered understanding of the uses of one manifested standardisation of normality or rather abnormality – the DSM manual. The DSM - Diagnostic and Statistical Manual for Mental Disorders – is an American manual used worldwide to understand mental disorders or irregularities. The inherent checklists that are used to diagnose individuals are based on the notions of normality within society. The DSM is constituted of checklists of different symptoms in behaviour, mood or other physiological effects that signifies mental disorders. How do the DSM and the uses of the DSM reflect the society? In the answer you will find economical, political and structural interests in using standardized ways of explaining the mental irregularities or differences of the human being.

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1. Introduction

A few days after the massacre in Oslo and Utöya island the psychological experts, interviewed in different news papers, claimed that the mass murderer Anders Behring Breivik was not to be considered mentally ill but mentally disturbed.[1] Anders Behring Breivik planned, organized and performed the bombing and the shooting very consciously for a longer period of time and he is therefore not considered mentally ill according to the way the professionals in psychology categorize disorders in to terms of diagnosis. This makes me wonder what is considered to be a mental illness or disorder and what is not. Who and what decide the definitions? At the same time, in the same discourse, there is a tsunami going on in the Swedish society that tumbles families around by diagnosing children with bipolar and attention deficit disorders. What decides how a person or a personal behaviour is diagnosed? What is considered normal behaviour and what is not? Where are the borders of normality and what is outside the borders? I personally feel that the free space for individual behaviour is being constantly tightened.

Science is one leading power regime in our society with its inherent production and claim of truth. The scientific method to deal with the unknown is to examine, analyze, categorize and finally define. When it comes to the understanding of the human being I question whether standardised tests and definitions on everything is the right way, simply because the human being is the human being's greatest mystery. In order to understand mankind I guess we need as many ways of understanding as there are people.

1.1 Project intentions

From a broad perspective the project is based on the experience of being in the clutches of a discursive pattern of thinking and behaviour. The project is based on both private and public thoughts of normality and adaptation. Your knowledge is bound to your discourse. By living together within a society you have to consider and adapt to general ideas and knowledge and to what is considered right. The project concerns power and knowledge structures in the society. It concerns the adaptation to systems of pronounced and articulated knowledge. It seems that only what is named exists. Or rather only what is named can be understood. But a way of seeing is also a way of not seeing…

The way of understanding yourself and other peoples way of understanding you has to do with the pronounceable ways of identity. That means we understand both our selves and each other through a grid of experienced forms of pronounced identities. You might say that there are predefined roles to enter. The project concerns how human beings discursively are understood and how they understand themselves. It also concerns how knowledge of the social and the embodied individual comes to be produced in different periods. This discursive knowledge circulates as representations within each discourse. I examine mental and physical spaces where the constant pressure for genesis and adaptation in the society's standards are performed. How does normative adaptation appear?

How do the regimes of normalization manifest them selves in the public realm? What do the regimes of normalization do to the individual? The project is connected to entire ways of understanding, interpreting and perceiving the world that are embedded in each society. It concerns the constructed and negotiated mental and physical spaces that embed the individual in to the society. These mental and physical spaces contain stories that we take for natural,

[1] *Bedöms vara störd – inte sjuk,* Anders Forsström, *Dagens Nyheter*, 26/7 2011

constructions and reconstructions of the world that we understand as true. The notions of the self determine how and to what you adapt yourself. It is the notions of the self that decide who you believe that you are. People can only understand themselves and be understood in relationship to each other. We are social creatures. I become me in relationship to you. But at the same time what is in me may not be in you. I understand you in terms of differences and similarities. The society is in a constant motion, notions of what is normal behaviour are flexible and renegotiable, the notions changes with the society. One crucial part in the project is that there is no fixed normality to which you can adapt, life is always something else than theory and constructed norms.

1.2 Questions

I have chosen to work with several questions that leads from a broader perspective of being a part of a discursive formation and a regime of normalization to a more narrow question that highlight one discursive example of how the regimes of normalization is manifested.
How does the endless eagerness to define, categorize and name everything in the society affect us as individuals? Where does this eagerness come from? How do the regimes of normalization manifest them self in the public realm? How do the regimes of normalization affect the individual?

I will, in the end of this paper, examine one example of manifested normalisation – the DSM document – Diagnostical and Statistical Manual for Mental Disorders, written by the American Psychiatric Association. I will also consider the process how the DSM document is used and the connections between different socializing institutions. **How does the uses of the DSM checklists reflect the society with its embedded notions of normality?** To pronounce and diagnose mental disorders or irregularities is about categorizing feelings, personal pain, behaviour and what is considered out-of-normalities. What does it mean for the individual that it is done with standardized tests?

1.3 Methodologies and contextualisation

In order to contextualize the addressed questions and the DSM I have used ideas from philosophy, anthropology, phenomenology, medicine, discourse theory and social constructivism. I will try to construct a weave of different perspectives of being in the world. The research is based on theorists like Michel Foucault, Michel de Certeau, Karin Johannisson, Dag Österberg, Mary Douglas, Richard Wilkinson. I want to underline that I do not claim to know the medical or psychological field but I am trying to understand what it can mean to be diagnosed with a disorder. In order to understand I am preparing a fabric in which all sorts of threads may be woven together in a complex weave.

The theories of Michel Foucault connect the individual to the society and the regimes of normalization that are embedded in each society or discourse. Foucault meant that each individual is an accomplice to his own oppression by disciplining and adapting himself/herself to prevailing norms. The regimes of normalization works because what is considered normal or the right way is difficult to deconstruct and break with because it has to do with the existing notions of normality that your discourse is embedded in. It is so natural that you do not see it. This is also the way the relationship between power and knowledge is constituted. The accessible knowledge that circulates in the discourse is normalizing the subjects through the perspective of the hegemony. Most important for this project is, of course, the meeting with every day life.

2. The regimes of normalization in relationship to the public realm

We are here together. Being is to put your thread in to the common weave of society. The weave was already there when you were born and it will continue growing after you are gone. Each individual is bound to and embedded in the regimes of the society. The personal experience is connected to the public realm. The notion of what is normal is negotiated inside the society. Each society, each context, has its own notions of what is normal. The norms are executed by power structures in different ways of using standardization and conformity. One example is the standardization of the education systems in obligatory school that determines which knowledge is worth knowing and which is not. Also the way the system batch the students together by age not by interest or skills even though people are organic and diverse. The standardisation is executed by both content and structure. In the 70´s the Austrian philosopher Ivan Illich claimed that school is not liberating or educational because it *reserves instruction to those whose every step in learning fits previously approved measures of social control*.[2] Illich meant that obligatory school polarizes the society.

That the individual struggle for adaptation is highly political and connected to power-structures in society has been presented by several theorist but by one in particular - the French philosopher Michel Foucault. His concern was in trying to understand how discursive formations, for example the medical or educational discourse on diseases, become natural representations of knowledge. He tried to uncover the structures and regulations through which knowledge is constructed. Foucault meant that it is the discursive knowledge that determines the conditions of possibilities. Discursive knowledge regulates what can be said and done, what is considered true or false, right or wrong and what is considered worth knowing. The discourse establishes and controls knowledge.

In the field of medicine there are historical examples of the ways that political uses of power frames who is included or excluded. The one who shows a normative and preferable behaviour will of course be included. If showing a non-normative and not preferable behaviour - excluded. The way of pronouncing and using these diversifications also indicates the notions of normality within the current society. The non-normative is pronounced in the criteria for mental diagnosing. The diagnoses are embedded with stories of the norms and ideas of ideals in the society. The diagnosing is a way of defining and mapping the borders between what is considered normal or not.

Using the writings of Mats Börjesson and Eva Palmblad in "I problembarnens tid"[3] they suggest that Sociology, Education and Medicine are inheritors of the Christianity and the moral philosophy, which includes a claim of how the good life should be lived and normative images of the boundaries of social order. Citizenship in society is a qualification rather than a right. If the individual is not situated within the normative limits, he or she should be corrected so that adaptation is possible, corrected by socializing institutions like schools, healthcare, social services, prisons.

3. Definitions of equality

According to the report of people´s health in Swedish society from the Swedish Social board, "Socialstyrelsens Folkhälsorapport 2009", concerning common and widespread diseases in

[2] Illich, Ivan; *Deschooling society*, p 11

[3] Börjesson, Mats och Palmblad, Eva; *I problembarnens tid Förnuftets moraliska ordning,* Carlsson Bokförlag (2003/2010) Helsingborg

the society, in Swedish called "folksjukdomar"[4], the diseases reflect the situation in the society and the individual outcomes in terms of physical or psychological pain. The report shows that teenagers and young adults are a group in society that since the 1990´s has a decreased level of mental health. The report provides an overview and analysis of how the health condition develops in different population groups. Health is unequally divided; heart diseases and diabetes are more common among low educated people, smoking is decreasing in all social groups except low educated women, survival after breast cancer is also lower among low educated women, life expectancy is increasing most among men and highly educated etc. Social positions, social situations and health are strongly connected.

Reading *The spirit level*[5]*,* written by Richard Wilkinson and Kate Pickett, I found a deeper understanding of how important equality is for the social position and for the notions of the self. People are constructed in relationship to each other, the closer people live to each other, the bigger impact on each other and on the notions of the self. The level of equality between people in a society is crucial for the notions of the self. Each individual understand himself/herself in relationship and in comparison to others, first to the own family and then to friends and neighbours. Similarities or differences between you and me, us and them. Differences in for example social status or economical situations affects us more the closer it gets to us. Your neighbour has a well-paid and interesting profession, a stable and happy relationship, well adapted kids and is a handsome son of a bitch. Does that affect you? You come from a highly educated family but you dropped out of school because you could not make it. They can afford to go for holiday abroad every year. You cannot? Does that affect your sense of who you are? What matters is the difference! Poverty is an example of social exclusion, poverty is not only about survival. The median levels of consumption correspond with the median wage and the normative way of thinking of consumption – what you want to eat, how you would like to dress, what you want to do and how you can live your life. If you are not within the levels of normality you do not have the same possibilities.

Where does the endless eagerness to define, categorize and name everything in the society come from? In order to understand and interpret the world we need to use our ability to categorize through a filter of experience. We categorize in order to understand what we just have perceived. Mary Douglas writes in *Purity and danger* that we need categories in order to understand and organize the world.[6] We learn to organize in categories - a shoe on the kitchen table is misplaced, it is a matter of an object out of its place. This way of perceiving and interpreting information divides the perceived into categories according to differences and similarities. When it comes to interpreting and trying to understand people you easily put them into categories and manifest people in groups, which can work in order to analyze and understand differences, but they also lock the notions about the embedded significance of difference. A problem is the very diversification that is focusing on the differences. The categories are constructed as normalized patterns or roles, which makes variable or changeable identities impossible. Diversification is fixating categories though the diversification is our way to understand the world.

4. Consequences of coexistence

The thoughts that are presented in this chapter are of importance also from another perspective; how the DSM is used to diagnose individuals from symptoms and not from a

[4] Socialstyrelsens Folkhälsorapport 2009 http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8495/2009-126-71_200912671.pdf

[5] Wilkinson, Richard and Pickett, Kate; *Jämlikhetsanden. Därför är mer jämlika samhällen nästan alltid bättre samhällen,* i översättning av Lars Ohlsson, Karneval förlag (2010) Stockholm

[6] Douglas, Mary; *Purity and Danger*

multilayered understanding, for instance a child from a poor area with a single parent is more often diagnosed with f ex ADHD than other children. We all circulate in different contexts like school, work, neighbourhood which all have an impact on us. The context is decisive for the notions of what is considered normal and not. Each context, each discourse, inhere its own notions of what is normal. Fixed roles for adapted manners and positions organize the every day mess we live in. How do you adapt to your context? Each context inhere a number of possible positions more or less normalized. What may be accepted in one context may not be accepted in another. [7]

Looking back at Wilkinson´s writing – the closer people are to you the bigger impact on the notions of your self and on the adaptation. That leads us to the neighbourhood.

The French philosopher Michel de Certeau, used the practices of everyday life to investigate how the individual is dealing with the power structures in society and therefore acting politically. Michel de Certeau presented a theory in *The Practice of Everyday Life*[8], about the productive and consumptive activity inherent in everyday life. According to Certeau, everyday life is distinctive from other practices of daily existence because it is repetitive and unconscious. De Certeau attempts to outline the way individuals unconsciously navigate everything in life. Everyday occupations, how school, work and activities that you do everyday affects and construct the subject. Everyday occupations are activities that are made over and over again until they become a habit that you perform without reflection. Without critical reflection and under the yoke of traditions and habits you are embedded into the regimes of normalization of the society where you live your life. My interest is in how we are constructed and how we discipline ourselves as subjects in order to adapt the self to what you believe is normal. What elements are of importance for the process of adaptation and the construction of identity?

> ”The neighbourhood is also the space of a relationship to the other as a social being, requiring a special treatment. To leave one´s home, to walk in the street, is right away to commit a cultural, non arbitrary act: it inscribes the inhabitant in a network of social signs that pre-exist him or her (proximity, configuration of places etc.). The relationship between entrance and exit, inside and outside, intersects with others such as between home and work, known and unknown, hot and cold, humid and dry weather, activity and passivity, masculine and feminine, this is always a relationship between oneself and the physical and social world; it is the organizer of an inaugural and even archaic structure of the urban ”public subject” through the unflagging, because everyday, stomping around, which buries in a determinate soil the elementary seeds (…) of a dialectic constitutive of the self-awareness that, in this come-and-go movement, in this move between social mixing and intimate withdrawal, finds the certainty of itself as immediately social.”[9]

What I understand from Certeau´s writing is that everything around me in my daily life has an impact on my self-construction and adaptation. Spaces that are social constructions and where I find myself a part of inscribes me in a context, such as my neighbourhood, in school or at work. I become one of the group, one part of the structure. Being is always *being-with*[10]*,* my existence include the co-existence with people and everything around me.

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[7] One example is the outsider in one context might be the insider in another context. I have a neighbour that has chosen a alternative way of living by dwelling and selling vegetables from his car. I live side by side with an eco-village and I have heard my neighbour talk about this man as an ideal or as a freak, all depending on the context.

[8] de Certeau, Michel, Giard, Luce och Mayol, Pierre; *The Practice of everyday life*, *Volume 2 Living and Cooking*, (1990, 1994) University of Minnesota Press, Minneapolis, London

[9] ibid, page 12.

[10] Nancy, Jean-Luc; *Being singular plural*; chapter 1

> An individual who is born or moves into a neighbourhood is obliged to take his or her social enviroment into consideration, to insert himself or herself into order to be able to live there. (…) The practice of the neighbourhood is a tacit collective convention, unwritten, but legible to all dwellers through the codes, just as any transgressions, is immediately the object of commentary: a norm exists and it is even weighty enough to play the game of social exclusion when faced with ”eccentrics”, those who ”are not or do not act like us.” Conversely, this norm is the manifestation of a contract that has a positive compensation: it allows for the coexistence on the same territory of partners who are, a priori, ”not linked”; a contract, thus a ”constraint” that obliges each person, so that the life of the ”collective public” that is the neighbourhood becomes possible for everyone.[11]

Everything I do I do in relationship to the others and the layers of structures in my neighbourhood. I use Certeau´s glasses when I think about my neighbourhood;

There is a woman living in my neighbourhood that is waiting every night at five to nine outside the local grocery store Konsum. Two minutes to nine she goes inside. It is her time. Two minutes to nine Konsum belongs to her. She always has greasy hair. I guess she doesn´t wash it as often as I do.

There is a man living in my neighbourhood that stays most of his time in his car. He is selling vegetables from there. One time he hugged me. He said he was happy to see me. I was surprised because we don´t know each other that well.

There is a girl living in my house. She doesn´t wake up when I wake up. She doesn´t get dressed when I get dressed. She doesn´t eat when I eat. Sometimes she goes to school. I go to school everyday. She says she learns more from the Internet.

There is a woman living in my house. She is used to do things the right way, as things are supposed to be done. The girl in my house doesn´t do everything the right way. Some days she stays in bed all day. Many days she stays in bed all day.

There is a man in my neighbourhood that started to weed his lawn two months ago, he works everyday from sunrise to sunset. His lawn became a brown field of soil but still he continues to weed his lawn.

The regimes of normalization require that most of the people adapt. Though people are always more or less adapted. It will cause the individual stress when she/he cannot adapt or make the close surroundings adapted. It is crucial to understand that taking the role of an outsider, a semi- or non- adapted individual in a society is also to connect and relate to the inherent norms and requirements in the current context.

Using the neighbourhood, as Certeau did, leads the project to thoughts about the impact of material surroundings. Dag Österberg, a Norwegian professor in sociology, analyzes how people´s feelings, ways of thinking and acting interweave with the material surroundings.[12] He uses the vocabular ”Socio-material” (sociomateria) that is an attempt to explain how the material surroundings and the human being is connected to each other, the surroundings appears like a socio-materialistic field of acting where the socio-material turns to the human being who answers with certain behaviours. The material surroundings are negotiated spaces that inhere expectations on you and it is claiming a normative behaviour. The social-material refers to everything you might find in the surroundings that is created by a human act, like the

[11] Ibid., page15.

[12] Österberg, Dag; *Stadens illusioner*

pavement you walk on, the walls of your house, your desk in school, the smell of the traffic or the sound of the alarm. In my reading it might even include the bodies of human beings. The socio-material surroundings may work as a weigh up on you or as a relief. The untouched nature is not considered a socio-material surrounding. For this project the very idea that the material surrounding has an impact on us is giving new ideas of the every day surroundings as a part of our social bodies. My bed, my home, the way I take everyday to work, school, kindergarten, the places I share everyday with other people are parts of the construction of the self. Again we are embedded in a context. Some places have a long leash on me others a very short. I can adapt more or less. I can feel more or less free. More free out into the woods without people or in the crowded street where I do not know anyone. More free when I do not have to many demands hanging over me. Less free standing in the subway-carriage at rush hour with other people far to close to where I prefer. I have an outside and an inside. The outside is visible for other people, the inside is me. My relationship with other individuals in the crowd is shallow and so is their relationship to me. By adapting myself to the group I look like them. That is a relief, a relief from my own individual character. To adapt is to become one of the crowd, not to stand out and becoming one of the crowd gives a place in the free landscape of anonymity. As one of the crowd, I can take a break from my self and from my own individual character. Out into the woods, I can be alone with my self, I can act without the gaze of anyone else. I feel as free as I can be. I ask myself what the gaze of the Other, the normalizing gaze do to me.

Through actions you change your environment, you characterize it with your intention, by the spoken word or other actions you change the materiality in a durable manner. This is a reason to act, to show who you are to others. But at the same time this is what I want to call your outside, the performative side of your self. This is what the Other understand is you, some how you become your own actions. [13] To summarize this chapter I suggest that the closer, the more structured and the more socializing your surroundings are the tighter individual space for non normative activities and the clearer the borders of suggested normative behaviour and expectations will came out. This chapter is the base of my installation *Socializing rooms* where I have chosen to work with two of the strongest socializing institutions in society – school and healthcare. Through life we are placed in different institutionalized rooms from where we learn how to guide our lives, form our values and define our notions of what is legitimate and what is not. I call these rooms of the socializing institutions *Socializing rooms*. The installation is both a *mise en scène* and a play with visual representations of rooms that contain discursive notions that dominate the society. The installation is build on individual stories of experience from the pressure for adaptation to normalization in the meeting with socializing institutions like school and healthcare. The stories include feelings of insufficiency, inclusion and exclusion.

5. The individual and the adaptation

Hanna Arendt wrote in her book *The Human Condition*[14] that people are equal and distinct at the same time. If people were not equal they would not understand each other and at the same time if people were not distinct in action and speech they would not need neither speech nor action to be understood. She also wrote that human distinctness is not the same as otherness – otherness is an important aspect of plurality and the reason why all our definitions are

[13] Österberg is using Jean Paul Sartre - *to be to yourself and to be for the Other*[13] – att vara för sig och att vara för den Andre – is exemplified by being in a park alone or in the presence of an unknown. When you are alone, the park appears as a field of action where you are the centre of every action. When you are in the park with someone unknown, you share the field with someone else, you are under the gaze of him/her and he/she is under yours. Your outside is being for the Other. To feel ashamed is to experience your being-for-the-Other. To feel proud is the same.

[14] Arendt, Hanna; *The Human Condition*

distinctions, that is why we are unable to say what anything is without distinguishing it from something else. Contextualizing what Arendt suggests to the DSM, in which symptoms are signifiers of mental disorders, the symptoms are described as behaviours or in how you show that you relate to your surroundings, symptoms are what you find in actions (behaviour) or in speech. So the symptoms are found in what actually distinct us from each other, what defines us as individuals. What signifies me might also be my problem if it is not within the borders of normality.

The process of adaption may not be easy or even possible. The individual body might not loose all those kilos or wake up early in the morning, the individual mind might not want to or be able to socialize as the neighbours do. The individual body and mind might offer a resistance against the adaptation. Being diagnosed can implicate that the notions of what is you will change, it might be the change from the notions of having a certain personality to becoming someone with a neuropsychiatric disorder. For some people or families it is a relief to get an explanation and definition of why you are not fully adapted or why you have certain pain or problems. For others a struggle of identity starts.

6. Ways of defining standardization

6.1 Ways of defining standardization in the past

When something is not yet pronounced or defined it is not organised and it might be a threat to the regimes of normalization. To suffer from a disease or illness that has not yet been established or understood within the realm of accessible medical terms is a threat and has to be diagnosed and named. If you are not diagnosed, if your illness is not defined there are no established forms of help, like treatment or social security.

Our understanding of the world is connected to entire ways of perceiving, interpreting and pronouncing experiences by using former experiences and knowledge as a grid through which we understand new things. Ways of thinking about identity has to do with pronounceable, utterable and imaginable ways of formulating singularity and identity. How do you formulate the unimaginable? Can you think without pronouncing the thoughts in one way or the other? For paradigmatic shifts new thoughts has to be articulated in advance, new thoughts has to be socially imaginable before you can start to use them.[15] Paradigmatic shifts are processes that require phases of social imagination. Looking back on paradigmatic ways of understanding and pronouncing circumstances and activities of life Michel Foucault gives examples that make the shifts come out clearly. (Pierre Pomme was a French doctor.)

> Towards the middle of the eighteenth century, Pomme treated and cured a hysteric by making her take “baths, ten or twelve hours a day, for ten whole months.” At the end of this treatment for the desiccation of the nervous system and the heat that sustained it, Pomme saw “membranous tissues like pieces of damp parchment…peel away with some slight discomfort, and these were passed daily with the urine; the right ureter also peeled away and came out whole in the same way.” The same thing occurred with the intestines, which at another stage, “peeled of their internal tunics, which we saw emerge from the rectum. The oesophagus, the arterial trachea, and the tongue also peeled in due course; and the patient had rejected different pieces either by vomiting or by expectoration.”[16]

[15] Hannula, Mika; *Politics, Identity and Public space. Critical reflections in and through the practices of contemporary art*

[16] Foucault, Michel; *The Birth of the Clinic*, Introduction

Was the female hysteria a medical invention? Or was it a Zeitgeist, a virus-like state of mind with accompanying behaviour that functioned as an answer to the prevailing paradigm? A whisper that reaches the individual mind through language, images, feelings, a non utterable something that leads to a certain expression. To faint for example was a much more common activity in the 19th century than it is today. Was female hysteria a cultural phenomenon? Are there in each timezone certain normalized or allowed behaviours of mental expressions? I think so and I use a quotation from Siri Hustvedt´s novel "How I loved" and the character Violet.

> Violet is still looking for the disease that is in the air, the Zeitgeist who whispers to his victims: scream, starv yourself, eat, kill. She is hunting the winds of ideas that blows through people's minds, and then turns into scars in the landscape. But how the disease comes from the outside and in is not clear. It circulates through language, images, feelings and through something else that I dont have a word for, something that exists between and among us.[17]

Other examples of paradigmatic shifts in the medical field is the diagnosis "Mad traveller disease"[18] or homosexuality that was considered a mental disorder in the first versions of the DSM. The borders between what is considered normal or not normal expression are constantly being renegotiated and reconstructed. I feel confused, in which level are we constructed by ideas and not of flesh and blood?

6.2 Ways of defining standardization today - the DSM

I highlight one example of manifested normalisation – the DSM document – The Diagnostic and Statistical Manual for Mental Disorders, published by the American Psychiatric Association. A bunch of prominent Psychiatrists publish and establish the diagnoses. The manual is used worldwide. The field of Psychiatry went through a paradigmatic shift from the 1960´s to the 1980´s, from being based on the theories of Freud to a diagnostic Psychiatry. The DSM was published for the first time in 1952, second edition 1968, third 1980, fourth 1994 and the latest edited version in 2000. The latest edition indicates 374 different mental disorders. The early editions did not make sharp distinctions between normal and abnormal behaviour but considered differences as a continuous dimension where more or less normal behaviour is a matter of level. The diagnoses were based on the underlying causes of the behaviour, the mood or other physiological effects. The symptoms were considered culturally signified not as indications of an underlying pathology.[19] The latest edition of the DSM classifies mental diseases and disorders from the symptoms not from possible underlying causes. Sharp lines between what is normal and abnormal are drawn as dichotomies. The understanding of the constitution of the disorders has also changed over time, most of the symptoms are explained by issues within the biological body. The discussion of however mankind is determined by genetics or environmental causes is today highlighting the genetic explanation. The reasons of irregularities or disorders are primary considered to be found within the biological body and not caused by social or other circumstances.

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[17] Hustvedt, Siri; *Vad jag älskade*, page 429, from my own translation; Violet söker fortfarande efter den sjukdom som finns i luften, den Zeitgeist som viskar till sina offer: skrik, svält dig, ät, döda. Hon är på jakt efter de idévindar som blåser genom folks sinnen och sedan blir till ärr i landskapet. Men hur smittan tar sig utifrån och in är inte klart. Den rör sig genom språk, bilder, känslor och genom något annat som jag inte har namn på, något som finns mellan och bland oss.

[18] Mad traveller disease was a mental illness that was born, flourished and died away within the span of about 20 years during the last decades of the 19th century. Albert Dada was the first to be diagnosed, he suffered from a strange compulsion that led him to travel obsessively, without knowing who he was or why he traveled. Further reading: Hacking, Ian; Mad travelers

[19] Pathology means the study and diagnosis of disease. The word *pathology* comes from Ancient Greek πάθος, *pathos* = pain, feeling, suffering

Let us focus on a more up to date disorder-discussion about attention deficit disorders. ADHD (attention deficit hyperactivity disorder) is a term used for out-spoken attention problems, hyperactivity, low activity and/or difficulty to control impulsiveness. DAMP (deficits in attention, motoric control and perception), is a Swedish neuropsychiatric diagnosis, the symptoms are difficulties to concentrate and impaired motoric skills. The diagnosis of DAMP was launched by the psychiatrist Christopher Gillberg. The two wordings are used in paralell. The diagnosis of DAMP is similar to the internationally established concept of ADHD but in a milder form. The diagnosis has been severely criticized in Sweden, mainly from Eva Kärfve, sociologist at the University of Lund and Leif Elinder, pediatrist in Uppsala.[20] Both Kärfve and Elinder argue that DAMP is a socially constructed illness and the causes are not to be found within the individual but is caused by the pressure in the society. They also argue that the condition known as DAMP/ADHD is a normal variation in human behaviour, not something unhealthy, and that society only needs this diagnosis to sort children into categories for the needs of society. Rather than medical treatment these children and adults would need shift of a dysfunctional society. Society needs to adapt to the individuals not the opposite.[21]

The shift of thinking is embedded in the different layers of the disciplines in society. Since the l990´s the focus is on the individual factors when it comes to explanations of disturbing or antisocial behaviour. There is a strong tendency to explain social problems with neuropsychological arguments and with diagnoses like ADHD, Asperger or disorders from the autism spectra for children and young people. As mentioned before the mental health of especially teenagers and young adults has decreased since the early1990´s. Is it possible to find the causes in the society? The disarmament of the Swedish Social welfare system is a discursive change that includes marketisation from public services to private with other ideas of management but also an included idea of explanations of individual pain or problems. The paradigmatic shift since the psychoanalytical era also concerns the treatment of different mental disorders, from psychoanalysis to medicine. Swedish studies (Socialstyrelsen) estimate that 3-5 % of children of school-age meets all the criteria for ADHD, the same amount have mild ADHD-like symptoms. According to National Health Statistics (NHSC 2004) 7,5 % of American schoolchildren or 10 % of the boys and 2% of the girls, have ADHD.[22] The proportion of Swedish school children treated with ADHD drugs increased six times between 2001 and 2007. This is mainly because the treatment has changed. According to Socialstyrelsens Folkhälsorapport 2009 it was twice as common for school children whose parents have only education from primary and secondary school to be treated with ADHD-drugs compared with children of parents with university education. It is also more common for children of single parents to receive such drugs compared with children of cohabiting parents.[23]

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[20] Artikel DN; http://www.dn.se/nyheter/vetenskap/hjarnkampen

[21] Kärfve and Elinder maintains that most of the medical research in this area is based on poor research or manipulated data. Christopher Gillberg was sentenced in June 2005 by the Gothenburg District Court (Kammarrätten) to a daily fine for not having disclosed the source material from his research to Eva Kärfve and Leif Elinder, which for years demanded this with reference to the principle of public access. Gillberg claimed the law of confidentiality/secrecy for the participants in the study. Kärfve and Ellinder never got access to the material because three employees of Gillberg´s had destroyed it. This is not only a battle between individuals, it is also a battle between two scientific/disciplinary cultures. Sociologists are fighting against scientists for the right to describe their perspective of reality.

[22] Brante, Thomas; Den nya psykiatrin: exemplet ADHD ur antologi Hallerstedt, Gunilla (red.); *Diagnosens makt. Om kunskap, pengar och lidande* (2006/2009) Bokförlaget Daidalos AB, Göteborg/Riga, page 79

[23] Socialstyrelsens Folkhälsorapport 2009 http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8495/2009-126-71_200912671.pdf

The DSM indicates signifying symptoms for different mental disorders. There are checklists to use for each disorder. The DSM is to be considered as a classification scheme. What is it that is being categorized and standardised as signifying practices? What is the disorder or the irregulation? In order to answer I will use the DSM checklist for Attention Deficit Disorder: I have chosen to look at the inattention symptoms (you need to score minimum 6 of 9 to rank Attention Deficit)

- often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
- often has difficulty sustaining attention in tasks or play activities
- often does not seem to listen when spoken to directly
- often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (no if oppositional behaviour or doesn't understand instructions)
- often has difficulty organizing tasks and activities
- often avoids, dislikes, or is reluctant to engage in tasks or activities that require sustained mental effort (such as schoolwork or homework)
- often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- often easily distracted by extraneous stimuli
- often forgetful in daily activities

How often is often? There is accompanying checklist to examine if the symptoms are mild, moderate or severe. Many individuals are diagnosed with double or triple diagnoses. A common double diagnosis is ADHD with Asperger. It is hard to understand how a ADHD diagnosis with symptoms of inattention and carelessness can cooperate with an Asperger diagnosis with symptoms of rigidity and control.[24] I cannot help thinking about Douglas´s theories of fixed roles and categorization. (see page 6) Can it be a matter of a categorization issue more than a deeper understanding of the individual?

There are, of course, economical issues of the DSM and medical treatments. Just as depression was treated with Prozac in the 1990´s or Zoloft today, ADHD is treated with medicals like Strattera (atomoxetin) produced by Eli Lilly, Conserta (metylfenidat) produced by Janssen-Cilag or Ritalina (metylfenidat) produced by Novartis. Novartis, Eli Lilly and

[24] The DSM checklist to Asperger:
A. Qualitative impairment in social interaction, as manifested by at least two of the following:
- marked impairment in the use of multiple nonverbal behaviours such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- failure to develop peer relationships appropriate to developmental level
- a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
- lack of social or emotional reciprocity
B. Restricted repetitive and stereotyped patterns of behaviour, interests, and activities, as manifested by at least one of the following:
- encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- apparently inflexible adherence to specific, nonfunctional routines or rituals
- stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupation with parts of objects
C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.
D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).
E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behaviour (other than in social interaction), and curiosity about the environment in childhood.
F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

Janssen-Cilag, as most of the medical producers, support neuropsychiatric research and associations that suggest medical treatment of mental diseases. In Sweden we have one big association for information about ADHD – Riksförbundet Attention. Attention has been supported by several big pharmaceutical companies as Eli Lilly, Pfizer, Janssen-Cilag and Bristol-Mayers Squibb Company but after the impact of critical voices they have denied further support from pharmaceutical companies. Today, Attention is supported by other big companies like Swedbank, Adobe systems and Microsoft. Novartis, as an example, found new ways to meet the recently diagnosed "customers". Among the information that you get from BUP (Barn- och ungdomspsykiatrin) or from the private teams that provide psychosocial assessments, there are shiny catalogues with personal written stories of how life changed to the better taking Novartis drugs. Would the support be the same if the professionals suggested psychotherapy instead of medicine?[25]

The DSM was initiated in an attempt to create a more uniform system within psychiatry. Before the DSM manual was published, arbitrary ways of defining and inventing different diagnoses was more common, different names of the same disease or disorder circulated. The credibility has increased with the DSM as a manual to understand symptoms. The development of the DSM has expanded the definitions of human behaviour in a wast field of behaviours identified as mentally disturbed.[26] How does the DSM checklists reflect the society with its embedded notions of normality? In order to answer how the DSM reflects the society I have used the checklists of symptoms for behaviour, mood or other physiological effects considered abnormal and the report from the Swedish Socialboard (Socialstyrelsen) that detects underlying structures of inequality as a cause for exclusion and illness. The economical, social and political power regimes are revealed in how the medical science is organizing structures in a society and producing the circulation of knowledge. In my point of view the overconfidence and overuse of the DSM is a manifestation of a power regime that is based on an international neoliberal marketisation in society that is including the idea of the individual as an object not a subject.

7. Final discussion

The DSM checklists do not consider the causes or the life around the individual. I believe that the DSM is a very important tool in trying to help people with mental pain. I know that a lot of people are relieved when they get a diagnosis. I criticize the noncritical uses of the DSM and I want to highlight how a discursive thinking and use of a knowledge system has an impact on both individual and collective values. These processes increase institutionalization of values. Values that include notions of right and wrong, good and bad, possibilities for identity and other values of life. In this essay I have tried to give parallel perspectives of what it is to be an individual in a society, what it means to live together and what a manifested normalization-tool can be, in order to put the individual in a context. By letting different voices position the individual in the world, like the voices of Certeau and Österberg that problematize thoughts of living together in socio-material surroundings, like the voice of Douglas that explain the eagerness to define and categorize the world in order to understand or the voice of Foucault that highlight the impact of discursive shifts in paradigmatic thinking in medical science in the past and today, in this weave of perspectives I suggest that mental stress and illness of people has to be critically understood in relationship to the embedded

[25] Riksförbundet Attention http://www.attention-riks.se och Hallerstedt, Gunilla (red.); *Diagnosens makt. Om kunskap, pengar och lidande* (2006/2009) Bokförlaget Daidalos AB, Göteborg/Riga

[26] Some diagnoses seems absurd to me. Is a coffein-related or a nicotin-related disorder a real example of a mental disorder?

notions of knowledge in the society and at the same time be aware of how power and knowledge is connected, constructed, reconstructed and used.

It is a political question – if the origin of mental disorders are to be found within the individual body you can give a damn about the social factors. If the DSM-based diagnoses of mental disorders are to be found in the individual body (caused by biological causes) there are no use for social equality. Does the higher frequency of ADHD diagnosed children in Tensta than in Östermalm make visible a genetic difference?

A huge paradigmatic shift would be needed in terms of self-evaluation of the discursive knowledge production in order to deal with the fact that each discourse is constructed of both acceptable truths and mistakes.

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