

Healthy persons are declared ill in a diagnostic society

by Leif Elinder, MD, pediatrician and school doctor in Uppsala

When cultural handicaps are classed as medical, nothing prevents new diagnoses like “dysfootballia”, e.g. inability to play football, according to pediatrician Leif Elinder. Dyslexia, DAMP, and Asperger’s syndrome are cultural handicaps. By giving each a medical diagnosis, we will make the social structure that contributed to the handicap permanent. There is also a danger that such a diagnosis stigmatizes the children and makes them passive.

Media reports that mental ill-health is increasing among children. Studies show that as much as 20% of the pupils are handicapped in their school environment. More questionable is the statement by medical experts that 100 000–150 000 children, i.e. 10–15% of all Swedish children, have hereditary or perinatal neuropsychiatric deviations, to which the diagnoses DAMP, dyslexia, and Asperger’s now are included [1].

No dyslexia if no written language

Disabilities have many causes, medical as well as social and cultural. Cultural handicaps can be considered as psycho-social deviations that are paid attention to only in certain social or cultural contexts. DDA (dyslexia, DAMP and Asperger’s syndrome) are currently counted to this group. Dyslexia (reading troubles) would not exist in a culture without a written language. DAMP (attention deficiency) would be rare without the schools. Asperger’s syndrome (social disability) would hardly be recognized in a differently structured society [2–7]. Usually there are certain standards to be met for a medical diagnosis, for instance that the diagnosed person experience a disability (as long as he/she is not hurting himself/herself or others) and that most physicians have the same opinion of what is “normal” and “not normal”. Moreover, the causes of the handicap should be thoroughly elucidated and symptoms be differentiated from those of other conditions.

When medical diagnoses are made on cultural handicaps, the standards should be even higher. It is hardly meaningful to make a medical diagnosis of a cultural handicap that affects a large portion of the population (e.g. “moderately” low IQ). Especially not if the handicap can be prevented by simple changes in the environment.

Hereditary disorders are rare. Millions of years of fight for survival have kept the prevalence of hereditary disorders at less than 1/1000 or 1/100.

DDA is a comprehensive concept that describes a large number of conditions with different causes and severity. In such a heterogeneous group it would be unnatural if no single persons were found with “brain damage” or hereditary defects. However, if the number of diagnoses increases far above what is expected for other hereditary disorders, one must ask what other factors beside the inheritance are involved.

Normal distribution of human qualities

Scientific evidence for the existence of hereditary cultural handicaps above a level of 1–2 percent is unknown to me. In a population, there is a normal distribution of human qualities. The average is the most common. High and low values diminish gradually. The average

intelligence (IQ) is 100. Two-thirds of all people have an IQ between 85 and 115. One third are below or above these limits.

Length, weight, ability profile, empathic ability, and so on are distributed in the same way. Thus 1/3 of the population has a “normally” uneven ability profile. It is reasonable to presume that our social (empathic) ability—i.e. the ability to understand how others think—is linked to our ability profile. One’s own shortcomings/strengths are easily recognized by one’s fellows. People from foreign cultures are more difficult to understand. The ability profile and experiences are too different. Thus persons with an uneven ability profile (Asperger’s syndrome) have difficulties in understanding persons with an even ability profile and vice versa. What is right and wrong, normal and not normal, is arbitrary in the sense that it is determined by the majority—i.e. “the average person”.

Not only the ability profile, but also the biological maturity is normally distributed. Thus it is “normal” that some children (boys) develop more slowly. During a period of their life they are clumsier than other children, the point of optimal learning displaced and adolescence delayed. Children that are lagging behind biologically and have an uneven ability profile are more sensitive to environmental stress.

In an intolerant society this unevenness (imbalance) is further deepened. The exchange of experiences becomes limited and the personal development hampered. The foundation of lacking self-confidence and DDA is laid.

Advantages and disadvantages with medical diagnostic

Everyone agrees about the importance of helping children with DDA-similar difficulties. However, it is not obvious that the medical diagnoses in the long run benefit them the most. Medical diagnosis has both advantages and disadvantages.

Advantages are the family getting a concrete, concise, and easily-understood explanation of the child’s problem. Feelings of guilt are alleviated, and the diagnosis is the basis required by society for support in the form of remedial teaching, personal assistant, allowance, etc.

Disadvantages are the social structures that contributed to the handicap becoming permanent as a result of the diagnosis. The blame/cause is put on the individual. The pupil is singled out as not normal and preventive environmental changes could be delayed. Moreover, there is a risk that the diagnosis makes the pupil more passive. The pupil gets the impression that the handicap is “congenital” and that nothing can be done about it. There is also a risk that the diagnosis stigmatizes the pupil in a way that can be significant for military service, future work, life insurance, etc.

The alternative to a medical diagnosis of cultural handicaps would be a social-educational description. This could be more fair and less “risky” than a medical/neuro-psychiatric diagnosis. A social-educational description would include usual DDA-problems such as (1) specific learning disabilities, (2) uneven ability profile, (3) biological development delay, and (4) damaged self-confidence.

Dysfootballia and dysinternetia

Many societies maintain their structure by transforming collective reasons for discontentment into personal problems. By stressing that the deviation lies with the individual, the society is avoiding a critical scrutiny of its own organization and with that also meaningful changes. When cultural handicaps are classified as medical handicaps, there is nothing to prevent forming new diagnoses like “dysfootballia”, an inability to play football (a neuro-orthopedic

disability), “dysinternetia”, the inability of the middle-aged to understand the Internet (a neuro-geriatric disability), “dyspiania”, the inability to learn to play piano (a neuro-musical disability), and others.

Unconsciously and relentlessly we lay the foundations of “the therapeutic society”, a society where medicine has made such astounding advances that practically no single healthy persons remain. A wholly-sound person would instead indicate lacking diagnostic thoroughness.

Furthermore the therapeutic society is a society that deprives the parents their functional responsibility for the children by transferring them to institutions (daycare/school/hospital), a society where the “not quite normal” citizen must report himself as a client in need of help. Not until a medical diagnosis has been established can the client be taken care of—leniently and cordially—by bureaucrats, doctors, therapists, and psychologists.

Stand up for our right to be different

In a society there is a constant fight about how our development should be viewed—between a biologically-oriented and a humanistic model. Looking in the rear view mirror, there have been tremendous changes in the outlooks, between thesis and antithesis, depending on the spirit of the time, what is popular and politically expedient. At the moment a narrow medical model rules. A sociological perspective would allow for a more open debate about the structural imperfections of our society and make way for a society that is preventing disabilities, instead of medically diagnosing them.

Medical diagnoses are indeed needed. Society must however stand up for our right to be different without a medical diagnosis and still get suitable support on the way.

REFERENCES

- [1] Ekman S, Gillberg C: “Skolan knäcker 120.000 barn” [School ruins 120 000 children], *Dagens Nyheter*, 20 March 1997: A4–A5.
- [2] Stanovich K E: “Does dyslexia exist?”, *J Child Psychol Psychiatry*, 1994; 35: 579–95.
- [3] Larsen S: “Läsforskningen har gått vilse” [Reading research is lost], *Pedagogiska Magasinet*, 1996; 3: 48–52.
- [4] Knutar I, Johnsen B: “Dyslexiprojektet vid foniatriiska avdelningen” [The dyslexia project at the Phoniatics Department], Uppsala Academic Hospital (unpublished), 1995.
- [5] Shaywitz B A: “Defining and classifying learning disabilities and ADHD disorder”, *J Child Neurol*, 1995; 10: 50–7.
- [6] Gustafsson P: “Från MBID till ADHD” [From MBD to ADHD], *Läkartidningen*, 1993; 90: 2979–82.
- [7] Bågenholm A: “Diagnos i spartid stort expertansvar” [Diagnosis at a time when there are pecuniary shortcomings implies a great responsibility for the expert], *Psykologtidningen*, 1996; 1: 24–5.

Läkartidningen 40: 3391–3393 (1997)