The medicalisation of compulsions through diagnosis incites four transformations of experiential knowledge that steer away from asking certain questions, recognising certain instances as (un)problematic, and shaping certain expectations for one’s life and living situation.

**Transformation 1: Pathologisation**

Neuropsychiatric scientific rationalisations of compulsive realties involve clinical diagnosis and start at the point that compulsions are seen as problematic that professional help is required to cope with them. For many people, this renders them an important – if not the most important – framework of understanding when they are diagnosed with TS. As 'Joe' puts it: “it had it my entire life of course, but officially I know it for only four years.” In lieu of failing to find sufficient answers to their compulsive experiences and the desperation that accompanies it, this new formal rendition offers a persuasive new understanding that could dissolve many confusions, or at least bring (partial) answers.

The diagnosis changes individuals having to take responsibility for their compulsive bodily movements to the admission that there was a problem in their body, thereby shifting the location of the problem away from themselves, and onto their diagnosed body, and/or Tourette’s (Schoenfeld and Sandle 2012, Bervoets forthcoming, Bervoets and Beljaars, in review). This transforms compulsivity as confusions (why do I perform this act?) to a problem of the individual (‘something is wrong with me’) and to a biological problem of their brain (‘my brain is faulty’). Nonetheless, the focus of the diagnosis on the individual does help to sift confusions rooted in questions about the self and one’s desires.

**Transformation 2: Biologisation and neuroscientific logic**

Another transformation entails the biologisation of the compulsive interactions as arising from a malfunctioning brain and the distorted processes that make up the nervous system. Compulsivity becomes a neurocognitive, endophenotypic, “whereby changes in behavioural or cognitive processes are associated with discrete deficits in defined neural systems” (Robbins et al. 2012: 81). Put simply, what bodies do is a direct expression of the functionality of the brain, so neuroscientific logic holds that if people do things that are considered abnormal, there must be something wrong with their brain. This logic reflects a conceptualisation of the problem fundamentally as a deficit.

The biologisation of compulsions and compulsive processes that preceed the acts are then positioned as whole explanation of the phenomenon or as partial explanation that fit the gaps that are left by the incomplete sense-making exercises. The focus on inhibition suggests that acts can be good or bad, and that therefore the problem is just a lack of neurocognitive-mechanical processes in the brain. This creates a reality that takes away the need to ask questions about this act, because it effectively shifts the focus to how any compulsion happens in the first place because it is a manifestation of a problem.

**Transformation 3: Erasure of performative difference**

The pathologisation and biologisation of compulsivity that analytically situates the brain and further nervous system as the sole causal focal point, leads to compulsive bodily movements being understood as effects of a brain problem. Their rendition as ‘symptom’ is considered more important than the intricacies of the compulsions themselves. A notable exception to this is phenotype studies that understand offerings in the descriptive mode but not as an analytically one.

Asking Tourettic people to primarily note frequency and severity and accept them as idiosyncratic more of less lifts the confusion as there seem to be no answers. However, it produces anxieties around what movements count as tics, as it led ‘Lowri’ to closely examine all her movements, habits, routines, rituals, and preferences that she could not quite explain, and consequently feeling ashamed for “not knowing” that a particular movement she used to do “was a tic”. In effect, the clinical rendition of her movements made her question her knowledge of her body as gathered throughout her life. Hence, the de-individuation transformation of compulsive interactions thus cannot help explain why this compulsion takes place here, now, and with this pattern. Therefore, we remain with very little insight into how specific kinds of compulsive acts come about and what differential effects they have on further life.

**Transformation 4: Erasure of circumstances**

Compulsions and tics are also deemed to be ‘waxing and waning’, which alludes to both the kind and temporal variations of compulsions in a given period. Situational variations in the clinical sciences have served to acknowledge how social worlds and activities have salience (Cohen and Leckman 1992, Conelea and Woods 2008, Woods et al. 2008, Cavanna and Nani 2013). However, the natural scientific pursuit of universal truths prevents the analysis of these circumstantial relations in all their complexity. Indeed, circumstances of compulsions are largely encouraged to be understood in quantitative psychological measures (e.g. stress), as physical activity only (Jackson et al., 2020), or through vague description (e.g. “spending time with friends”) (Christenson et al. 1993, Silva et al. 1995, Miltenberg et al. 1998), and not by thorough examination of compulsive situations in spatial socio-material terms. Reflecting their marginal presence in TS research, more complex and nuanced inquiries of how situated compulsions remain unaddressed in evaluations of clinical interventions.

This transforms TS compulsivity into a sole matter of inhibition and personal control over the body, regardless of the circumstances (see Hollenbeck 2003) and in which the surroundings are narrowly cast as function of such control.

**Results / Moving forward**

To a certain extent, the four knowledge transformations about compulsive interactions are helpful for Tourettic people through the depersonalisation that diagnostics grants. However, these transformations do not provide complete answers to people’s own experiences and conceptions examined on its potential to create the foundations of a new kind of therapeutic engagement. Considering Tourettic people as having particular sensibilities that to a certain extent are shared by a broader group, there is a need for a more sophisticated conceptualisation of wellbeing beyond pathology. This book ends with an exploration of politico-ethical questions that this conjoins. As such, this book suggests what a new wave of patient emancipation in biomedical and clinical research may look like, to raise renewed considerations of what empathetic, context-sensitive care may look like in the 21st century.

**Conclusions / Remainder of the book**

The book continues to develop a theory that highlights the intricate patterns with which the bodily surroundings mediate and, in turn, are mediated by compulsive interactions. What follows is a sophisticatedly balanced ecologies of just-rightness and situated wellbeing, which is examined on its potential to create the foundations of a new kind of therapeutic engagement. Considering Tourettic people as having particular sensibilities that to a certain extent are shared by a broader group, there is a need for a more sophisticated conceptualisation of wellbeing beyond pathology. This book ends with an exploration of politico-ethical questions that this conjoins. As such, this book suggests what a new wave of patient emancipation in biomedical and clinical research may look like, to raise renewed considerations of what empathetic, context-sensitive care may look like in the 21st century.