MEDICALIZING CHILDREN AND ADOLESCENTS

MEDICALIZANDO CRIANÇAS E ADOLESCENTES

MEDICALIZAR A LOS NIÑOS Y ADOLESCENTES

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ABSTRACT: The medicalization is a progressive phenomenon characteristic of contemporary society. The purpose of this article is to critically analyze the foundations of the disease model based on the biomedical perspective that justifies diagnosing and treating children's behaviors with psychiatric drugs, understanding them as mental illnesses. At the center of the justification for the medicalization of children's behavior is the idea that drugs (psychopharmaceuticals) will correct an underlying biological, brain abnormality. However, the medicalization of childhood lacks sufficient scientific evidence and works as a strategy for social control and normalization. The term 'mental disorder' is used to designate people who do not behave in the expected way or when they do not conform to social norms. It is the expression of social control disguised as medical treatment. The negative consequences of medicalization constitute strong threats to public health, culture, and human rights.

KEYWORDS: Medicalization. Children. Adolescence. Childhood behaviors.

RESUMO*: A medicalização é um fenômeno global, progressivo, característico da sociedade contemporânea. A proposta deste artigo consiste em analisar criticamente os fundamentos do modelo de doença baseado na perspectiva biomédica que justifica diagnosticar e tratar com drogas psiquiátricas os comportamentos infantis, compreendendo-os enquanto doenças mentais. No centro da justificativa da medicalização dos comportamentos infantis se estabelece a ideia de que as drogas (psicofármacos) irão corrigir uma anormalidade biológica, cerebral, subjacente. Contudo, a medicalização da infância prescinde de evidências científicas suficientes e funciona como estratégia de controle e de normalização sociais. A nomenclatura 'transtorno mental' é utilizada para designar pessoas que não se comportam da forma esperada ou quando não se conformam com as normas sociais. Trata-se da expressão do controle social disfarçado de tratamento médico. As consequências da medicalização constituem fortes ameaças para a saúde pública, a cultura e os próprios Direitos Humanos.*

PALAVRAS-CHAVE*: Medicalização. Crianças. Adolescência. Comportamentos infantis.*

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***RESUMEN**: La medicalización es un fenómeno global y progresivo, característico de la sociedad contemporánea. El propósito de este artículo es analizar críticamente los fundamentos del modelo de enfermedad basado en la perspectiva biomédica que justifica el diagnóstico y el tratamiento de las conductas infantiles con fármacos psiquiátricos, entendiéndolas como enfermedades mentales. En el centro de la justificación de la medicalización de los comportamientos de los niños se encuentra la idea de que los fármacos (psicofármacos) corregirán una anomalía biológica, cerebral, subyacente. Sin embargo, la medicalización de la infancia carece de pruebas científicas suficientes y funciona como una estrategia de control y normalización social. La denominación "trastorno mental" se utiliza para referirse a las personas que no se comportan como se espera o cuando no se ajustan a las normas sociales. Es la expresión del control social disfrazado de tratamiento médico. Las consecuencias de la medicalización constituyen fuertes amenazas para la salud pública, la cultura y los propios derechos humanos.*

***PALABRAS CLAVE**: Medicalización. Niños. Adolescencia.* Comportamientos infantiles.

Introduction: Something scary is going on

> *Many refuse to entertain the idea that society as a whole may be lacking in sanity. They maintain that the problem of mental health in a society is only the number of 'non-adjusted' individuals, and not a possible maladjustment of the culture itself (Erich Fromm, 2017, p. 252, our translation).*

'Scary' things have not been said. Wars continue to occur, threats of destruction of the planet grow, as well as the astonishing increase in social and economic inequalities with the pandemic situation in place. But there is another aspect whose dimension has been underestimated: the way in which contemporary society tracks, produces, identifies and treats mental illness in childhood and adolescence. This fact is so frequent that it becomes rare to find a 'normal' child or teenager. So, does being normal mean having some kind of mental disorder and being framed in diagnostic categories in psychiatric manuals? What would be the current conception of normality?

According to Allen Frances (2017), head psychiatrist of the team that produced the fourth edition of the DSM (APA, 2000), considered as the 'bible of psychiatry', it is possible that "the pool of normality is shrinking to a mere puddle" (FRANCES, 2017, p. 3, our translation).

An avalanche of technologies promises to identify genetic determinants of psychiatric conditions. Promise constantly delayed for decades. Clinical manifestations are grouped and then divided into subgroups. Brain and even chromosomal regions are defined, and the genome and its variations are attempted to be deciphered. However, the current situation of this type of research shows that the screening of the genetic code further fragments the explanations

(ANSERMET; GIACOBINO, 2012). Thus, genetic research is convened with the hope of isolating a biological rather than a psychic causal factor, but the advances in genetics lead to multifactorial heterogeneity.

Let's look closely at these frames:

> A recent analysis of data from the 2016 National Survey of Child Health, published online in JAMA Pediatrics, indicated that one in six children in the United States ages 6 to 17 has a mental disorder, such as depression, anxiety problems, or an attention deficit/hyperactivity disorder – ADHD (WHITNEY; PETERSON, 2019, p. 389, our translation).
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> The pandemic lit the alert in parents all over Brazil. In the second episode of the series, you will understand that ADHD is much more intense than the occasional bout of boredom. Intense and frequent, it affects one in 20 children. And it is in the school day, among the students, that the disorder becomes more evident (TDAH, 2021, [n.d.], our translation).

From these situations, it is possible to observe the increasing chances of children and adolescents having mental illness. Because? Compared to a relatively recent past, what's different? Are we bringing more vulnerable beings into the world than in the past? Has the environment and society been deteriorating, to the point of making children and adolescents more and more sick? Or has it always been that way, but that today we have better means to identify mental health problems? Many questions are unanswered, despite the great efforts of biological psychiatry and neurosciences to produce answers.

There is an undeniable fact: medicalization has become part of everyday life in a perverse and tyrannical way (SZASZ, 2001; MOYNIHAN; HEATH; HENRY, 2002). Through various means of communication, we are informed every day about what was considered normal, but which, in fact, are symptoms of pathologies or signs of risk.

Taking this perspective, absolutely nothing can be neglected that is behind the tendency to be distracted, idle, agitated, impulsive, messy, grumpy, irritated, aggressive, silent, or even to manifest inconvenient, uncomfortable or unexpected behaviors. It is increasingly conveyed, through the media and social networks, that these behaviors can be symptoms of mental illness or disorders.

To resolve this doubt, it is recommended that you seek a doctor as soon as possible, preferably a psychiatrist, if not a psychologist. However, on the Internet, questionnaires, assessments and tables, designed to detect a supposed self-diagnosis, are also available in accessible language for lay people.

In addition, a multitude of professionals exhaustively sell their expertise on social networks. So, if the problem is due to attention deficit hyperactivity disorder, depression, eating

disorder, autism, anxiety (and so on), a wide network of services is readily structured to serve the consumer diagnostics market.

As with diseases in general, it is assumed that the earlier psychiatric disorders are identified, treated and dealt with, the better the prognosis. For this reason, the important thing would be to overcome prejudice in relation to mental illnesses, since a psychiatric disorder is a disease like any other. Thus, it starts from premises that are not consistent with the reality of the facts.

And what's 'scary' about it? At the very least, since psychiatric disorder is a disease like any other, what can be frightening is the fact that we do not have a solid health system capable of welcoming and treating all these demands with quality. Furthermore, what is 'scary'?

Many researchers claim that there is something being developed today that could completely change the future of humanity. The root of these promises lies in the changes produced by biotechnologies, which, over time, may be irreversible (NICOLELIS, 2020; WHO EUROPE, 2004). These promises and 'advances' need to be carefully analyzed, as they produce effects on the social imaginary, on culture and often do not correspond to reality.

It is worth asking what the respective roles of biological, psychological, cultural, educational-pedagogical, social and economic processes in the development of the so-called psychiatric disorders are.

In an effort to transcend mind-body dualism in medicine, in the late 60's and 70's a biopsychosocial approach was developed by George Engel. Engel (1977, p. 131, our translation) criticized the reductionism of the biomedical model and argued that “the inclusion of psychosocial factors is indispensable”, in order to be able to account for phenomena such as patients' life experiences. The effects of living conditions on the development and course of the disease, the effect of the doctor-patient relationship on treatment outcomes, continue to be essential variables to consider. The need for an authentically biopsychosocial approach continues to challenge us.

Therefore, the purpose of this article is to carry out a critical analysis of the phenomenon of medicalization of childhood and adolescence, as well as its consequences. First, a presentation will be made of what is meant by 'medicalization'. Then, the fundamental dyad will be critically addressed, the two pillars that support the biomedical model of psychiatry: psychiatric diagnosis and drug treatment (DEACON, 2013). Finally, we observe the negative consequences of medicalization as threats to Public Health, culture and Human Rights themselves.

Medicalization of childhood and adolescence

In general terms, medicalization' consists of the process of incorporating phenomena that had other explanations in the field of health, specifically medicine. Immediately, this process is characteristic of the expansion of medicine into other fields.

Medicalization refers to the expansion of the jurisdiction of medicine to fields that are not medical or that were not medical, with living itself being captured by this discourse. The discourses and practices of medicine began to penetrate the social fabric, shaping both individuals and society itself. The power of medicine operates as a force that produces realities, creates practices and discourses that engender forms of care and ways for individuals to understand, regulate and experience their bodies and their feelings. We think of medicalization as a process of biomedicine intervention through the redefinition of experiences and behaviors as if they were medical problems.

Embora seja um processo característico da própria medicina, as disciplinas 'psi' que integram o campo da saúde tendem a seguir a mesma lógica (HELMAN, 2004), com raras exceções. Como é o caso da psicanálise criada por Freud (1976), que originalmente construiu um campo epistemológico muito próprio e alternativo à lógica do modelo biomédico. Ele propôs uma reflexão ética, política e cultural anti-hegemônica.

Historically, countless physical, emotional and social conditions and behaviors have passed into the domain of health, medicine, and the care of professionals (FREITAS; AMARANTE, 2017).

According to psychoanalyst Christian Dunker (2020), the grammar of suffering has changed in contemporary society, as has diagnostic grammar. Every culture, every era and every family has its own way of dealing with and recognizing which suffering deserves attention and which should be 'swallowed' as part of life or acceptance of the inescapable tasks of existence. The grammars of suffering are multiple and there is a certain political conflict for their management, to decide which one will become prevalent at each moment, including with the corresponding affection.

Among these different policies for suffering, there are some with which it is difficult to agree, for example, the one that states that all suffering is a symptom and that every symptom must be cured or treated, usually by a specialist or by a set of procedures. Primarily drug treatments, performed in a chronic way, without diagnostic review, with very low patient participation and without reserving any space for the word, for the interpretation or subjective work that someone has in relation to themselves (DUNKER, 2020).

Discourses and medicalizing practices usually claim scientific support to give them legitimacy. The tendency is nothing to escape, as new conditions are systematically incorporated into this progressively expanded field, such as gender issues (PARKER; BARBOSA; AGGLETON, 2000), female bodies (OFFMAN; KLEINPLATZ, 2004; SHAW, 2013), masculinity (MARSHALL, 2006; ROSENFELD; FAIRCLOTH, 2006), schooling, birth, pregnancy, death, or even fertility and its vicissitudes (BELL, 2016), among others.

Medicalization engenders subjectivities, even being part of intersubjective relationships, of the economy, politics, legal system, social security system, and so on (SZASZ, 2001). The association between medicalization, commercialization of diagnoses and the provision of services and treatments needs to be analyzed in order to build new reading lenses.

The production of the sick social role

In order for there to be patients, it is essential that the social construction of their role and place in society be carried out. The characteristics of the subject affected by ADHD, for example, have been historically constructed. Therefore, it is important to make a comparative reading between the different editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), from the first edition to the current one (MARTINHAGO; CAPONI, 2019; KIRK; KUTCHINS, 2008)

The behaviors that make up this diagnostic category are: inattention, hyperactivity and impulsivity (AMERICAN PSYCHIATRIC ASSOCIATION, 2014). However, if we trace the history, we observe many other ways of dealing with these behaviors.

According to a reading of signs and symptoms, such behaviors cannot be understood from new ways of educating or as a product of interpersonal relationships, difficulties in the family network, frustrations, precarious socioeconomic conditions, insecurities, but they are understood as brain disorders that quickly become the object of intervention of mental health professionals, hyper-specialized in detecting traces of pathologies, with fixed protocols established to deal with each prism of the disease. The plurality of explanations about children's behavior was undermined.

Biology (and its operators) has become the primordial device of contemporary psychopathology, basing currents of thought that claim to be atheoretical because they are grounded in naturalistic ethics. These currents reduce subjectivity to cognition and have a menu of therapies and protocols aimed at treating every nuance of the categories described in psychiatric manuals.

Neurosciences provided the instruments that guide the construction of the hegemonic psychiatric explanation. From this point of view, psychopathology claims to have finally found its scientificity in fact and in law. Its scientific status would finally have been achieved. Furthermore, the new psychopathology believes that it has found its medical vocation, in a process that began in the early 19th century and was based on biological discourse (BIRMAN, 1999). Certainty and truth seem to reside in the biological response. It is with this contemporary fiction that we have to deal.

In this hermetic perspective, it is worth asking what the place of psychic suffering is, of the singular and of the subject. At what point does 'normal' suffering become 'pathological'? Would there be space designated for discomfort or for what is not going well?

The collective matrix of suffering is rejected, giving way to the individual imperative of happiness and performance. If we live under the imperative of well-being/happiness, and if not being well is not 'normal', how do we deal with the inclement weather of life? If we do not correspond to this fantastic script of happiness, the biological and medicalizing response buffers any possibility of subjective questioning, immediately transforming suffering into pathology.

The same is true for children and adolescents. Based on symptom screening – the frequency with which the patient: does not pay attention to details or makes careless mistakes in schoolwork, at work or during other activities; has difficulty maintaining attention in tasks or play activities; he does not seem to listen when someone speaks to him directly; does not follow through on instructions and fails to complete schoolwork, chores, or duties; has difficulty organizing tasks and activities; avoids, dislikes, or is reluctant to engage in tasks that require prolonged mental effort; loses things necessary for tasks or activities; distracted by external stimuli – they are understood in terms of psychiatric disorders, based on characteristics that make up a certain nosological category.

Psychiatric diagnosis is termed, in anthropology, the 'ritual of initiation' into a new social status, when new authorities and practices can exercise power where they previously had no jurisdiction, and where a new history of the person is written to legitimize this (DE CASTRO CAVALCANTI, 2020). Therefore, if there is a patient, it is necessary to have qualified professionals to assist him. A new market is created and we can see the commodification of the diagnosis.

The social construction of mental health professionals and the commodification of the service network

Whether preparing them through specialized training, or also accrediting those who have the necessary skills or not, or even inculcating in society the need to resort to these hyper-specialized professionals, for example, in ADHD, the need to train professionals with specific qualifications, to detect, treat ADHD and convince parents, teachers, children and adolescents themselves of the need to seek treatment as soon as possible (REED, 2007).

One cannot lose sight of the fact that, for decades, Lasch (1983) had already warned about the proliferation of psychiatric medical advice that undermined the trust of parents, at the same time that they fostered an exaggerated notion of the importance of child upbringing techniques and parental responsibility for their failure. Lasch (1983) pointed out that, as the family has lost not only its productive functions, but also many of its reproductive functions, men and women are no longer able to raise their children without the help of guaranteed specialists. The transformations of these old ties of dependence had a reverse, a lesser autonomy of the family in relation to the care of its members vis-à-vis the representatives of the State, doctors, psychologists, teachers etc. (SINGLY, 2007).

In this way, the family socioeconomic context of children and adolescents starts to be evaluated through generalist biological markers, which raise more questions than answers. The once tolerated aggressive impulses, as well as the undesirable behaviors that were part of the infantile universe, entered the psychiatric universe. These behaviors would represent risk indicators for serious mental illness in adult life and, therefore, need to be excised with medicated forceps.

In a medicine captured by the logic of the market (which is not restricted to medicine, as it spills over into psychology, pedagogy and related areas), there is no space for welcoming people in suffering, however, there is an incessant attempt to soften the helplessness through the medicalization of symptoms. Despite the excessive technicality, specialisms and apparent competence to assess and diagnose pathologies, there is an increasing presence in the market of professionals with controversial and deficient training.

Social control and the loss of the subject's autonomy

Another important component of medicalization is social control. Historically, medicalization has replaced traditional forms of social control and the normalization of social space, replacing or relativizing the power of religion and law (ZOLA, 1972). The boundaries

between the normal and the pathological are systematically broken (CONRAD; SCHNEIDER, 1992).

When a child referred to the doctor (or specialist) returns to school with a diagnosis, there is a change in the way of dealing with him. It seems that the diagnosis itself confers a kind of understanding that was absent, unknown. A network of professionals and services capable of treating that diagnosis is quickly structured. However, the diagnosis imprisons, tames and immobilizes the moving reality, often incurring in classificatory violence.

Thinking about the child diagnosed with ADHD, society less and less tolerates punishments, or, for example, sending a child to a boarding school to educate a very ‘naughty’ child. With ADHD, the problems are not addressed in educational terms per se, but as a pathology. The social control of children has become much more important to our culture than educating and caring for them (TIMIMI, 2009; UNTOIGLICH, 2019). There is the loss of the subjects' autonomy, another very relevant aspect for the study of medicalization.

Medicalization removes from subjects their ability to know how to deal with the vicissitudes of life, with everyday problems (ILLICH, 1976). This biological rationality fits as a response to the imperatives of neoliberalism reproduction, for the unlimited creation of new goods to circulate in the consumer goods market (TIMIMI, 2008). Therefore, the psychic geography of the neoliberal subject bears the marks of the medicalization of life.

According to McKinnon (2021), in the book *Genética neoliberal*, the rise of biological and genetic discourse is congruent with the rise of neoliberalism, since neoliberalism has developed a kind of global policy to manage human suffering.

So why are people getting sick?

What's the answer? As far as we know, taking the scientific literature as a reference, there is no simple, single answer or linear causality.

Immediately, the market generated by psychiatric disorders in childhood and adolescence grows rapidly, systematically encouraged by the alliance between medical corporations and the pharmaceutical industry (WHITAKER; COSGROVE, 2015). The recommendations that arrive are: seek to track psychiatric disorders in increasingly younger children (MAYO CLINIC, 2022; ABENEPI, 2018).

The selling idea is that this is due to the spectacular scientific advances that have made possible the discovery of psychiatric illnesses and diagnoses. The euphemism refers to the breakthroughs by scientists and physicians that illuminate some of the darkest mysteries about

the human mind and bring hope for treatments to alleviate (or even cure) the suffering of millions of children and families.

Despite having so much widespread propaganda, the reality is configured differently. Either because the existing psychiatric diagnoses lack solid scientific bases, or because the dominant treatment is through medication, with disastrous results in most cases. In fact, there is a spectacular failure to find any reproducible evidence that conditions such as ADHD, or Autism Spectrum Disorder, or childhood depression are the result solely of genetic, biochemical, or other localized brain or genome abnormalities.

This fact has been admitted by prominent personalities in the international psychiatric field, as admitted by Dr. Thomas Insel, director of the NIMH for thirteen years (INSEL, 2022), if not by the head of the team that produced the DSM-IV, Dr. Allen Frances (COCHRANE AUSTRALIA, 2022).

Despite the colossal investment to discover the biological causes of psychiatric conditions, there is abundant evidence of social determinants in so-called disorders. (BERESFORD *et al.* 2016; READ *et al.* 2013; COHEN, 2016; SMAIL, 2005).

Structural changes in the context of childhood and adolescence: the context of increasing medicalization

The space of childhood has changed in contemporary Western culture. We cannot think about childhood and adolescence without taking into account the civilizing process that builds what it is to be a child, adolescent, youth, adult, elderly person. Being a child or teenager today is not the same as it was a few decades ago, at the beginning of the 20th century or at the beginning of modernity (ARIÈS, 1978).

The excessively biological approach reduces the "bio-psycho-social" to "bio-bio-bio" (READ, 2005). More and more prominent psychiatrists are speaking out against the corrupting role of pharmaceutical companies and the simplistic model they promote to sell their products. In 2005, Dr. Steven Sharfstein, then President of the American Psychiatric Association (APA), wrote:

> If we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession will be compromised. In approaching these Big Pharma questions we must examine the fact that as a profession we have allowed the bio-psycho-social model to become the bio-bio-bio model. (SHARFSTEIN, 2005, [n.d.], our translation).

More recently, criticism of the biomedical model of psychiatry has been made by no less than the United Nations. The Doctor Dainius Pūras, Lithuanian psychiatrist, United Nations rapporteur, wrote:

> Current mental health policies have been largely affected by power asymmetry and biases due to the dominance of the biomedical model and biomedical interventions. This model has led not only to the excessive use of coercion in the case of psychosocial, intellectual, and cognitive impairments, but also to the medicalization of normal reactions to the many pressures of life, including mild forms of social anxiety, sadness, shyness, absenteeism, and antisocial behavior (...) This message can promote the overuse of diagnostic categories and expand the medical model for diagnosing pathologies and providing individual treatment modalities that lead to excessive medicalization. The message diverts policy and practice from embracing two powerful modern approaches: a public health approach and a human rights-based approach… Excessive medicalization is especially harmful to children, and global trends to medicalize complex psychosocial and public health issues in childhood must be addressed more strongly with a political will (HUMAN RIGHTS COUNCIL OF UNITED NATIONS, 2019, our translation).

On 10 June 2021, the World Health Organization (WHO) joined this worldwide call for overcoming the biomedical model of psychiatry, with a 300-page document entitled *Guidance on community mental health services: Promoting person-centred and rights-based approaches* (WORLD HEALTH ORGANIZATION, 2021). The document states:

> The predominant focus of care in many settings continues to be diagnosis, medication and symptom reduction. Critical social determinants that affect people's mental health, such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, lack of access to housing, social safety nets and health services, are often neglected or excluded from mental health concepts and practices. This leads to an exaggerated diagnosis of human suffering and an excessive dependence on psychotropic drugs, to the detriment of psychosocial interventions (...) A fundamental change is needed within the field of mental health in order to put an end to the current situation. This means rethinking policies, laws, systems, services and practices in the different sectors that negatively affect people with mental health conditions and psychosocial disabilities, ensuring that human rights underpin all actions in the field of mental health. In the specific context of mental health services, this means a move towards more balanced, person-centred, recovery-oriented practices that consider people in the context of their lives as a whole, respecting their will and preferences in treatment, implementing alternatives to coercion, and promoting people's right to community participation and inclusion (WORLD HEALTH ORGANIZATION, 2021, p. 20, our translation).

The medicalization of childhood and adolescence in the context of neoliberal society

The growth of child psychiatric medicalization is contemporary with important psychosocial changes in the context of childhood and adolescence. We often observe the medicalization of family relationships and generational tensions.

In a schematic way, here is an overview of some of the main changes in contemporary family structure:

> Family structure – disappearance of the extended family, increase in separations and divorces, increase in parental working hours, decrease in time spent by parents with children (BOUNDLESS SOCIOLOGY, 2022). Parenting is now defined not only by biology, but by socio-affective and civil factors, being increasingly determined by the social that acts through specialists. The social models the relationship between parents and children mediated by the action of health professionals, educators and representatives of the law, figures of the social third part.
> Family style – increased mobility, loss of community roots, increased quest for individual gratification. The democratization of the private sphere is currently the order of the day (BOUNDLESS SOCIOLOGY, 2022). It is worth noting, according to Giddens (1993), the importance of democracy in this contemporary family style. Democracy means that the opportunity for the strength of the best argument to be preponderant, as opposed to other ways of making decisions. In contemporary times, the democratization of family life has taken place.
> Children's style – decline in the amount of physical activity, changes in diet with increases in sugars and fat and decreases in essential vitamins, minerals and fatty acids, childhood 'domestication' due to fears, health and safety risks that result in seeking activities at home, such as using computer, TV and tablets (BOUNDLESS SOCIOLOGY, 2022).
> Childhood marketing – increased consumption of goods for children and the creation of new commercial opportunities in childhood, for example in the food, care industry and pharmaceutical industry (BOUNDLESS SOCIOLOGY, 2022).
> Educational system – strong emphasis on academic performance, productivity and competition. Jerusalynsky (2018) claims that there is a growing demand for professionals in the 'psi' field by the school, whose complaints gravitate around depression, lack of motivation, intolerance and even virtual lynchings.

If we turn our attention to what has been happening with Brazilian children in recent years, the reality is too shocking:

- The number of children aged six and seven in Brazil who cannot read and write grew by 66.3% from 2019 to 2021 – explaining one of the effects of the COVID-19 pandemic on Brazilian education. According to data from the NGO *Todos pela Educação*, 2.4 million Brazilian children are not literate in this age group. The number corresponds to almost half (40.8%) of children in this age group. (CNN BRAZIL, 2022).
- Of every four public schools in the city of Rio de Janeiro, three suffer from shootings nearby (CRUZ; GRINBERG; PERELLÓ, 2022). Rio de Janeiro, one of the main tourist postcards in Brazil, is a frequent scene of clashes between rival drug-trafficking factions or with the police, especially in Rio's favelas.
- Violence and helplessness, as well as the multiple transformations of contemporaneity, explain the complexity that gravitates around children's behaviors, since these are not limited to the biological paradigm.

The question of narcissism

Another major psychosocial determinant refers to a culture that is anchored in narcissism. According to Lasch (1983), medicine and psychiatry reinforce the pattern created by cultural influences, in which the individual examines himself interminably looking for signs of old age and illness, for symptoms that indicate psychic tension, for stains or imperfections that may diminish your attraction, or to confirm indications that your life is going according to the scheme. Thus, contemporary medicine has created new ways of producing insecurity, on the other hand, narcissism seems to represent the best way to fight for equality of conditions with the tensions and anxieties of life. As a result, social conditions tend to bring out the narcissistic traits present, to varying degrees, in all of us. The belief that a society has no future, while based on a certain realism about the dangers of becoming, also embodies a narcissistic inability to identify with posterity or to feel part of the flow of history.

The ideology of personal growth, superficially optimistic, radiates a deep despair and resignation, according to Lasch (1983, p. 78, our translation): "It is the faith of those who have no faith".

For Birman (2019), there was a historical emergence of narcissism as a problem and as a contemporary field. Therefore, it is necessary to give due attention to the social emergence of the image problem in contemporary times. The diffusion of the culture of the image with the narrowing of the culture of the argument was made possible with the advancement of new technologies, in close relationship with the discourse of science and in the form of the discourse of technoscience. Thus, another world began to be meticulously reconfigured, ostensibly by the impact of the image on life forms. The promotion of the simulacrum, the appearance and the ephemeral, in a political economy of the sign in contemporary times is guided by the void as a fundamental axis.

The culture of narcissism has become the central axis in the life of neoliberal societies, including the lives of children. The 'freedom' of neoliberalism presupposes deregulation. Companies should be as free from regulation as possible. Social subjects are reduced to individuals trained to compete with others. Maximizing earnings is the main benchmark for being successful. There is very little to be gained from social responsibility (only if it increases one's market share). On an emotional level, the call for freedom can be understood as a call to free ourselves from the restrictions imposed by authority (such as parents, communities and governments). Which implies searching for the wants (not needs) of the individual (in other words, narcissism). The culture of neoliberalism forms subjects according to essential imperatives for the reproduction of the system's rationality (DAVIES, 2021).

Increasingly, the need for admiration is being created, the appreciation of disrespect for the feelings of others, increasing the inability to deal with criticism and frustrations. Neoliberalism finds fertile ground to spread with the articulation between the phenomenon of medicalization, the culture of narcissism, performance and individualism, which are mutually reinforcing.

The biomedical model: psychopharmacological diagnosis and treatment

The biomedical model is in the DNA of psychiatry (GOODWIN; GEDDES, 2007). One of its assumptions indicates that psychic disorders are diseases that can be distinguished from one another, defined in diagnostic categories, scientifically validated and verified by any – minimally – trained clinician. The other linked assumption postulates the existence of drugs that treat the biological determinants of pathologies. The disease-treatment (medication) dyad is the fundamental pillar.

However, there is no reliable scientific evidence to say that a disorder x, y or z is caused by a specific chemical imbalance in the brain, whether specific, localized or systemic (BENTALL, 2009; MONCRIEFF, 2009).

Ehrenberg (2010) calls "therapeutic evidence" the idea that, in the absence of biological markers in psychiatry, it is the effect of the medication that establishes or confirms the diagnosis and treatment.

Psychopharmacological diagnosis and treatment

When, for example, clinical depression in an adolescent is diagnosed, has the cause of the problems presented by the patient been discovered? Is there objective evidence to support the diagnosis? The answer to both questions is no.

Psychiatric diagnosis is based on subjective belief, on conviction. There are questionnaires that supposedly provide objective parameters. These questionnaires claim reliability and validity, the message conveyed is that they have been tested and that they measure what is proposed. However, as the diagnosis is interposed between the doctor-patient relationship, an almost insurmountable barrier is created for the interpersonal interaction itself. After labeling and transforming the common subject into a patient, it is not simple to do without the diagnosis (BENJAMIN, 2018).

So how is a diagnosis made? There are no blood or imaging tests, x-rays or brain scans to demonstrate that there is something wrong with the brain as the sole and original source of mental illness. The so-called tests for psychiatric diagnoses are exercises with pen and paper or through clinical examination based on the physician's observation and subjectivity.

Regarding the child, a set of questions is carried out or a questionnaire is asked to be filled in by those responsible. What do these tests and quizzes measure? The obvious: the perception that those responsible have about the child. But it is not a medical examination itself. What is the reliability, validity and ethical commitment of this type of evaluation?

Let's take the two commonly diagnosed childhood disorders as a reference and see how the biomedical model of psychiatry approaches them, as well as their consequences.

ADHD

The DSM-5 defines ADHD in the following terms: a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning and development. Due to space limitations, readers are recommended to consult the DSM-5 to note how the symptoms are officially described.

It is noteworthy the use of imprecise, vague terms, such as: “often”, “difficulty”, “seems like”, “easily”, “excessively”, used to determine the symptoms of ADHD as “objectivity”. However, how to define them? The most used term is “often”, but what does that mean? Behaviors that appear at least once a day or every minute? In all circumstances or in some? Which?

As there is no medical examination to support it, the decision on the existence of ADHD results from an arbitrary decision, which depends on subjective judgment, the clinician's conviction and his or her instituted power.

In the absence of objective tests, the cut-off line between 'normal' and ADHD is arbitrary and controversial. This rigid and obscure border does not include differences, inequalities, socioeconomic realities, family issues, school difficulties or other variables that may be intervening and, on the other hand, confer a high presence of comorbidities.

Psychopharmacological treatment: Stimulants

Popular brand names: Ritalin, Equasym, Concerta, Dexedrine, Adderall.

The most common medications used to treat ADHD are central nervous system stimulants that contain methylphenidate, such as Ritalin. They are stimulants from the same chemical family as drugs like ecstasy and cocaine. Stimulant drugs are potentially abusive drugs and categorized in the legal system as 'controlled drugs'. Being stimulant drugs, their cognitive and behavioral effects are the same, whether in children diagnosed with ADHD or in normal children. They are psychoactive drugs, therefore, they produce cognitive, behavioral and affective-emotional changes.

In Brazil, the 'drug for obedience', as it is called, has had a spectacular increase in consumption. We are the second largest consumer of methylphenidate in the world (EVAS, 2012).

The evidence

The evidence on the harmful effects of stimulants is plentiful. Only a few were selected. There was a marked increase in the tendency to play alone, related to the use of Ritalin, and a corresponding reduction in social interactions (RUSSEL, 1978). Stimulant use has also been linked to reduced children's curiosity to explore their environment (FIEDLER, 1983) and loss of liveliness (DAVY, 1989). Children medicated with methylphenidate often become passive, submissive and socially isolated (GRANGER; WHALEN; HENKER, 1993).

Ritalin, despite improving performance in repetitive and routine tasks that require constant attention, does not have the same effect on reasoning, problem solving and learning, which do not appear to be positively affected (SROUFE, 1973). Another study suggests that Ritalin does not produce any benefit in relation to reading, spelling, or math and, on the contrary, hinders one's ability to solve problems (RIE, 1978).

The main effect of stimulants appears to be an improvement in classroom management skills (RUSSEL, 1978). In 1995, the NIMH designed a study to assess long-term outcomes. Considered the 'first major clinical trial' conducted by the Institute of a Childhood Mental Disorder, the NIMH Collaborative Multisite Multimodal Treatment Study observed that the short-term results achieved the goals of drug treatment: dramatically reducing a range of core ADHD symptoms, such as task-irrelevant activities (e.g., finger tapping, fidgeting, fine motor movements [behavior] unrelated to the task during direct observation) and classroom disturbance (RICHTERS *et al.*, 1995).

After 14 months of treatment, the researchers periodically followed up with the students, assessing their performance and their use of ADHD medication. After three years, they found that medication was a significant marker not of a beneficial outcome, but of deterioration. In other words, participants who used medication in the period of 24 to 36 months showed an increase in symptomatology during this period, compared to those who were not taking medication (JENSEN, 2007).

In addition, there was a significant increase in delinquency rates among those who used long-term medication. Specifically, at the end of three years of use. This fact could mean that users were more likely to get into trouble at school and with the police (MOLINA *et al.*, 2007).

At the end of eight years, medication use was associated with worse hyperactivity/impulsivity and symptoms of oppositional defiant disorder (ODD), as well as greater global functional impairment (MOLINA *et al.*, 2009). The conclusion of the study was clear: there were no beneficial effects. In the short term, medication will help the child to behave

better, however in the long term it will not. This important information must be very clear and transmitted to parents who choose the drug route.

Medications can also have serious side effects, including growth retardation. Unfortunately, few doctors and parents seem to be aware of the lack of efficacy of these psychotropic drugs (SROUFE, 2012).

The emergence of manic and psychotic states in children undergoing drug treatment for ADHD has also been verified. Canadian researchers reviewed the charts of children being treated for ADHD treated from January 1989 to March 1995. During the 5 years, 192 children were diagnosed with ADHD, 98 receiving psychostimulant treatment. Of the children being treated with these drugs, 6% developed psychotic symptoms during treatment. The children were followed for an average of 1 year and 9 months (CHERLAND; FITZPATRICK, 1999). To compare demographic and clinical characteristics among adolescents with bipolar disorder with and without a history of stimulant treatment, researchers found a tendency toward bipolar disorder among those adolescents who had prior psychostimulant treatment (DELBELLO *et al.*, 2001).

Childhood depression

Technically, clinicians rely on criteria developed to diagnose adults. At this point in the study, we suggest consulting the DSM-5 to see how depression symptoms are described.

An adult must have at least five of the nine symptoms over a two-week period to be diagnosed with major depression. The DSM-5 makes only two comments about children: depression can be an irritable mood or failure to achieve expected weight gain. In other words, angry outbursts or frequent tantrums can be classified as a symptom of childhood depression (BISMAHER; RYAN; WILLIAMSON, 1996).

There are also initiatives to expand the notion of depression in children between 5 and 12 years old (KORECZAK; GOLDSTEIN, 2009). The justification would be that most adult disorders originate in childhood, and most childhood disorders have consequences that will extend into adulthood (KOVACS; FEINBERG; CROUSE-NOVAC, 1984). It goes as far as to say that MDD can exist in preschoolers (LUBY *et al.*, 2014; CASTELLO; ERKANLI; ANGOLD, 2006).

Psychopharmacological treatment: Antidepressants

The most well-known brand names: Prozac, Zoloft, Luvox, Paxil.

Prozac entered the market in 1988. At this time, only one in 250 children and adolescents under the age of 19 in the United States were taking an antidepressant. Until then, studies carried out with tricyclic antidepressants (those existing at the time) showed that their positive effects were not superior to placebo in this age group (FISCHER, 1997).

We know about all the fuss created around Prozac, considered as the happiness pill (KRAMER, 1997). This is the new generation of antidepressants, the selective serotonin reuptake inhibitors (SSRIs). With the introduction of SSRIs, the percentage of medicated young people tripled between 1988 and 1994 and, in 2002, 1 in 40 children and young people under 19 years of age were taking an antidepressant in the United States (DELATE *et al.*, 2004).

The results of published research tend to favor the benefits and hide the harm, such as the number of suicides in young users of antidepressants, according to what is systematically recognized in the scientific community. (WHITTINGTON, *et al.*, 2004; JONATHAN, 2006; JUREIDINI *et al.*, 2004).

Psychopharmacological treatment: Antipsychotics

The most common brand names: Risperidone, Zyprexa, Seroquel, Abilify.

Common sense until recently was that this class of psychiatric drugs should only be used for severe mental illness in adults. As with contemporary psychopharmacology, from the 1990s onwards, there was an absurd expansion of new consumers, especially children and adolescents.

Antipsychotics have been prescribed for non-psychotic conditions: ADHD, impulsivity, insomnia, aggression, Post Traumatic Stress Disorder, obsessive-compulsive symptoms, eating disorders, poor frustration tolerance (OLFSON *et al.*, 2006). Which is a very controversial procedure clinically.

Recently, even the prescription of antipsychotics for children and adolescents has increased dramatically in most countries (VARIMO *et al.*, 2020; SHRODER *et al.*, 2017).

Final considerations

The medicalization of childhood and adolescence has at the center of its justification the idea that drugs will correct an underlying biological abnormality. Although initially presented with a strictly technical and objective guise, it is a verifiable scientific fallacy from the diagnostic description itself, the use of the medication and its respective effects in the short, medium and long term. The ever-delayed promise of scientific evidence to support and justify drug interventions has no counterpart in the description of the categories found in psychiatry manuals. The medicalization of childhood does not require sufficient scientific evidence and works as a strategy for social control and normalization.

The diagnoses are made from imprecise descriptions that make up the diagnostic categories. Therefore, it becomes urgent to question the ethical-political dimension of psychiatric diagnosis and its continuous expansion.

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