PSYCHIATRIC DIAGNOSIS AND CHALLENGES FOR ANOTHER CHILDHOOD BIOPOLITICS

O DIAGNÓSTICO PSIQUIÁTRICO E DESAFIOS PARA OUTRA BIOPOLÍTICA DA INFÂNCIA

DIAGNÓSTICO PSIQUIÁTRICO Y DESAFÍOS PARA OTRA BIOPOLÍTICA INFANTIL

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ABSTRACT: From "orders" that arrive at services for the care of children and adolescents, we question the psychiatric diagnosis and contemporary challenges for another childhood biopolitics. We critically reflect on the classification system of diagnoses in mental health and its specific uses in childhood. We discuss how the hegemonic psychiatric knowledge has transformed childhood into a privileged locus for governing conduct and intervention on risk and performance. Finally, we ask questions to produce, at the same time, care for children with mental suffering and less normative and disciplinary care practices.

KEYWORDS: Psychiatric diagnosis. Childhood. Biopolitics.

RESUMO: *A partir de "encomendas" que chegam a serviços de atendimento de crianças e adolescentes, problematizamos o diagnóstico psiquiátrico e desafios contemporâneos para outra biopolítica da infância. Refletimos criticamente em torno do sistema classificatório de diagnósticos em saúde mental e seus usos específicos na infância. Discutimos como o saber psiquiátrico hegemônico tem transformado a infância em um lócus privilegiado de governo da conduta e intervenção sobre risco e desempenho. Por fim, colocamos questões para produzir ao mesmo tempo acolhimento de crianças com sofrimento mental e práticas de cuidado menos normativas e disciplinares.*

PALAVRAS-CHAVE: *Diagnóstico psiquiátrico. Infância. Biopolítica.*

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RESUMEN: *A partir de las "órdenes" que llegan a los servicios de asistencia a niños y adolescentes, problematizamos el diagnóstico psiquiátrico y los desafíos contemporáneos para otra biopolítica infantil. Reflexionamos críticamente sobre el sistema de clasificación de los diagnósticos de salud mental y sus usos específicos en la infancia. Discutimos cómo el saber psiquiátrico hegemónico ha transformado la infancia en un lugar privilegiado de gobierno de la conducta y de intervención sobre el riesgo y el rendimiento. Por último, formulamos preguntas para producir tanto la acogida de los niños con trastornos mentales como las prácticas de atención menos normativas y disciplinarias.*

PALABRAS CLAVE*: Diagnóstico psiquiátrico. Infancia. Biopolítica.*

Introduction

"Grandpa, what is an adult?
It's a dead child"
Ademir Assunção (our translation)

> Wesley, 15 years old, has been in an internment intervention at Fundação CASA for 40 days, committed an infraction while serving a socio-educational measure of assisted freedom. He has been accompanied since he was 7 years old by the city's social assistance and health services network, due to issues of social vulnerability and school dropout. During the period of hospitalization, he has shown hostile and defiant behavior towards employees and other adolescents, which has made it difficult for him to participate in socio-educational activities. He also has insomnia. In the last week, the situation has been causing greater concern as his defiant posture has become more accentuated, he swears at other teenagers and employees, such functioning has made him constantly isolated. We forwarded it to the CAPS for children and adolescents for evaluation and conduct (our translation).
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> Teo is 5 years old. He still doesn't speak fully and becomes inattentive during play. He always chooses the same toys and plays with them over and over again, while repeating the same words. This behavior was also noticed at school. After several searches on the internet, we identified that it could be both ADHD and autism. We brought our son to the health center because we want to know how to get a referral to find out what the child has and what the treatment is (our translation).
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> Raquel, 08 years old, has been presenting recurring difficulties in the school environment, she is often inattentive and irritable during activities. She is unable to perform the proposed pedagogical tasks, she gets up many times and sometimes walks around the room. When called to attention, the child maintains the same behavior and often does not do the tasks sent home. She cries easily. She recently failed to participate in a proposed collective game, became hostile and threw the board on the floor. After discussion among the school's pedagogical body, we chose to refer the child to the CAPS for children and adolescents for diagnosis and conduct (our translation).

From these and other "orders" that arrive at public health services for the clinical reception of children and adolescents, we seek in this article to reflect on psychiatric diagnosis and some contemporary challenges for another biopolitics in childhood. We use the term

"orders" because those who are dedicated to the care of children and adolescents are often called upon to deal not with psychic suffering, but with the demand for a specific psychiatric diagnosis rationality, which involves a universalizing and normative expectation of behavior and child development.

In these services, we professionals hear phrases such as: "my son has ADHD"; "A doctor said he is autistic"; "I need a prescription to take 'ritalin' (methylphenidate) just like the colleague"; "the shelter wants a medical report to refer the child to APAE"; "the teacher asked for a diagnostic report to have an extra assistant in the room"; "he is CID F71 and receives benefit". From different actors and institutions – family members, social assistance bodies, schools and specialized centers – health services are obliged to assess and issue a diagnosis of some "deviant behavior". We chose to open the text with three fictional situations, inspired by hundreds of cases that we attend to or supervise in family health teams and/or child and adolescent psychosocial care centers (CAPSij).

We will present critical reflections around the diagnosis and its specific uses in childhood. Then, we will discuss how the hegemonic psychiatric rationality understands and classifies different conduct deviations as individual and brain disorders and how medical knowledge and power have configured childhood as a privileged locus of conduct government.

Finally, we pose questions that we consider necessary to think about other childhood biopolitics, which guarantee at the same time access and reception of children and less normative and disciplinary care practices.

We state in advance that we recognize both the existence of children living with serious illness processes and the importance of their access to clinical care and to social rights and specific public policies. It is also worth noting that, despite the generalized incidence of psychiatric knowledge on society and childhood, it is possible to identify different modulations and expressions of disciplinary power over children from social groups historically violated and deprived of rights, especially the poor and black population (BARROS; BALLAN; BATISTA, 2021).

Discussion: psychiatric diagnosis and its context in childhood

Diagnosis plays a significant role in culture and society (ROSE, 2019; ROSENBERG, 2006). The act of diagnosing – that is, naming a set of clinical manifestations – organizes symptoms into a pattern that becomes recognizable to both physician and patient and allows for

a narrative unification around a set of heterogeneous manifestations and hardly connectable outside of a clinical interview.

Psychiatric diagnosis is used socially as a condition of eligibility for treatment; as justification for absence from work and school and coverage of benefits; and as a registry and organization of health institutions and epidemiological and clinical research, including the feasibility of their funding.

Overall, two classification systems for mental disorders and illnesses are used: the DSM (Diagnostic and Statistical Manual of Mental Disorders) and the ICD (International Classification of Diseases) (ASSOCIAÇÃO AMERICANA DE PSIQUIATRIA, 2014; ORGANIZAÇÃO MUNDIAL DA SAÚDE, 1993).

The DSM is published periodically by the American Psychiatric Association and used as the “gold standard” for mental health diagnoses. The document, first edited in 1952 and currently in its fifth edition, in 2013, proposes the standardization of criteria for the classification of mental disorders, to facilitate the establishment of “more reliable” diagnoses. Its objective is to produce a “common language” in the field of psychopathology and to serve as an instrument for collecting epidemiological data. To this end, it defines mental disorders as syndromes characterized by a “clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior” that produce “dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (ASSOCIAÇÃO AMERICANA DE PSIQUIATRIA, 2014, p. 463, our translation). It recognizes, however, that social deviations from behavior and conflicts that are primarily concerned with the individual and society are not mental disorders “unless the deviation or conflict is the result of a dysfunction in the individual” (ASSOCIAÇÃO AMERICANA DE PSIQUIATRIA, 2014, p. 62, our translation).

Although in everyday practice the DSM is not commonly cited and used by psychiatrists in an up-to-date and textual manner, its categories are a reference for the organization of health systems and research in mental health. And also for the categorization of mental illnesses and disorders from ICDs (International Classification of Diseases and Related Health Problems, regularly published by the WHO), produced in dialogue with DSM updates.

This interconnected and hegemonic system of medical classification of mental illnesses has undergone abrupt changes in each version in recent decades. Internal (FRANCES, 2010; MCCARTHY, 2013) and external (CAPONI, 2014; ROSE, 2019) controversies in the professional field of psychiatry continue to animate the project of cataloging diagnoses of mental disorders. With varied emphases and positions, such criticisms seek to demonstrate the fragility of the American Psychiatric Association's project to aim for a "atheoretical" and

"purely descriptive" guide in the field of mental health, avoiding commitment to any particular theory of causality. What is at stake in this search for reliability is the ideal image of a psychiatric diagnosis represented by a singular entity with a specific underlying biological substrate for each unique condition, that is, a kind of "obligatory crossing point" for its emergence (ROSE, 2019).

Such notion of "underlying lesion" is related to the concept of "natural history of the disease", of the identification of an embryonic state of lesion that would naturally develop its course when not obstructed by some intervention. It is worth noting, however, that despite the fact that the search for tissue, biochemical, and genetic markers of mental disorders has received substantial investments in recent decades, there is no consensus or definitive proof of the existence of psychological suffering and disorder as a result of a pathology specifically brain or genetics (ROSENBERG, 2006).

As different investigations show (CASTEL, 1978; FOUCAULT, 2006), psychiatry was never just a practice that was concerned with the diagnosis and treatment of people with mental disorders. It has always been involved in social and political issues. For example, in Nazi Germany, the first people who went to the gas chambers were psychiatric hospital patients; later, the "Mental Hygiene" movement advocated mental cleansing in factories, schools, families and communities as a way of reducing social maladjustments and illnesses; and today, with suicide prevention campaigns all over the world, in Brazil represented by "Yellow September", alerting to the importance of preventing, identifying and intervening on suicide.

Psychiatric knowledge has never been limited to the identification and treatment of mental disorders but has also created its definitions and boundaries of normality and prescribed appropriate ways of managing our mental health and preventing the risk of disease. Today, different "psi" knowledge helps to shape the ways in which people understand themselves and evaluate and devise projects for their mental states (CARVALHO *et al.*, 2020).

Here the debate is linked to the notion of social medicalization, understood not as a complex phenomenon of inclusion and invention of everyday problems to the medical universe from a heterogeneous and complex process of proliferation of health "experts" who have been inventing and executing procedures diagnostics and therapeutics to visualize and intervene on the health-disease process (CARVALHO *et al.*, 2015; CONRAD, 2007).

This expansion of psychiatry as a regime of power initially registered in the asylum and later present throughout the community is significant: if before medical practices in relation to mental disorders were almost exclusively restricted to the institutionalization of cases considered serious or dangerous, the deinstitutionalization and combating the stigma of those

with mental suffering were accompanied by the proliferation of knowledge and practices of analysis and daily intervention on subjectivity. Consequently, there has been a generalized social expansion of psychiatric diagnoses.

In this sense, Ian Hacking (2009) describes a redundant (looping) effect of mental health knowledge on subjectivity itself, in which its classifying practices would not be simple representations derived from the observation of behaviors but would also provide feedback ("feedback") and would modify the intentional ways of acting and thinking of all those potentially diagnosable.

Caponi (2018) identifies the growing formation of a "psychiatric hermeneutic of the self". Making a parallel with the reading of Michel Foucault's Christian hermeneutics, the author questions the role of psychiatric knowledge in relation to the government of the self and others, from the expansion of diagnoses for everyday suffering, the need for acceptance and subordination to the psychological and medical truth and, finally, to the permanent enunciation of a truth about ourselves, cataloged in pathological terms.

Despite the increasingly assimilated and used use by society of the diagnostic categories of psychiatry ("depression", "anxiety disorder", "bipolar disorder" etc.), there are a number of contradictions and problems in the classifications, criteria and nomenclatures for psychic suffering. Rosenberg (2006) demonstrates how these limits and boundaries between what is considered normal or pathological have been the subject of dispute in the last century and argues that psychiatry is experiencing a moment of coexistence of reductionist hopes linked to the dream of discovering the biological and molecular truth of disease in the brain, at the same time that numerous criticisms of this biological and behavioral reductionism of illness are produced. While we are aware as never before of the arbitrary and socially constructed quality of psychiatric classifications, never have we been more dependent on these same diagnoses, both by the bureaucracy of health services and by the widespread dissemination of an understanding of subjectivity reduced to behavior and the brain.

The reality of psychiatric diagnosis gains specific contours in the context of childhood. In recent decades, there has been a significant increase in children and adolescents diagnosed with mental disorders. Systematic reviews of the medical literature (PATEL *et al.*, 2007) estimate that at least one in four to five children and adolescents in the world population will suffer from at least one mental disorder during a one-year period. In Brazil, a prevalence of 13% of inhabitants between 7 and 14 years of age with some mental disorder is estimated, which would total at least a total of 3 million diagnosed in this age group. Such expansion is accompanied by the proliferation of discourses and technologies about the identification and

intervention on "deviant behaviors", whose psychic risk would threaten healthy child development.

As Michel Foucault (2006) pointed out in one of his courses, psychiatric power escapes from the asylum and starts to modulate social relations, especially within the family (including its new functions), preparing children for the future and their destinies, the prevention of deviations and the production of certain subjectivities. Especially during the 19th century, psychiatry interacted heterogeneously with the wealthier classes and gradually with poor families, entering the family regime and producing specific modes of disciplining based on the control of posture, gestures, and behavior. Foucault (2006) questions how the techniques of control and coercion of asylum psychiatry come to appear within the family itself – tying hands; raise the head; remain upright: disciplinary instruments established inside the hospice make the child's sexuality an object of knowledge and intervention. With this, the child becomes a central target of psychiatric work, since

> [...] psychiatry says: let the little crazy children come to me. Or: one is never too young to be crazy. Or even: don't wait to get bigger or adults to be crazy. And this is all translated by these institutions, at the same time of surveillance, detection, framing, of child therapies, which you see developing at the end of the 19th century (FOUCAULT, 2006, p. 155, our translation).

When investigating the emergence of the first abnormal children, Lobo (2015) demonstrates that psychiatry does not historically approach childhood to treat children considered "crazy", but rather to identify pathologies in child development. The first figures of this intervention were the idiot and the delinquent. For much of the 19th century, it was only adults (or, at best, teenagers) who went crazy; the abnormal child emerges centrally from the figure of the "idiot", considered a "complete monster", and the notion of development and instinct are central to categorizing and correcting deviations in learning and behavior.

Donzelot (2012) points out that psychiatry seeks in the idea of "vagrant" a final synthesis between the mad and the abnormal, in which their "childish nature" plays a central role, due to suggestibility, emotionality and excessive imagination. These "weaknesses" of children, caused by the "fragility" and "disorganization" of their brains, would need to be corrected and framed in time. The author argues that child psychiatry is not born specifically around a childhood pathology, but in the figure of the "vagrant" for medical knowledge; and the need to create an object of intervention not only for those admitted to hospices, but to preside over inclusion and social correction, taking shape "in the void produced by the search for a convergence between

the prophylactic appetites of psychiatrists and the disciplinary demands of social apparatuses" (DONZELOT, 2012, p. 105, our translation).

This variety of "specialized" knowledge about children and adolescents, with emphasis on psychiatric and/or psychiatric knowledge, is not limited to the meeting of children with doctors in their offices but has been helping to design the forms of relationship between children and the world. In the name of "health" and "normality", not only "professionals" are called upon, but the whole of society to interact with childhood from a perspective that privileges the detection of risks and professional and institutional intervention.

Unlike adult care, the child always arrives at the health services through the mediation of a companion – be it a family member, a school worker or a social worker from some institution. The symptomatic enunciation or the child's deviant behaviors is necessarily mediated by their relationship with those responsible who need to decode the demands and symptoms to which they seek naming and intervention. In this sense, the diagnosis does not make a priori sense for the child and the nomenclatures of the psi field can interdict the possibilities of elaboration about themselves and about the world through fantasy, games and playfulness. In addition, several ongoing aspects of the constitution of these children give rise to therapeutic techniques considered effective in relation to already established diagnoses.

A double shift occurs here: the intervention is always based on a demand positioned in and by the world of adults and governed by classificatory and therapeutic systems historically linked to the suffering and mental illness of adults. That is, adults design and send orders to childhood "experts", who are more trained to identify and prevent the emergence of sick adults based on diagnostic criteria specifically from the adult universe than to understand and interact with a uniqueness of children themselves and their childhoods.

The modification of our vocabulary to describe common and everyday aspects of children's constitution, words such as - skills, emotional intelligence, performance, stimulation - have become increasingly common, not just in offices. This context of "neoliberal governmentality" (ANDRADE; CARVALHO; OLIVEIRA, 2022) has been producing an ideal of subjectivity governed by a permanent evaluation of productivity and quality. The government not only of ourselves, but also of the children we seek to govern, presupposes the reduction of subjectivity and psychic life to the figure of the "I", in a logic of economic investment in the child for the return in adult life. The "performance evaluation" emerges in childhood, a work of surveillance and control over the mind, emotions and behavior, a kind of "business rationalization" of desire and subjectivity (SAFATLE; JUNIOR; DUNKER, 2021), with ideals specific health measures equated with the ability to concentrate, focus, emotional

intelligence and productivity. The child's health is evaluated based on a curricular list of pre-defined skills and experiences, in which the absence of items from this minimum checklist becomes failure, weakness and the need for diagnostic evaluation.

This healthy child development project, based on the prevention of risks and the development and maximization of cognitive and emotional capacities for the future life, collides with absolutely everyday issues of children's experience: anguish, frustration, disobedience, conflict, the error, the mismatch. Thus, “disobedient”, “deviant”, “backward”, “unpleasant”, “unbearable” and “abnormal” children appear, who end up being referred for medical diagnosis, considered scientific and, therefore, truly capable of understanding and naming the causes and explanations of unexpected behavior.

Regardless of the intentions, the proliferation of technical and scientific discourses around everyday situations experienced by families for decades ends up disregarding a heterogeneous and generational knowledge of child care, historically outside surveillance and specialized intervention. It is not, therefore, about announcing the invalidity of the previously affirmed diagnosis and the return to care only to the family nucleus, but to assume that the increase in diagnostic techniques and management of child development with “proven efficiency” is simultaneous with the process of disqualification of knowledge that is often considered “minor” and that cannot be scientifically validated.

Furthermore, these “true” ways of naming and intervening on the behavior considered pathological end up saying more about the ways that one seeks to govern childhood and lead children’s behavior to certain “places” and cultural chains than a demand for understanding, deal with and interact with their ways of life and behavior itself.

This is what happens with the diagnostic classification according to the criteria announced by the DSM, devoid of a sociocultural context and configured from the medical interview between professionals and the children accompanied by the family or institution.

Brief notes on “orders”

We can, for example, do a brief diagnostic framing exercise of the situations described at the beginning of the text. Unfortunately, many children are currently evaluated in the same brief and simplistic way that we present here the use of diagnostic manuals and therapeutic approaches made by psychiatrists and other mental health professionals.

Wesley's hostile behavior could end up being named Oppositional Defiant Disorder (ICD10 F91.3), “a pattern of angry/irritable mood, questioning/defiant behavior or temper;

vindictive action lasting at least six months". The DSM itself points out, among the associated characteristics that help in its identification, the fact that the disorder is more prevalent in families "in which child care is disturbed by a succession of different caregivers or in families in which aggressive, inconsistent or negligent practices of parenting are common". The manual also links the condition to Wesley's increased risk in the future for "a range of adjustment problems in adulthood, including antisocial behavior, impulse control problems, substance abuse, anxiety and depression."

Teo's case, on the other hand, would require further refinement of the description and assessment of learning and behavior at school. From the hegemonic psychiatric perspective, a descriptive assessment of the pattern of "lack of attention" would be necessary to ascertain whether the child would "truly" fit a diagnosis of Attention Deficit Hyperactivity Disorder (described in ICD10 as an F90-Hyperkinetic Disorder) or a more severe case of autism spectrum disorder (ICD10 F84).

Raquel's case could, finally, be discussed also as the beginning of Wesley's clinical situation (F91.3 - Oppositional Defiant Disorder), but also as a Disruptive Mood Dysregulation Disorder, a specific childhood depressive condition whose diagnosis cannot be done before 6 and after 18 years of age and common for having "recurrent and severe outbursts of anger manifested by language" disproportionate to the situation experienced, on average three or more times a week in the last 12 months.

It is not a question of caricaturedly reducing the classification manuals to specific quotations of passages that describe situations we experience both in health services and in any place where children and adolescents circulate. But, following important debates already mentioned here around the DSM and hegemonic psychiatry in the contemporary world, to problematize the use (and abuse) of these diagnostic categories and their effects on the ways we have acted on childhood.

In the name of a "quiet" classroom, of a "violence-free" reception service, of a "no red marks" school report, of more professionals specialized in education and social assistance services, countless children have been placed in services of specialized care, with an already high volume of children with clinical conditions of severe psychological distress. Many end up undergoing medical evaluation and receiving a diagnosis and drug therapy and will live a part (or the rest) of their lives with the name of diseases and disorders in constant reformulation and permanent criticism.

Several of these orders to health services already appear "diagnosed" from psychiatric nomenclatures and without any kind of contextualization of the experience lived by the

children. This indiscriminate use of the pathological classification of mental health gradually modulates and reduces the projects and life plans of these subjects to the biomedical universe, linked to a normal pattern of behavior expected for the development phase and, in the limit, for what is idealized as a healthy child.

Under the justification of performing an accurate and true diagnosis of individuals after a standardized medical evaluation, the clinic gives rise to the discovery of the name of a disease, capable of synthesizing and locating a biological, neurochemical and behavioral substrate previously validated by updated science. The diagnosis thus becomes the guiding thread of the clinical and therapeutic procedures recommended for each of the children with a mental disorder.

Final Considerations: challenges for another childhood biopolitics

In the transition from the 19th to the 20th century, medical society was scandalized by the notion that children have sexuality. It seems to us that at the beginning of the 21st century, the scandal would be linked to the idea that they cannot be summarized and restricted to a space of detection and intervention on risk and performance improvement. This question is not just philosophical, it is a synthesis of the way children's playfulness has been apprehended, monitored and scrutinized along with the modes of subjectivation of neoliberal rationality.

If the playfulness has been understood as the privileged space for the constitution of the child subject linked to the production of desire, the elaboration of rules, the ability to enter into games, to elaborate one's own reality and deal with the conflicts inherent to the production of desire and freedom, what are the consequences of the playful life being inserted into training for a more productive and engaged adult life? Here, even, the very notion of playfulness comes into conflict with neoliberal morality, since the notion of “playing for the sake of playing” becomes meaningless for adults, who begin to convert the playful space into an investment by the child on itself, with a view to specific gains for the child's "I".

Neoliberal subjectivation does not necessarily prohibit play and play, but it operates in the modulation that this space, necessary for the child subject, is sometimes converted into investment, sometimes into a permanent space for the detection and measurement of anomalies and risks and the formatting of problems subject to specialized intervention. Even if involuntarily, the expansion of hegemonic diagnostic rationality has corroborated the production of “individualized” and “atomized” subjects, and also with possibilities for the future linked in increasingly rigid systems.

Paradoxically, this phenomenon produces, at the same time, the proliferation of diagnosed children and the maintenance and even worsening of the non-guarantee of access to treatment for children with severe psychological distress. Furthermore, even though this onslaught of neoliberal subjectivity reaches childhood globally, it is configured in a heterogeneous way according to race, class and gender, with the possibility that families with poor and black mothers and children are more subject to be offered a diagnosis and, at the same time, denied various social rights.

In this opportunity, the creation of other modes of interaction with childhood involves both a criticism of the modulations of the "I" designed as normal, healthy and expected, the recognition of an impoverishment of the imaginative capacity of adults and, finally, the production of forms of life and government that include children and their anguish and adversities.

If we take childhood as a recent invention, we must locate it in its historical and political time and linked to certain government projects and the production of subjectivity. In the neoliberal context, adults have shown themselves to be increasingly deprived of their imaginative capacities and hostage to a notion of child care restricted to surveillance and, in case of any dissonant behavior, looking for an "expert" in child health.

It seems to us that this bet on the conduct of children's behavior that inserts the behaviors, gestures and looks of children in the characteristics of psychiatric medical power is connected to an ascending vector, in which adults feel increasingly responsible for acquiring medical information and and from them to observe and deal with children. This productive dimension of the ways of governing children feeds back adults deprived of authority to deal with conflicts inherent to childhood or to bear their sufferings. At the same time, as a downward vector, child impoverishment is notable, since children's experiences are constantly being considered inferior, in the name of information and observation of development and behavior. A power diagram is formed that controls behavior and guarantees surveillance, calling not only psychiatrists, psychologists, pedagogues, occupational therapists, etc., but the whole of society to be a "psychiatric eye" on childhood.

As Lajonquière (2021) provokes, the adult world no longer needs to divide its attention between imagination and children. If before adults kept an eye on children playing in the street and the other attentive to imagination, now adults do not take their eyes off children locked up at home or at school. When parents and teachers get tired of looking so much without seeing anything, they ask specialists to take a "look" at the child, write a report and, if they are doctors, also prescribe a medication and a set of scientifically validated therapeutic procedures.

In an arid world of social guarantees, the possibilities for the future designed for children are based on the notion of childhood as an "investment", in which the correction of any deviation is about an "autonomous and promising" future, for the production of future "winners", linked to a notion of "I" not guided by singularity, but by exploring the limits of each individual capacity.

In short, thinking about other possible ways for children to inhabit the world must go through a restitution of adults with the ability to imagine a future, which contains adversity, unpredictability and some intrinsic damage to life. It will also require the removal of mechanisms that fix the perception of the "I" as something timeless, non-relational and impervious to the context and social contingencies.

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How to reference this article

MARÇON, Luana; ANDRADE, Henrique Sater. Psychiatric diagnosis and challenges for another childhood biopolitics. **Estudos de Sociologia**, Araraquara, v. 27, n. esp. 2, e022024, 2022. e-ISSN: 1982-4718. DOI: https://doi.org/10.52780/res.v27iesp.2.16823

Submitted: 15/06/2022
Required revisions: 10/07/2022
Approved: 12/08/2022
Published: 30/09/2022

Processing and publishing: Editora Ibero-Americana de Educação.
Review, formatting, standardization and translation