CHILDHOOD AND MEDICALIZATION OF LIFE: AN ANALYSIS OF THE DIAGNOSTIC MAKING AND ITS LINKS WITH THE SCHOOLING PROCESSES

INFÂNCIA E MEDICALIZAÇÃO DA VIDA: UMA ANÁLISE SOBRE A PRODUÇÃO DIAGNÓSTICA E SEUS NEXOS COM OS PROCESSOS DE ESCOLARIZAÇÃO

INFANCIA Y MEDICALIZACIÓN DE LA VIDA: UN ANÁLISIS SOBRE LA PRODUCCIÓN DIAGNÓSTICA Y SU RELACIÓN CON LOS PROCESOS ESCOLARES

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ABSTRACT: In the past decades, there has been an increase of diagnoses for disorders and disabilities, especially regarding children. This increase is associated with changes in diagnostic criteria, the advance of diagnostic-making in the school context, and the influence of interests associated with pharmacological conglomerates production described by scholars of the area. This paper aims to analyze the medicalization of children's life and the diagnostic production that is linked with the schooling processes. To do so, we present a brief history about the constitution of the DSM, in tune with the contemporary academic debate. We seek to discuss how the engendering of this manual contributes to the production of what we understand by diagnostic inflation. The analysis considers the process of medicalization of life in the childhood context, based on procedures that tend to reduce the human phenomena to behavioral manifestations that could be codified in dynamics that reaffirm the subject as the center of the fault to be corrected.

KEYWORDS: Special education. Diagnosis. Medicalization. Pathologization.

RESUMO: *Nas últimas décadas tem ocorrido uma ampliação dos diagnósticos referentes aos transtornos e deficiências, principalmente no que tange ao público infantil. Esse aumento associa-se a modificações de critérios diagnósticos, ao avanço da produção diagnóstica no contexto escolar e à influência de interesses associados aos conglomerados da produção farmacológica descritos por estudiosos dessa temática. Este artigo se propõe a analisar a medicalização da vida infantil e a produção diagnóstica que se vincula aos processos de escolarização. Para tanto, apresenta-se um breve histórico a respeito da constituição do DSM, em sintonia com o debate acadêmico contemporâneo. Busca-se discutir como os engendramentos desse manual contribuem com a produção do que se compreende por*

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inflação diagnóstica. A análise considera o processo de medicalização da vida no contexto infantil, com base em procedimentos que tendem a reduzir os fenômenos humanos a manifestações comportamentais que poderiam ser codificadas em dinâmicas que reafirmam o sujeito como centro da falta a ser corrigida.

***PALAVRAS-CHAVE**: Educação especial. Diagnóstico. Medicalização. Patologização.*

***RESUMEN**: En las últimas décadas ha habido una expansión de los diagnósticos relacionados con trastornos y discapacidades, especialmente con la población infantil. Este aumento está asociado con los cambios en los criterios de diagnósticos, el avance de la producción diagnóstica en el contexto escolar y la influencia de intereses asociados con los conglomerados de producción farmacológica; descritos por académicos de este tema. Este artículo propone analizar la medicalización de la infancia y la producción diagnóstica que se vincula a los procesos escolares. Con este fin, presentamos una breve historia sobre la constitución del DSM relacionado con el debate académico contemporáneo. Se pretende discutir como la conformación de este manual, contribuye con la producción de lo que entendemos como inflación diagnóstica. El análisis considera el proceso de medicalización en el contexto infantil, basado en procedimientos que tienden a reducir los fenómenos humanos a manifestaciones conductuales que podrían codificarse en dinámicas que reafirman al sujeto como el centro de la falta de corrección.*

***PALABRAS CLAVE**: Educación especial. Diagnóstico. Medicalización. Patologización.*

Introduction

Historically, we have followed the need to classify those that do not fit the established standards as an expression of normality. From the most primitive societies to the most recent, it is possible to find reports on the types of "attention" given to people considered deviant in relation to the concept of normality imposed at each time.

In one of the most famous works of Brazilian literature - *O Alienista* (The Alienist) -, Machado de Assis (1988), through his character Simão Bacamarte, problematized the existence of an established border between normality and abnormality. In an excerpt from the work, in a dialogue with Crispim Soares, The Apothecary, Bacamarte says the following:

> I suppose the human spirit as a vast shell, my end, Mr. Soares, is to see if I can extract the pearl, which is the reason; in other words, let us definitively demarcate the limits of reason and madness. The reason is the perfect balance of all faculties; out of there insanity, insanity, and only insanity (ASSIS, 2008, p. 7, our translation).

From the quote from *O Alienista*, we can reflect on some principles. In addition to problematizing the diagnostic boundaries for mental health, the author presents the diagnostic criteria used at the time: rationality and madness. It is, of course, a way of understanding

human rationality, but the departure from this fundamental skill was described as a pathological criterion as early as the 17th century and continues to be proposed by many currents as a diagnostic criterion. It is worth remembering that reason - or the lack of it - is understood by many as intrinsic to the subject.

We started our writing talking about reason and madness, initial markers of the boundaries established between the normal and the pathological. With the emergence of psychiatry in the 19th century, a dimension of supposed care directed at institutions that removed those who had no reason to live together was also expanded. A new guise for prison and abandonment. The formation proposals and research related to the area remained guided by the clear split between madness and mental health, disregarding the constitutive nexus of a continuous articulating thread that is associated with the social conditions of production of these phenomena. The proposals to break with this logic are not yet part of a structural cycle of professional formation, as stated by Paulo Amarante, in an interview that discusses psychiatry in Brazil (MEMÓRIA, 2015). The thinking of scholars like Franco Basaglia, analyzed by Paulo Amarante, evokes a need for attention that is distant from our daily lives. One of the consequences discussed here is the strengthening of the understanding that psychic changes would be intrinsic to the subjects, resulting in the assumption that such changes can be captured through behavioral observation, which would simplify the identification and the diagnostic criteria themselves. This simplification becomes one of the factors that favor the numerical expansion of cases identified as "disorders".

In this article, we seek to analyze the process of medicalization of life in the context of childhood, as well as the diagnostic production that has intensified in the last decade when we refer to school phenomena. The text presents a brief historical review of one of the most influential diagnostic manuals today, the Diagnostic and Statistical Manual for Mental Disease (DSM), published by the American Psychiatric Association (APA), which is currently in its fifth version. Based on this resumption, we set out to discuss factors that contribute to the production of what we understand by diagnostic inflation and medicalization of life, with particular attention directed at childhood and educational processes.

Incompleteness and the risk of classifications: the case of DSM

In The Order of Things, Foucault (1990) uses a short story by Jorge Luis Borges, in which the poet states that we cannot succeed in trying to classify the universe. According to this poet, such attempts are frustrated because they are arbitrary and conjectural, since we do

not even know what the universe is. According to Bezerra Junior (2014, p. 13, our translation), "[...] classifications are not mirrors of reality, but constructions, arrangements that configure a domain of reality, systematizing its multiplicity in an intelligible way [...]". From these statements, we can ask ourselves how the whole classification system is incomplete and relative to the principles that engendered it. When we turn our attention to the theme of this text, we underline the same characteristics in existing classifications in psychiatry that are known to have an impact on a subject's social and school life.

Fernando Ramos (2014) addresses this theme in his article "*Do DSM-III ao DSM-5: traçando o percurso médico-industrial da psiquiatria de mercado*" (From DSM-III to DSM-5: tracing the medical-industrial path of market psychiatry). The author retrieves the history of the Classification Manuals of the American Psychiatric Association (APA) and its connection with the concept of health of the World Health Organization (WHO) and with the Medical-Academic Industrial Complex (MAIC). This analysis provides us with important clues to reflect on the formulation of diagnostic parameters and the strength of groups that reaffirm their understanding (or their interests) about certain phenomena. When changes in procedures and diagnostic criteria occur, a necessary question should be: who are the beneficiaries with these changes?

Since it emerged as a medical specialty in the beginning of the 19th century, psychiatry had two major paradigms: the clinical-descriptive (by Pinel and Esquirol) and the etiological-anatomical (by Morel, Kahlbaum and Griesinger). We can mention two important representatives of the area who influenced the middle of the 20th century: Emil Kraepelin and Sigmund Freud. The first founded the foundations of contemporary classifications; the second went from the description of symptoms to psychodynamics. Thus, these macro-divisions gave rise to two major fields that guided psychopathology until the end of World War II: somatic-constitutionalist (the symptom was seen as a sign) and psychodynamic-relational (founded on the presumption of the symptom as a sign). There was still a third front, known as existential phenomenology (Karl Jaspers, Eugene Minkowski and Kurt Schneider). However, such theoretical guidelines did not use systematic classifications as we know them today, for statistical and clinical purposes (BEZERRA JUNIOR, 2014).

According to Grob (1991), the first psychiatric classification in the United States originated in the 1840 census, which presented only the categories of insanity and idiocy. In the year 1880, a new classification was created, addressing seven categories: mania, melancholy, monomania, paresis, dementia, dipsomania and epilepsy. It was only in 1917 that a classification was launched for the purpose of hospital records. After the Second World

War, a classification system emerged that was based on psychodynamic assumptions, distancing itself from biological bases. Thus, in the final period of the war, there were three classification systems: the Standard Classified Nomenclature of Disease; Armed Forces Nomenclature; and the Veterans Administration Nomenclature. However, these were not systems used in hospital reports. With the end of the war, strong pressure from veterans was established. They claimed actions from the government that would help them reintegrate into society. This movement is highlighted by Diniz (2007) in an analysis of the concept of disability and the predominant social groups, based on the advancement of the so-called social model of disability in more recent decades.

The understanding of this historical process shows us that there was a need to adapt the classificatory systems, since the existing ones did not contemplate the needs of veterans who mostly suffered from chronic neurological syndromes, as well as presenting psychic trauma due to the situations experienced in the war. Thus, the APA developed the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952. This first classificatory manual was influenced by psychoanalytic-based psychopathology and presented 106 categories, organized in neurotic, psychotic disorders and character. The central idea of the DSM-I was that

> [...] mental illnesses were considered as a reaction to existential situations to which the individual would not be able to offer an adequate response. The manifest symptoms were understood as the expression of underlying conflicts that disorganize the individual's subjective life, imposing stereotyped patterns of conduct and experiences of psychological pain [...] the symptoms had a strong symbolic and relational dimension, carrying in themselves a meaning that needed to be unveiled to trigger therapeutic strategies. [...] the set of psychopathological reactions perceived more as a spectrum that allowed continuity between the domains of health and disease and between the different degrees of psychological impairment (BEZERRA JUNIOR, 2014, p. 19, our translation).

In the second version of the manual (DSM-II), launched in 1968, the number of categories increased to 182. The new classification continued with a psychoanalytic basis, understanding that the symptoms had a symbolic nature and should be interpreted. Bezerra Junior (2014) points out that the DSM-II did not have much impact in other countries, its use being restricted to the United States. The year 1968 was marked by social conflicts around the world, bringing profound changes in society, which characterized the 1970s, and also reflected in psychiatry.

According to Ramos (2014), between the 1980s and 1990s, the WHO concept of health had, in the social and political context of the time, the opportunity to develop a market-oriented perspective. In addition, the author points out that

> [...] working the logical reverse of the definition of this concept, globalized post-industrial capitalism transformed the idea that health is physical, mental and social well-being and not just the absence of disease, but the existence of physical, mental and social malaise, or even that lack of health is not only the presence of disease, but also the risk of a future disease. It will be in the systematic categorization of this malaise and risk - which, on the one hand, represent an absence, real or potential, of health, but which, on the other hand, do not constitute the presence of disease - that the DSM series, from 1980, will develop (RAMOS, 2014, p. 211, our translation).

In 1980, with the publication of the DSM-III, there was an important change in the direction of psychiatry. The new manual did not understand the diagnosis as a key to the understanding of psychic or relational conflicts that appeared through the symptoms, thus transforming it into the element that would determine the identification of disorders. For some authors, such as Fendrik (2011), Sibemberg (2011), Frances (2014a) and Bezerra Junior (2014), with the publication of the DSM-III, the growing expansion of diagnoses and the consequent pathologization of everyday life begins. Bezerra Junior (2014) analyzes this process, indicating that such trends can be identified.

> [...] for the predominance of the biological or cognitive paradigm to the detriment of psychodynamic, psychosocial or humanistic conceptions, for the subordination of clinical practice to the dictates of the pharmaceutical industry, for the infiltration of the psychopathological vocabulary in the processes of construction of cultural identities, for the evacuation of notions of subject and unconscious of clinical reasoning, and so on (BEZERRA JUNIOR, 2014, p. 15, our translation).

From its third version, the DSM has strongly influenced both psychiatry and society, not only in the United States, but worldwide. According to Zorzanelli (2014), several authors have corroborated the idea that the DSM series can be considered a cultural object, in addition to its bureaucratic usefulness as a classification manual for mental illnesses. Among these authors, Zorzanelli (op. Cit.) Cites the example of Demazeux (2013), who spoke about the dynamics and premises followed by the groups involved in the preparation of the manuals.

The well-known and controversial psychiatrist Allen Frances coordinated the task force of the then new APA manual, published in 1994. The DSM-IV had 297 disorders, characterized as a multiaxial system. Izaguirre (2011) states that the referred manual was constituted as an empirical, categorical and dimensional classification. For this author, his

categories were heterogeneous with unclear limits, leaving aside nosological criteria to favor the statistical aspect, "[...] whose objective is to achieve the greatest flexibility without considering the differences in the theoretical orientations of the professionals" (IZAGUIRRE, 2011, p. 18, our translation).

We can read in the DSM-IV itself that its objectives are clinical, research and educational. The 1994 manual also says that it is aimed at clinicians and researchers who follow different orientations, be they biological, psychodynamic, cognitive, behavioral, interpersonal and family. Thus, it is reaffirmed the assumption of one that this manual would be a pragmatic device and not linked to certain theoretical fields. Currently, we are under the DSM-5 guidelines (APA, 2013), which, according to Frances (2014a; 2014b), is nothing more than a consequence and unfolding of the manuals that preceded it. The DSM series is, for this author, the product of the conflicts that permeated the history of American psychiatry, as well as the result of other political, cultural and technological elements that influence society. The preparation of the DSM-5 took place amid a wide controversy regarding the guidelines that supported it. Such analyzes came from the psychiatric community itself, and one of the most striking critics was Allen Frances himself, coordinator of the group that developed the DSM-IV, published in 1994.

Cosgrove and Krimsky (2012) state that the task force responsible for DSM-5 had as one of its objectives to solve problems such as the excess of diagnoses and the high rate of conflicts of interest that occurred in the groups that participated in the preparation of previous versions. However, in addition to the issue not being resolved, it has intensified with the publication of this new manual. According to the authors, there are studies that demonstrate that 69% of the DSM-5 task force was linked to the pharmaceutical industry, that is, "[...] conflicts of interest materialized in research financed by pharmaceutical companies, participations in consultancies, among others" (ZORZANELLI, 2014, p. 59, our translation).

Zorzanelli (2014) highlights two fundamental aspects for understanding his analysis. The first one concerns a certain distance from the Brazilian reality, since the International Classification of Diseases and Related Health Problems (ICD), in its specific chapter for mental and behavioral disorders, is the manual used for Brazilian medical definitions and bureaucracies in the field of mental health[4]. Second, the author questions the importance

[4] Although the ICD is used for protocol and "bureaucratic" practices in the medical field in Brazil, it can be said that both - ICD and DSM - are governed by similar parameters in terms of the constitutive dimension, valuing the descriptive perspective, as well as the behavioral and symptomatic plan. Despite an international debate that seeks to emphasize contextual issues and the enhancement of functionality and support needed for each subject in a unique way, the aforementioned characteristics of these manuals remain those that predominate. Within the

given to the DSM in Brazilian psychiatry and even in international psychiatry, since it is a manual of American psychiatry. Zorzanelli (op. Cit.) Justifies by saying that, by putting such aspects in suspension in the form of questions, she is allowing us to think about the place of the DSM and the impact that such a classification system has on our culture.

The author also draws attention to the meaning of the DSM as a broader cultural object, in addition to a simple classification system with administrative and bureaucratic intent for exclusively medical use. Although we recognize the relevance of these reflections, this cultural object dimension must be identified as part of a phenomenon that, at the same time, expresses the constitutive way of thinking of an era and participates in its own formulation, feeding explanatory propositions and ways of understanding phenomena relating to mental health.

Frances (2014b) corroborates this idea and also highlights that, while the DSM reflects cultural values, it has a strong impact on culture, modifying the lay vocabulary and making it capable of expressing our daily suffering in its diagnostic categories.

> [...] the classification received by groups and individuals is appropriated actively by each one of them, generating a retroactive effect of the classifications that, in the limit, can interfere in the source of nomination. With this diffuse action, the limits between specialized knowledge and lay knowledge blend, generating more than psychiatric diagnoses: sensitivities, concerns, patterns of attention to the signals that the body gives us. The action of the DSM is not limited to doctors, it is spread among educators, teachers, patients, people interested in improving health and quality of life, health consumers who show growing interest in mental disorders and are able to handle words that before were only from specialists (ZORZANELLI, 2014, p. 61, our translation).

With this historical rescue on the DSM, we would like to draw attention to the relationship between what was exposed and the theme of this work. The idea of diagnosing risk signs in childhood and the whole movement that involves this issue in the world and, above all, in Brazil, are linked to the context in which the fifth version of the DSM appears. In 2013, the year of publication of the DSM-5, the “Guidelines for the Rehabilitation of People with Autism Spectrum Disorders” were launched in Brazil, which aim to guide professionals

scope of this study, DSM was more prominent because this diagnostic classification system has produced, throughout history, according to many studies, a strong socio-anthropological influence. Burkle (2009) states that in psychiatric practice, the DSM is the manual that has represented, for professionals in the field, a kind of reliability for the elaboration of a diagnosis. "[...] which perhaps indicates that in some way these manuals are not only 'effective’ but considered effective because they reflect and form a certain way of approaching psychic disorders" (BURKLE, 2009, p. 17, our translation). To recognize this influence of the DSM, in psychiatry and in education itself, we chose to highlight it in the present analysis, with an illustrative dimension of the dynamics that constitute the elaboration of these systems.

linked to the Unified Health System (SUS) network regarding the health of people with disabilities and their families. This document highlights the importance of early identification of signs of risk of autism, meeting ideas that are linked to the line that, according to Caponi (2016), structures the DSM-5: the logic of prevention and the anticipation of pathological psychiatric risks.

Allen Frances (2016) reports that one of the causes of diagnostic inflation is the need to classify the possible "sick". According to the author, this premise is allusive to some dangers, and we would be running the risk of placing too much attention on a particular group, failing to give due attention to those who really need it. Most of the well-known investigative devices designed for such an evaluation are standardized and schematic proposals for behavior analysis. Such evaluative scales tend to be simplified to facilitate application and are in line with principles that do not consider the importance of reciprocity between the observed subject and the observing subject.

For Gaines (1992, p. 19, our translation), "[the] nosological classification process always classifies people, not merely diseases". Banzato and Pereira (2014, p. 48) affirm that the diagnostic nomenclature and psychiatric classifications could serve as an example of "[...] the possible impact exerted by concepts in the forms of subjectification and description (or redescription) of the concrete human experience". After a medical diagnosis, there is a tendency for the subject to incorporate it as part of his own identity, using it as a reference to live his present and his future. In fact, at the same time that the diagnosis gives the subject a name, in general, it is associated with prognoses that should be part of the social expectations aimed at people.

The medicalization of life in childhood territory

What are the boundaries established between normal and pathological in the childhood territory? We know that the school context and the criteria established by the hegemonic understanding of learning, in many cases, can be decisive in establishing the production of diagnoses in this age group. Silva (2016) shows us how the diagnoses of intellectual disability have increased, analyzing the effects, in the Brazilian context, associated with the terminological change that led us to use this concept instead of mental disability. In addition, there are also other groups of subjects identified as the target audience of special education, such as Autism Spectrum Disorder and other categories of disorders that have links with behavioral issues, such as ADHD, or schoolchildren, such as specific learning disorders.

As Rocha and Cavalcanti (2014) point out, diagnosing nowadays has become an "easy" task. With the expansion of the means of communication, information is available to many. The search for diagnostic hypotheses related to our symptoms became accessible as a quick search on the internet. Coincidentally, in recent years, there has been an increase in the demand for clinical spaces, by families with children identified, in their social and/or educational context, as children with behavioral issues and learning difficulties. In many cases, the family arrive at the clinical space already pointing out the diagnostic hypothesis.

The diagnostic expansion is related to several factors already mentioned here, however, among them, we can reinforce the influence of the DSM, which, from its fourth version, contributed to a significant increase in the diagnoses of Attention Deficit Hyperactivity Disorder (ADHD). After the launch of DSM-5, the numerical contingent of diagnoses of autism also expanded. Frances (2016), in her criticism of the DSM-5, analyzes the diagnostic increase with emphasis on ADHD, Autism Spectrum Disorder and Bipolar Disorder in childhood.

Rocha and Cavalcanti (2014) also report that they could argue that the increase in diagnoses could be the result of "improper diagnosis" or poorly performed. However, they understand that:

> [...] the phenomenon seems to be a predictable effect of a logic, present in a diagnostic conception and practices, which, aiming at scientific objectivity and reliability, reduced the diagnosis to a simple conference of the classification of signs, disregarding the subjective experiences they engender the psychic symptom (ROCHA, CAVALCANTI, 2014, p. 233, our translation).

Based on this logic, the symptoms have not been taken as signs or clues to be investigated, but are now part of pathological conditions that can be reached quickly. According to Cordeiro and Yaegashi and Oliveira (2018), if the evaluation focuses on the subject's behavior, we run the risk of simplification. If, for example, a student has difficulties in mathematical logic and difficulties associated with attention, he can easily be assessed as a possible student with ADHD or dyscalculia. By simplifying phenomena and manifestations, we are denying the complexity that constitutes human development issues and the manifestations of social interaction. We agree with Farias and Cruz (2019) when they recall that, although Vygotsky recognizes the biological subject, he considers social, historical and cultural determinations to be decisive. In this way, we highlight the danger that we run when, in the name of a supposed objectivity, we stop asking ourselves about the possible

motivations linked to the context and start to analyze the isolated symptoms of a child. We start to always ignore plot, history, and the possible causes of a learning disability.

With regard to this discussion, Bridi and Baptista (2012, p. 8) state that currently

> Classification systems are characterized by the attempt of objectivity, predictability and controllability of the manifestations of human behavior; refer to human thought in a given historical period; represent a paradigm. In the school field, the description of the behavioral paradigm of each category produces an image of who these students are. In general, we have the reaffirmation of a homogeneous representation, which often prevents perceptions about the specifics of each one and the construction of unique experiences (our translation).

As we have already stated, there is a predominance of diagnostic processes based on behavioral analysis, and the advance of etiological explanations for the learning difficulties that would be associated with biological criteria. In both cases - biology or behavior - the phenomenon is interpreted as concerning the subject in question. In parallel, it is important to highlight that, in the context of studies in special education, the concept of disability has come to be understood in recent years as a historical-social construction, distancing itself from a reductionist and intrinsic conception to the subject. This premise had a strong influence on the discussions and guidelines presented in the UN Convention on the Rights of Persons with Disabilities in 2006. In the Brazilian context, Diniz (2007) has been a scholar who analyzes the emergence of the so-called social model of disability, however, there is a slight advance in the sense that this model is assumed as a guideline for investigations and practices.

As Moyses (2008, p. 3, our translation) points out, “What escapes the norms, what does not go well, what does not work as it should. Everything is transformed into a disease, a biological and individual problem”. The standardization of life and, in this case, childhood, has fertile soil in the educational territory. “Medicalizes education, transforming pedagogical and social problems into biological and pathological issues” (MOYSES, 2008, p. 11, our translation).

According to Giroto and Araujo and Vitta (2019), there is a discursivization of the theme of what they call “diseases of not learning”. This process is crossed, according to the authors, by social, historical, and ideological values that are linked to “[...] an ideal of normality taken as homogeneity and erasing of differences” (GIROTO; ARAUJO; VITTA, 2019, p. 2, our translation).

The expansion of diagnostic criteria, mainly from DSM-5, has been associated with phenomena supported by diverse interests, including those of a corporate and economic

nature. The numerical increase in the number of people identified as "sick" has the consequence of expanding a network of services, formative spaces, treatment systems and the use of devices that can be chemical or technical support. Thus, grows the search for specialized spaces for diagnostic evaluations, follow-up, guidance from family members etc.

However, there are many risks of this phenomenon. The diagnostic inaccuracy and the error of a diagnosis given unnecessarily and/or mistaken serve as examples. In this sense, Allen Frances warns us:

> Diagnostic labels cannot be applied with surgical precision to accurately distinguish who actually needs a diagnosis and who does not. At the extremes of severe illness and complete health, the distinction is really obvious. However, the boundary between mental disorder and normality is so blurred that, whenever we rapidly expand the use of psychiatric labels to identify a few individuals who need help, we are mistaken with many others who do not (FRANCES, 2016, p. 107, our translation)

Freitas and Baptista (2019, p. 4) state that the dynamics of medicalization place greater emphasis on symptoms to the detriment of the subject "[...] in a movement that is configured in an 'extreme biologism'". For these authors, it is not a question of denying the importance of diagnosis, regarding the treatment and prevention of certain impairments. What is questioned is the excessive search for identification and its effects related to the label, with the consequent exclusion of this subject from the educational process in common spaces.

It is a fact that we are increasingly expanding the pathologizing processes of life. In the social and educational context, we have witnessed an excessively increased diagnostic production in all age groups, but mainly in the child context. By pathologizing students identified as having learning difficulties, we further expanded the boundaries established in the school context (SANTOS; OLIVEIRA; BIANCHINI, 2018). What we propose in this writing is to problematize these developments that make up the phenomenon discussed. We reiterate the understanding of the existence of risks that exist in a medicalizing logic of childhood and reaffirm the need to understand the processes of initial/diagnostic evaluation as a process that should be linked to the provision of specialized support. Thus, to identify means to explore the potential, in addition to any difficulties, to insert them in a planning that can support educational or therapeutic paths. This understanding has favored investments in school as a plural learning space.

Final considerations

Throughout this text, we discussed medicalization in childhood, diagnostic production and inflation, seeking to problematize the paths we have taken in the constitution of being a child and being a student. This work aimed to identify some of the movements that constitute the studied phenomenon, starting from the understanding that it is a complex and multidetermined phenomenon. We have dedicated ourselves more firmly to the school context, which historically has enhanced the imaginary about what is normal for a large group of children. This enhancement occurs, in most cases, by the division between students with or without learning difficulties, emotional and behavioral issues.

We consider it necessary to analyze the schooling process in a broad way, and not only focusing on fragmented issues, but such also as the learning problems conceived as products of the difficulties of these students. As Souza (2008, p. 6, our transaltion) points out, it is necessary to "shift the axis of the individual's analysis to the school and the set of institutional, historical, psychological, pedagogical and political relationships that are present and constitute the school daily routine". By shifting our gaze to the social and educational context, we take a broader view of our students. Establishing boundaries in the identification process does not favor us, as we challenge the split established in the school context regarding the learning and non-learning processes.

In the present reflections, we are concerned with analyzing the historicity and the engenderments of the constitution of the DSM, which is in its fifth version. Frances (2016) states that the scores presented by the American Psychiatric Association, in its diagnostic manuals, contributed to a greater discussion on the topic; however, they also contributed to the diagnostic expansion.

> The DSM has an ambiguous background. Its editions served the extremely valuable function of raising the reliability of the diagnosis and stimulating a revolution in psychiatric research. But they also had the most dangerous unwanted consequence of leveraging and helping to maintain uncontrolled diagnostic inflation, which threatens the normal and results in massive overtreatment with psychiatric medication (FRANCES, 2016, p. 94, our translatione).

Frances (2016) also says that the DSM has a strong influence in establishing the boundaries between normality and mental illness, and that this was one of the reasons for gaining social relevance (FRANCES, 2016). However, we call attention to the risks linked to the predominance of simplification dynamics expressed in the expansion of the debate and proliferation of procedures, as there is a clear trend that has favored an analysis that neglects

the multiple meanings expressed in a symptom. The manifestations of each subject are taken into account by the different institutions - family, school and health services -, as supposed effects of disorders that would keep a close relationship with the pathological plane as an individual phenomenon. Despite the contemporary debate involving the social approach to disability, the viability of this perspective, as a new lens for analyzing social processes, remains our great challenge.

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