THE DISCOURSE ON DYSLEXIA IN THE DSM-5 AND ITS IMPLICATIONS IN THE PROCESS OF MEDICALIZATION OF EDUCATION

O DISCURSO SOBRE A DISLEXIA NO DSM-5 E SUAS IMPLICAÇÕES NO PROCESSO DE MEDICALIZAÇÃO DA EDUCAÇÃO

EL DISCURSO SOBRE LA DISLEXIA EM EL DSM-5 Y SUS IMPLICACIONES EM EL PROCESSO DE MADICALIZACIÓN DE LA EDUCACIÓN

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ABSTRACT: The medicalization of childhood and adolescence is linked to the medicalization of education in relation to "*diseases of not learning*". In this context, the diagnosis of Dyslexia is legitimized by the DSM, Diagnostic and Statistical Manual of Mental Disorders, used by health professionals. The purpose of this article is to analyze how the DSM-5 diagnostic classifications influence the medicalization of the reading appropriation process. The data were analyzed using a Dialogic Discourse Analysis. The results revealed that the medical discourse, materialized in the DSM text, directly implies the medicalization of education. The DSM-5 presents a version of Dyslexia that disregards the history and the socio-cultural context in which students or adults in non-school circumstances, manifest or have produced symptoms in reading. The ideology on which the document is based is inserted in a biologizing perspective, in which, the specific problems to the learning of reading result from neurobiological disorders and, therefore, can be easily measured, through standardized measures. The consequences of this can be significant, which not only mark the school trajectory, but also contribute to the configuration of a story that is marked by the inability to learn.

KEY WORDS: Dyslexia. DSM-5. Medicalization. Diagnostic.

RESUMO*: A medicalização da infância e da adolescência se articula com a medicalização da educação com relação às "doenças do não aprender". Nesse contexto, o diagnóstico da Dislexia é legitimado pelo DSM, Manual Diagnóstico e Estatístico de Transtornos Mentais, utilizado pelos profissionais da saúde. O objetivo deste artigo é analisar o modo como as classificações diagnósticas do DSM-5 faz efeito na medicalização do processo de apropriação da leitura. Os dados foram analisados a partir da Análise Dialógica do Discurso. Os resultados revelaram que o discurso médico, materializado no texto do DSM, implica diretamente na medicalização da educação. O DSM-5 apresenta uma versão da Dislexia que desconsidera a história e o contexto sociocultural no qual os estudantes ou adultos em circunstâncias não escolares, manifestam ou têm produzido sintomas na leitura. A*

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ideologia na qual o documento se baseia se insere numa perspectiva biologizante, na qual os problemas específicos à aprendizagem do ler decorrem de desordens neurobiológicas e, portanto, podem ser medidos facilmente, por meio de medidas padronizadas. As consequências desse modo de olhar têm desdobramentos significativos que marcam a trajetória escolar e contribuem com a configuração de uma história que passa a ser marcada pela incapacidade de aprender.

***PALAVRAS-CHAVE**: Dislexia. DSM-5. Medicalização. Diagnóstico.*

***RESUMEN**: La medicalización de la infancia y la adolescencia está vinculada a la medicalización de la educación en relación con las "enfermedades del no aprendizaje". En este contexto, el diagnóstico de Dislexia está legitimado por el DSM, Manual diagnóstico y estadístico de los trastornos mentales, utilizado por los profesionales de la salud. El propósito de este artículo es analizar cómo las clasificaciones de diagnóstico DSM-5 tienen un efecto en la medicalización del proceso de apropiación de lectura. Los datos se analizaron mediante un análisis del discurso dialógico. Los resultados revelaron que el discurso médico, materializado en el texto del DSM, implica directamente la medicalización de la educación. DSM-5 presenta una versión de la Dislexia que ignora la historia y el contexto sociocultural en el que los estudiantes o adultos en circunstancias no escolares, manifiestan o han producido síntomas en la lectura. La ideología en la que se basa el documento se inserta en una perspectiva biologizante, en la cual, los problemas específicos para el aprendizaje de la lectura son el resultado de trastornos neurobiológicos y, por tanto, pueden medirse fácilmente, a través de medidas estandarizadas. Las consecuencias de esta forma de ver tienen características significativas que no solo marcan la trayectoria de la escuela, sino que también contribuyen a la configuración de una historia que está marcada por la incapacidad para aprender.*

***PALABRAS CLAVE**: Dislexia. DSM-5. Medicalización. Diagnóstico.*

Introduction

Medicalization is defined as the process in which collective, social and political issues are converted into biological and individual issues. In this sense, the instances of power in which problems are originated and perpetuated are exempt from responsibility (MOYSÉS; COLLARES, 2013).

To think about the medicalization of education, specifically the process of reading appropriation, it is necessary to reflect on the learning and teaching of reading. In addition, it must necessarily lead to a reflection on the locus in which it is constituted and in which it materializes - the school and, in some cases, the clinic. It is in this context that the construction of "*diseases of not learning*" is legitimated, a context in which what is understood by dyslexia is discussed.

The hegemonic discourse recognizes Dyslexia as a specific learning disability, of neurobiological cause, characterized by difficulties in word recognition and in decoding and spelling skills, resulting from a deficit in the phonological component. Such conditions could also result in difficulties related to reading comprehension, scarce experiences with texts, thus implying lexical development and knowledge of the world. These manifestations would be incompatible with academic instruction or cognitive skills (MOUSINHO; NAVAS, 2016).

In practice, what happens is that, when students do not correspond to what the school predetermines as normal, this breach of expectation is attributed to a neurobiological disorder and intrinsic to the subject. Some authors analyze this issue from the concept of Foucault's device (1977), when they affirm that, through scientific discourses, the devices of medicalization produce subjectivities and translate the lines of knowledge, the school being a concrete machine of medicalization, because, it is in the school that places are created to occupy light regimes and the statements engender and medicalize the being and the learning (CHRISTOFARI; FREITAS; BAPTISTA, 2015). On the other hand, we have teachers strongly influenced by the discourse of psychiatry who end up contributing to the rooting of medicalization in the educational environment (ELIASSEN, 2018; GIROTO; ARAUJO; VITTA, 2019), as they prioritize biomedical hypotheses to the detriment of pedagogical knowledge (AZEVEDO, 2018). Dyslexia thus begins at school, with the referral, by the teacher, of the student considered as the one who does not learn, although that same teacher does not know the concept of Dyslexia (ELIASSEN, 2018).

As for families, these are also not on the margins of this process, what is observed is a strong adherence of parents to the medicalization of their children's difficulties, since the search for a report and a medical explanation are the first resources used by families (AZEVEDO, 2018). Thus, the family seeks a diagnosis that justifies the "*not learning of the child*". In this way, the medical discourse on genetic causes is emphasized at the expense of school, subjective and cultural issues. The weight of medical examinations overlaps with the student's sociocultural conditions (poor literacy, restricted literacy habits, bullying, emotional aspects). This is also how the "abnormality" (im)posed by the diagnosis of Dyslexia is legitimized by the family.

Initially proposed for the health field, diagnostic manuals seem to fulfill this classificatory function, demarcating what would belong to the order of normal and pathological. The DSM was created in 1953 by the American Psychiatric Association (APA), with a list of 106 disorders, configuring the first manual of mental disorders with a clinical focus (ARAÚJO; NETO, 2014; MOYSÉS; COLLARES, 2013). Until that time, mental disorders were listed as an integral part of the International Statistical Classification of Diseases and Related Health Problems (ICD). In 1968 the second edition was launched, organized in conjunction with the ICD-8. DSM-I and DSM-II have the characteristic of categorizing disorders, discriminating those that have an organic basis from non-organic ones (MOYSÉS; COLLARES, 2013; ARAÚJO; NETO, 2014). The third edition, however, breaks with this logic and starts to consider that all psychic pathology has a biological origin, disregarding the patients' narrative (ARAÚJO; NETO, 2014; CAPONI, 2015). In 1994 APA launched the fourth edition, which was revised in 2000 and entitled DSM-IV-TR, being used until the beginning of 2014 (ARAÚJO; NETO, 2014), when the most controversial of all versions was published: DSM-5.

To harmonize the classifications, the DSM-5 and the ICD-11 were planned together. With a pact, they formed "task force" teams motivated by the need to facilitate the collection of data on mental disorders, epidemiological research, clinical trials and tests for new treatments, the global applicability of results and the replication of studies in different countries. Thus, the organizing teams opted for a shared work organizational structure (APA, 2013). This strategy of aligning the documents, although with the virtuous justification of facilitating the clinician's work, implicitly unveils a biopower enterprise, an alliance between hegemonic forces, literally, "task forces" united in favor of the certification of the ideologically marked discourse through exclusion and medicalization (BAKHTIN, 2014).

Without a doubt, the DSM-5 is the most criticized edition of all previous versions - although considerations have been directed to DSM at least since the third edition - largely because some researchers consider that the terminological consensus sought by the manual, in which the pathologies must be standardized, in order to fit the diagnostic classification, would practically extinguish communication between clinicians, academic purpose, among other demands (DUNKER, 2014).

As a result, resistance movements and different discussion forums have strengthened the fight against medicalization based on classifying manuals. Internationally speaking, the Stop-DSM Movement, which originated in France in 2010, is against the existence of a diagnostic code that is unique, mandatory and universal (CAPONI, 2014).

It is important to note that the negative assessments directed at the DSM-5 started even before its publication. The main issues raised referred to 3 points: (i) the lack of scientific consistency; (ii) the favoring of medical practice and (iii) the strong relationship with the pharmaceutical industry market (MARTINHAGO; CAPONI, 2019). Added to these issues, of course, is the strong tendency to multiply unnecessary diagnoses (CAPONI, 2015).

Thomas Insel, director of the National Institute of Mental Health (NIMH), the largest scientific organization dedicated to research, understanding, treatment, prevention and promotion of mental health is one of those critics (CAPONI, 2015). Shortly before the publication of the manual, he declared that the institute would no longer be guided by the DSM, considering it to be a list of symptoms constructed based on assumptions and conventions. The criticism, however, was called into question when it was realized that Insel actually had his expectations frustrated by the DSM not having indicated biological markers and scientific studies that would validate the diagnoses (CAPONI, 2015).

Another name that caused great surprise when directing criticism to the DSM-5 was Allen Frances, responsible for the team that prepared the previous version, the DSM-IV. For Frances, the weaknesses of the DSM can be divided into two groups: the first refers to lexical choices, which could lead to errors of interpretation; and the second is related to errors in the elaboration, writing, vagueness and assumptions of pathologies, which in his opinion can lead to a true pandemic of mental disorders. Francis also points out that DSM-5 could promote millions of “false positives”, which would result in countless unnecessary, expensive and harmful treatments (CAPONI, 2014).

Dunker (2014) emphasizes that the DSM-5 ends up being the target of many psychiatrists because it does not correspond to scientific discoveries, presenting only new names for the symptoms and concepts of syndromes.

In this scenario, there are still questions about the nature of the relationship between the pharmaceutical industry and members of the APA, as well as about the economic interest in financing certain research and in the formulation of the DSM itself (CAPONI, 2014).

The crucial point of discussion, then, seems to be the relevance of apprehending the expansion of biological psychiatry, which characterizes and classifies as mental disorder what was previously understood as subjective, as part of a subject, who is historical, social and linked to a culture.

From this context, the objective of this article is to analyze how the diagnostic classifications, in particular the Diagnostic and Statistical Manual of Mental Disorders (DSM), in its fifth edition, have an effect on the medicalization of the reading appropriation process. We specifically want to reflect on the DSM-5 on Dyslexia and the relationship of this discourse with the pathologization of education. The discussion will be conducted from the Dialogic Discourse Analysis (ADD).

Specific Learning Disorder in DSM-5: new cloths, old symptoms

The idea of standardizing learning disorders underlies the intentional adoption of concepts used in an attempt to legitimize difficulties such as “diseases”; they are: *neurobiological; specific; persistence; disorder*; among others. Then, they go through conceptions focused on surveillance, measurement, control, disciplinary evaluations, standardizations, seeking to re-emphasize the biological discourse. The signs selected to compose the manual reveal axiological positions, ideologies, which favor certain places and social groups (BAKHTIN, 2014).

In DSM-5, Dyslexia is designated as Specific Learning Disorder, which may include difficulties in the domains of reading, written expression and mathematics, configuring a more global framework, but with specific codifications for each altered sub-skill. In the case of specific difficulties in the domain of reading, that is, in the case of a “pure” case of Dyslexia, the clinician must indicate that it is a Specific Learning Disorder with impaired reading. However, this change was not accepted without reluctance by researchers and professionals working in this area (MOUSINHO; NAVAS, 2016). And, after much debate, DSM-5 included a note indicating that dyslexia would be an alternative term used to refer to a pattern of particular difficulties in reading. It is not just a matter of replacing one name with another. What happens is the re-concentration of a speech. Adopting a specific disorder instead of dyslexia implies a change in the look of the very definition of dyslexia. The need to explicitly refer to the specific term draws attention here, although conceptually the picture is characterized as global in this view. So, wouldn't dyslexia be more limited to reading difficulties? What is the interest in changing the concept? What other speeches does this response address? The transition from Dyslexia, Dyscalculia, Dysgraphia, Dystography and other "DIS" to Specific Learning Disorder seeks to ensure the possibility of comorbidities, a strong current discourse, while at the same time reiterating the delimitation of the neurobiological disorder. The manual advises that the diagnosis of Specific Learning Disorder be determined based on four diagnostic criteria (Figure 1), which must be fulfilled by the clinician.

Figure 1 – DSM-5 criteria for the diagnosis of Dyslexia

Criterion A: Difficulties in learning and using academic skills, as indicated by the presence of at least one of the following symptoms that has persisted for at least 6 months, despite the provision of interventions aimed at these difficulties:
1. Reading words imprecisely or slowly and with effort (for example, reading isolated words aloud, incorrectly, or slowly and hesitantly, often guesses words, has difficulty spelling them).
2. Difficulty understanding the meaning of what is read (for example, you can read the text accurately, but do not understand the sequence, relationships, inferences, or the deeper meanings of what is read) (...)

Criterion B: The academic skills affected are substantially and quantitatively below expectations for the individual's age, causing significant interference in academic or professional performance or daily activities, confirmed by standardized performance measures administered individually and by comprehensive clinical evaluation. For individuals aged 17 and over, a documented history of learning disabilities with impairment can be replaced by a standardized assessment.

Criterion C: Learning difficulties begin during the school years but may not fully manifest until the requirements for the affected academic skills exceed the individual's limited capabilities (for example, in timed tests, in reading or writing long complex texts and with a short term, in high overload of academic requirements).

Criterion D: Learning difficulties cannot be explained by intellectual disabilities, uncorrected visual or hearing acuity, other mental or neurological disorders, psychosocial adversity, lack of proficiency in the language of academic instruction or inadequate educational instruction

Source: APA (2013, p. 67) – Adapted

Criterion A presents as a main point the statement "*occurrence of persistent symptoms*", which seems to us an attempt to facilitate the complicated discrimination between what is understood as a disorder and a learning disability, corroborating to what has already been said about Dyslexia, that it would be a non-transitory picture, which persists. What the DSM-5 re-emphasizes in relation to what was put forward, concerns a more objective definition of what that persistence would be and how to measure it. In this case, persistent becomes what persists for a period of more than six months, even with some type of support. The discursive intention used in the *persistent* label intends to naturalize the disorder, starting from a very objective and apparently easy to measure parameter (counting the elapsed months), to maintain that its characterization is biological and intrinsic to the subject. It is known that, until then, the traditional model of diagnosis was based on the observation of the IQ-yield discrepancy, in which IQ values (intellectual quotient) were compared to reading performance.

In this way, the determination of the diagnosis of Dyslexia is radically transformed. It goes from a diagnosis given a priori, in which the child is seen failing year after year, without any support, and that after subjecting him to a transversal evaluation, the report as dyslexic, to a longitudinally constructed diagnosis, where, as a sign of any difficulty, there is intervention with child for a certain period and if the child does not overcome the difficulties previously presented, dyslexia is confirmed, which at first seems to be an advance.

Looking more closely at the discourse presented in the manual, this strategy actually turns out to be potentially more medicalizing than the previous proposal, for at least two reasons. Firstly, due to the vagueness regarding the intervention directed to be offered to the child, since there is a silence about who would do the intervention, based on which methodology, frequency or conception of reading, giving scope for them to be ineffective or insufficient and in this case not serving as a parameter for differentiating between extrinsic and intrinsic influences, as intended by such criterion. This silencing and the “vacuum” of discussions about the type of care reveals the understanding of what is reading, language and subject. Given the dissonant effects of meaning of these concepts for the interlocutors involved in this field, these empty spaces are filled by the dominant discourse that, due to its asymmetric position of power, takes advantage of these unspoken words (BAKHTIN, 2014).

When describing the symptoms of dyslexia, the manual also reveals that it is based on a conception of language as code and of reading as decoding (passive interlocutor). Here, the reductionism is pointed out when one starts from this conception. After all, both the oral text and the written text (reading) are addressed to a specific interlocutor and the meanings of the statement are constructed in dialogical practice, therefore, neither fixed nor predetermined. In this sense, reading and understanding are directly related to the meaning of the statement, which, in turn, is inseparable from the concrete situation in which it takes place, that is, reading involves different meanings, based on the dialogic interaction between the reader and the text (interlocutor) and uses with/on/of the language.

Another point that deserves to be highlighted is the rigidity in establishing a time for intervention without, however, clarifying based on which this period was established; in what context and by whom it would be carried out; how often and how long the intervention should take place; or even if in individual or collective mode. Once again, those unspoken have something to say, they have an implicit meaning, they expose the idea of homogeneous subjects, as well as their symptoms and pathologies. This crystallization reveals the intention of the discourse materialized and made official by the manual, to serve as a mechanism for the control of the medical profession over the subjects. Thus, those caught by the diagnosis, remain to resign themselves to be controlled, submit to the administration of an action and respond to it as expected (stimulus-response-reinforcement), as if reading practices and the subject's relationship with the language/reading, were not socio-historically constructed, as if they were controllable and could be predetermined. If so, the teachers at the school would teach all students in the classroom at the same previously established time and all students would have the same route.

The other obscured point behind criterion A is related to the institution of the notion of risk, which, in turn, leads more and more prematurely to early identification. Again, it seems advantageous to be able to identify learning-related problems as soon as possible. However, it should be considered that this unpretentious idea reverberates with ideologies that understand “school failure” and illiteracy as a “plague” that must be eliminated and controlled, based on reading and literacy campaigns that are disconnected from any reflection on social inequalities, literacy practices, different values attributed to the school and the different ways of transmitting cultural capital.

It also concerns the state of vigilance in which the child is placed, the fact that each step must be taken at the “right time”, again from a standardization. It is a concern not to consider, without obviously relativization, that each subject has their time respected and not even wait for the biological time of maturation, a criterion that was previously essential and now totally abandoned.

This is how the apparently naive discourse of the concept of risk and early diagnosis, together with the DSM classification, configure biopower strategies and materialize the medicalization of childhood (MARTINHAGO, 2018; ELIASSEN, 2018). Thus, it is noted in this document the performance of centripetal forces, forces of homogenization, ideologically marked (BAKHTIN, 2014).

Criterion B indicates that the investigation of Dyslexia should be based on quantitative and standardized measures, to measure the subject's performance in relation to his age group. The concern that this criterion generates concerns the disregard of social factors, while at the same time overvaluing the biological, since age overlaps the subject's school trajectory. In addition, it is known that standardized measures contribute little to the understanding of how the subject operates with/on/about language, which is a living phenomenon and inherent to social interaction (BAKHTIN, 2014).

It is known that the emphasis given to the use of quantitative and standardized assessment strategies is based on speeches based on neurobiological explanations, which reduce constitutively complex phenomena to brain processing, such as language/reading. Such conduct proves to be somewhat perverse, since it imposes on subjects a single way of analyzing their symptoms, denying them the right to choose other modes of interpretation on the process of appropriating reading, since naturalistic and qualitative practices are discredited. It should be noted here that the subjects are constituted in the social, based on verbal interaction and through the relationship that is established with their symptoms. In this way, how the child is seen and signified by the other influences his subjectivity.

The labels chosen for this criterion, "[...] quantitative and standardized measures", seek to validate only said evidence-based speeches. But it is worth remembering that “[...] the notion of efficacy in Evidence-Based Medicine (EBM) is associated with treatment in ideal world conditions, that is, the suppression of symptoms” (DUNKER; NETO, 2011, p. 622, our translation).

Criterion B also mentions a comprehensive clinical evaluation. However, it does not indicate what is meant by this assessment. Would it be an investigation conducted by a single professional, who delves into the various aspects related to learning, or a broad team of professionals, in which each one in their specificity analyzes the different factors related to Dyslexia? And it is in this way, with all vagueness and imprecision, that the DSM-5, considered the “bible of psychiatry”, therefore enunciating unquestionable truths, leads to mistaken diagnoses, being subservient to medicalization. Diagnoses that, in most cases, silence the voice of the school (the voice of the teacher), the voice of other professionals, voices that would act in favor of centrifugal forces and that would resound against the hegemonic discourse of clinical/biological bias (BAKHTIN, 2014).

Criterion C refers to the period of onset of dyslexia symptoms, being most frequently manifested when the child enters school, although it can also be diagnosed in adulthood, as knowledge and requirements expand. APA, in pointing out Dyslexia in this way, suggests, for example, that students, even without previous complaints, when entering university and facing difficulties with discourse genres typical of the academic context, can be classified as dyslexic. Or even, that adults in stressful situations, as for example in assessments or tests applied in a limited time, in cases of unsatisfactory results, would have the Reading Disorder. Thus, dyslexia could manifest itself in all life cycles: before (through risk signs); during (with typical symptoms); and after schooling is completed (in specific situations), that is, the subjects are always in the sights of the DSM-5, in the process of being medicalized.

Caponi (2014) states that the fact that the boundaries between what is normal and pathological are so unstable, ambiguous and diffuse, ends up facilitating the medicalization of behaviors considered as undesirable, and the DSM, aware of this fragility and the strength of its speech, seems to take advantage of this fact, expanding, beyond the period of literacy and the school context, the appearance of Dyslexia.

The last diagnostic criterion, criterion D, lists the exclusion factors, configuring a differential diagnosis model, as it is prescribed that other commitments are excluded. A coherent concern is seen here: to discard factors that may cause or interfere in the process of reading appropriation to ensure that it is Dyslexia. However, this task seems to be somewhat ambitious, considering the nature of reading and even more due to the difficulty of evaluating and excluding subjective aspects.

Now, not even questions considered more objective are so easy to observe, even more so if we consider the context of Brazil, where access to health policies is not always guaranteed. To exclude a hearing deficit, at least one otorhinolaryngologist and a speech therapist are required. To rule out visual difficulties, there is a need for an ophthalmologist. Eliminating intellectual disabilities and mental or neurological disorders demands professionals from psychology, psychiatry and neurology. Not to mention the other aspects. By the way, how would it be evaluated, considering the requirement of DSM-5 regarding the use of standardized tests, the occurrence of psychosocial adversities, lack of proficiency in the mother tongue, inadequate educational instruction?

It is worth mentioning that the reality of Brazilian education differs greatly from the production context in which the manual was discussed, the United States of America. Given this scenario, can one speak of adequate academic instruction? In this sense, it appears that the diagnosis of Dyslexia is aimed at the most economically vulnerable classes. The poor, who no longer have access to exams and specialized professionals, and who often do not have access to quality education, are also denied the right to normalcy. Even if the context in which one is inserted does not favor learning. On the other hand, the bourgeoisie, naturally provided with all the resources that capital can offer, frees its children from the etiquette of stupidity, as many subjects diagnosed with Dyslexia recognize themselves or are called, thus guaranteeing the maintenance of their status quo. Thus, the medicalization of education, materialized in this case by the DSM-5 discourse, is yet another tool that promotes inequality and social exclusion.

In addition to the diagnostic criteria, the DSM-5 includes Dyslexia severity specifiers (Figure 2). This parameter refers to the moment of the evaluation, which may differ during the individual's life.

Figure 2 – Dyslexia severity specifiers proposed by DSM-5

SEVERITY	DIFFICULTIES PRESENTED
Mild	Some difficulty in learning skills in one or two academic domains, but with a sufficiently light severity that allows the individual to be able to compensate or function well when appropriate adaptations or support services are provided, especially during school years
Moderate	Marked difficulties in learning skills in one or more academic fields, so it is unlikely that the individual will become proficient without some intervals of intensive and specialized teaching during the school years. Some adaptations or support services for at least part of the day at school, at work or at home may be necessary to complete activities accurately and efficiently.
Severe	Marked difficulties in learning skills in one or more academic fields, so it is unlikely that the individual will become proficient without some intervals of intensive and specialized teaching during the school years. Some adaptations or support services for at least part of the day at school, at work* or at home may be necessary to complete activities accurately and efficiently.

Source: APA (2013, 67-68) – Adapted

In this way, the determination of severity is measured through the functional impact presumably resulting from the difficulties and the need for adaptations or interventions. Thus, a mild Dyslexia would allow the subject to overcome his difficulties, provided with some type of support. Moderate cases would necessarily require more intensive adaptations and interventions. And severe dyslexia would imply systematic and rigorous monitoring, without ensuring as a result a functional and independent reading. In the latter case, the subject with severe dyslexia is trapped in a crystallized position, in which there is little or no room for improvement and movement towards an ideal and effective reader.

And this discourse, being an official discourse, therefore, overestimated, ends up serving as a punishment for the "carrier", who must adapt and undergo prolonged interventions, even without a guarantee of improvement and exempting the responsibility from the teaching system and the teacher, who will have a simplified justification of why his student does not read: Dyslexia (ELIASSEN, 2018). And to say that a subject does not learn due to his own disability is to create processes that will stigmatize the individual, which will be conditioned to medical-political interventions of subjection, tutelage and control built by psychiatric discourses (MOYSÉS; COLLARES, 2013). In addition, medicalizing in this scenario means ignoring what the symptom wants to reveal, it is suppressing its meaning and disregarding the context in which it occurs (MARTINHAGO, 2018).

And still in an attempt to exhaust all knowledge about Dyslexia, the DSM-5 presents what it calls functional consequences of the specific learning disorder, among which he cites: low academic performance; higher dropout rates; lower rates of higher education; high levels of psychological distress; worse general mental health; unemployment; underemployment;

low income and suicide. Placing suicide among the consequences of Dyslexia, just because it is considered a "neurobiological" problem, clearly shows the APA's intention to flaunt the whole society about the dangers of Dyslexia, further corroborating the stigmatization of subjects who fail at school and the proliferation of discourses that legitimize social and educational exclusion.

To think that school difficulties, whether they are of organic or social origin, can be determinant for school and social failure, for unemployment, for depression, shows a certain levity and recklessness, since the only perspective envisaged would be death, suicide. Thus, in the face of such a damning disease there seems to be nothing left but to root it out (ELIASSEN, 2018).

This view, however, reveals the purpose of excluding and then including, and this "false inclusion" will follow the logic of exploiting to maintain the social inequality that feeds the capitalist system. In view of this, the school community must review its *modus operandi* and be cautious with the referrals that put students out of school, always considering the conception of the professionals who perform the diagnosis, as well as how they read the DSM-5. In order to avoid submitting students to mistaken diagnoses and medicalization devices, which can have a substantial impact on the school and life trajectory of these subjects.

Thus, it can be seen that the criteria suggested by DSM-5 for the diagnosis of Dyslexia, despite being masked behind a scientific, neutral and cautious discourse, present gaps, contradictions and represent a medicalizing ideology. In this sense, the Dyslexia Chronotope in the DSM-5 takes place in a complex scenario that alternates between the clinic and the school. These spaces, created, influence each other, leaving the clinic the role of determining the parameters of normality, and then the school identifies the "signs of the problem", which it sends back to the clinic to evaluate, certify and finally the school that validates medical discourse. This game takes place in the "*era of disorders*", at a time when "*an excluding school*", unable to deal with differences in the classroom, makes use of the MBE's argument, legitimizing the neurobiological deficit. At a time of precarious education, polarization of ideologies, scarcity of public policies and loss of constitutional rights.

Final considerations

This study aimed to analyze the way Dyslexia is presented in the DSM-5 and the effects produced on the medicalization of the reading appropriation process. Therefore, it focused on Specific Learning Disorder with impaired reading, which deals with Dyslexia. Research in this area is proving to be increasingly fundamental, given the reverberation of medical discourse, materialized in the DSM text, in the scientific community and among health and education professionals, directly implying the medicalization of education. One of the points that must not be overlooked is that the reading of the DSM-5, what it represents and how its speech proliferates “outside the walls”, is not even known by the vast majority of education professionals.

In this sense, the teacher's doubt as to whether the student is “dyslexic”, who initially leaves the school for the clinic, returns to it, with the confirmation of a lauded neurobiological disorder based on the DSM-5. However, the teacher is unaware that the DSM-5 presents a version of Dyslexia that disregards the history and the socio-cultural context in which students or adults in non-school circumstances manifest or have produced symptoms in reading. The ideology on which the document is based is part of a biologizing perspective, in which the specific problems of learning to read stem solely from neurobiological disorders and, therefore, can be easily measured by means of standardized measures. The document also considers a homogenizing view of subjects and language/reading, as well as underestimating the existence of social inequalities and educational opportunities.

The consequences of this way of looking have significant consequences, which not only mark the school trajectory, but also contribute to the configuration of a history that is marked by disability (Dyslexia) and not by possibility (subject in the learning process).

In this way, the urgency for the mobilization of society about the dangers and losses of diagnostic classifications that consequently result in the medicalization of education is revealed, given the need to fight for a society that recognizes diversity and uniqueness, also in relation to the way of learning. More than clash strategies, it is necessary to promote a reflective space that allows, especially to educators, a truly expanded look at schoolchildren, welcoming the subject and the difficulties he presents, but, above all, consider him a reader (still under construction) with the potential to appropriate written language.

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