MEDICALIZATION AND SPEECH THERAPY PERFORMANCE ADDRESSING SCHOOL COMPLAINT

MEDICALIZAÇÃO E A ATUAÇÃO FONOAUDIOLÓGICA FRENTE À QUEIXA ESCOLAR

MEDICALIZACIÓNEN YACTUACIÓN FONOAUDIOLÓGICA DELANTE DE LA QUEJA ESCOLAR

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ABSTRACT: School complaints are generally characterized as experiences of failure in the educational context that manifest themselves in the expression of suffering and involve actors such as the child, the family and the school. Few studies seek to understand the process of production of school complaints and the relationship between this process and medicalization. Thus, this study aimed to analyze reports from speech therapists about their work with children who had school complaints and identify how much this work approaches or distances itself from practices that contribute to the process of medicalization of education. It is a qualitative and transversal study, based on a socio-historical theoretical-methodological perspective. Six speech therapists who attended children with school complaints in the public and private networks in the region of Salvador/BA participated. Data were collected through semi-structured interviews that, after transcribed, were categorized and analyzed based on the proposed objectives and theoretical reference based on studies on school complaints, school failure, speech therapy and medicalization. Concepts about enunciation and dialogue were also important for the selection and analysis of data. The analysis of the interview statements made it possible to observe that similarities, differences and contradictions crossed the narratives about the various clinical practices related to school complaints. The statements of the speech therapists were marked by practices that were sometimes medicalizing, sometimes not medicalizing, and point out that there is still a long way to go in the attempt to break with the ideological perspective of the biomedical and medicalizing clinic in the performance with the school complaint.

KEYWORDS: School complaint. Speech therapy. Medicalization. Education.

RESUMO*: A queixa escolar é, em geral, caracterizada como experiências de fracasso no contexto educacional que se manifestam pela expressão de sofrimento e envolve atores como a criança, a família e a escola. São poucos os estudos que buscam compreender o processo de produção das queixas escolares e a relação deste processo com a medicalização. Deste modo, este estudo teve como objetivo analisar relatos de fonoaudiólogos sobre a sua atuação com*

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crianças com queixas escolares e identificar o quanto essa atuação se aproxima ou se distancia de práticas que contribuem para o processo de medicalização da educação. Trata-se de estudo qualitativo e transversal, fundamentado em perspectiva teórico-metodológica sócio-histórica. Participaram seis fonoaudiólogas que atendiam crianças com queixas escolares na rede pública e privada da região de Salvador/BA. A coleta de dados foi realizada por meio de entrevistas semiestruturadas que, após transcritas, foram categorizadas e analisadas tendo por base os objetivos propostos e referencial teórico baseado em estudos sobre queixa escolar, fracasso escolar, fonoaudiologia e medicalização. Conceitos sobre enunciado e dialogia também foram importantes para a seleção e análise dos dados. A análise dos enunciados das entrevistas tornou possível observar que semelhanças, diferenças e contradições atravessaram as narrativas sobre as diversas práticas clínicas relacionadas às queixas escolares. Os enunciados das fonoaudiólogas foram marcados por práticas ora medicalizantes, ora não medicalizantes, e apontam que ainda há um longo caminho na tentativa de romper com a perspectiva ideológica da clínica biomédica e medicalizante na atuação com a queixa escolar.

***PALAVRAS-CHAVE**: Queixa escolar. Educação. Medicalização. Fonoaudiologia.*

***RESUMEN**: La queja escolar, en general, se caracteriza por experiencias de fracaso en el contexto educativo que se manifiestan por la expresión de sufrimiento e involucran a actores como el niño, la familia y la escuela. Hay pocos estudios que buscan comprender el proceso de producción de quejas escolares y la relación entre este proceso y la medicalización. Por lo tanto, este estudio tuvo como objetivo analizar informes de terapeutas del habla sobre su trabajo con niños con quejas escolares e identificar cuánto este trabajo está cerca o lejos de las prácticas que contribuyen al proceso de medicalización de la educación. Este es un estudio cualitativo y transversal, basado en una perspectiva teórico-metodológica sociohistórica. Participaron seis terapeutas del habla que atendieron a niños con quejas escolares en las escuelas públicas y privadas de la región de Salvador / BA. La recopilación de datos se realizó a través de entrevistas semiestructuradas que, después de ser transcritas, se clasificaron y analizaron en función de los objetivos propuestos y el marco teórico basado en estudios sobre quejas escolares, fracaso escolar, logopedia y medicalización. Los conceptos sobre la expresión y el diálogo también fueron importantes para la selección y el análisis de los datos. El análisis de las declaraciones de la entrevista permitió observar que las similitudes, diferencias y contradicciones cruzaban las narrativas sobre las diferentes prácticas clínicas relacionadas con las quejas escolares. Las declaraciones de los terapeutas del habla se caracterizaron por prácticas que a veces son medicalizadas, a veces no medicalizadas, y señalan que aún queda un largo camino por recorrer para tratar de romper con la perspectiva ideológica de la clínica biomédica y medicalizadora en el tratamiento de las quejas escolares.*

***PALABRAS CLAVE**: Queja escolar. Educación. Medicalización. Fonoaudiología.*

Introduction

The child who experiences a history of inadequacy or school difficulties is, in some cases, taken by the family or guardians to health posts, school clinics, specialized care centers or private clinics with the so-called 'school complaint' (MACHADO, 1997), characterized in some studies (RODRIGUES; CAMPOS; FERNANDES, 2012; CAVALCANTI; AQUINO,

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2018), mainly by behavioral and/or learning difficulties. Several professionals such as speech therapists, psychologists, psychopedagogues, doctors (especially neurologists) work with the school complaint, however, few are concerned with the complexity of factors - cultural, historical-social, economic, political and biological - that determine their production.

Psychology is the precursor profession in the debate on the subject of school complaints from a historical-critical perspective, especially in the areas of Educational and School Psychology. Maria Helena Sousa Patto's studies on the production of school failure in the 1980s were important for Psychology to move away from the biologizing and medicalizing perspective (PATTO, 1985; 1988). The emergence of these studies did not mean, until the present day, unanimity or homogeneity in the area. Although Critical Psychology has expanded the studies on school complaint and failure (ANGELUCCI, 2007; VIÉGAS, 2016; FARIA; INSFRAN, 2018; PATTO, 2015), in recent years, we still have a large number of psychologists working in a medical clinic.

Like Psychology, throughout its history, Speech Therapy has also been building different paths. In one of these paths, based on the biomedical roots and the corrective ideals that started its practices, as Berberian historicizes (1995), speech therapy has produced (and still produces) a clinic that we can call medicalizing. It is this clinic that welcomes school complaints and reproduces social stigmas about the educational process and about school failure. Attributes diagnoses based on looking at the body and starts to justify not learning due to pathologies such as deficits in auditory, visual and phonological processing, for example, disregarding the subject's singularity, its social and cultural references and the reading acquisition process and writing that occurs in a singular and historical way (OLIVEIRA; TEIXEIRA; SANTOS, 2014). These labels generate implications that go far beyond the clinical space and accompany the subject through other spheres of his life, leaving important marks (SIGNOR; BERBERIAN; SANTANA, 2016).

Contrary to the medicalizing clinic, a clinic has been built detached from the concern to categorize and label language pathologies, a clinic based on a discursive view of language and a conception of a singular and historical subject (SANTANA, 2001; GUARINELLO *et al.*, 2008; BARROS, 2012).

It should be noted that, in this study, the term medicalization is understood according to the Carta of the IV International Seminar '*A educação medicalizada: desver o mundo, perturbar os sentidos*' (Medicalized education: unveiling the world, disturb the senses), published by the Forum on Medicalization of Education and Society, in 2015:

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> Medicalization involves a type of deterministic rationality that disregards the complexity of human life, reducing it to issues of an individual nature, be it in its organic aspect, in its psychic aspect, or in a restricted and naturalized reading of social aspects. In this conception, behavioral characteristics are taken only from the perspective of the isolated individual, who would become the sole responsible for his failure to adapt to the dominant social norms and standards. Medicalization is a fertile ground for the phenomena of pathologization, psychiatrization, psychologization and criminalization of differences and poverty (FÓRUM, 2015, p. 1, op. cit. OLIVEIRA; HARAYAMA; VIÉGAS, 2016, p. 102, our translation).

It should be noted that medicalization and pathologization are not synonymous. Pathologization necessarily involves a disease, and the medicalization process, not always. They are related processes, since pathologization is always involved in a broader medicalization process (OLIVEIRA; HARAYAMA; VIÉGAS, 2016).

Starting from the fact that the theoretical bases that support speech therapy practices are not homogeneous, this article aimed to analyze reports by speech therapists about their performance with children with school complaints and, thus, to identify how close or distant this performance is from practices that contribute to the process of medicalization of education.

Methodological aspects

This research used a qualitative methodological approach, with a transversal character, based on a socio-historical perspective, to overcome the reductionism of the empiricist and idealist conceptions (FREITAS, 2002). According to Freitas (2002), the work with qualitative research in a socio-historical approach "[...] therefore consists in a concern to understand the investigated events, describing them and looking for their possible relationships, integrating the individual with the social" (p. 28, our translation). This research followed the rules established by resolution 466/12 and was submitted to the Research Ethics Committee of the Institute of Health Sciences (ICS), of the Federal University of Bahia, and approved under number 2.128.468.

In order to carry out this research, we opted to select speech therapists who attended subjects with complaints of school difficulties (reading, writing, behavior, inattention, among others) in the city of Salvador (BA), in public and/or private service clinics. As an inclusion criterion, these professionals should have at least two (02) years of professional experience in caring for children with school complaints.

The professionals were selected according to the criterion of the snowball technique, in which each participant would indicate another one that met the inclusion criteria (FLICK,

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2009). The first participant was selected from the professional relationship cycle of one of the researchers, who took a *latto sensu* postgraduate course in the language area during the beginning of this study and lived with speech therapists with different backgrounds and who worked clinically in different institutions.

Thus, a total of six (06) speech therapists aged between 26 and 31 years old participated in this study, identified in this article with the letter 'P', followed by the numbers from 1 to 6. In Chart 1, it is possible to observe information detailed information of each participant with regard to training and the work sector:

Chart 1 – Profile of Participants

	Age	Graduation	Time of professional experience	Public/Private services actuation	Other formations
P1	27 years	Public	5 years	Public	Language Specialization Master's Student in Public Policy
P2	29 years	Private	9 years	Private	Does not have
P3	28 years	Public	5 years	Private	Specialization in Language and Orofacial Motricity
P4	31 years	Public	3 years	Private	Specialization in Language
P5	26 years	Public	4 years	Private	Specialization in Language
P6	31 years	Public	9 years	Public and Private	Specialization in Language Master and Doctorate in Education

Source: Author’s archive

As a strategy for data collection, a semi-structured interview was used that addressed the following themes: professional performance with children with school complaints, professional formation and their relationship with important actors in the schooling process (teachers, principals, pedagogical coordinators, for example). The interviews were carried out on the day, time and place stipulated by the researcher and interviewee, taking into account an environment of easy access and comfort for both. The interviews were recorded on audio and had an average duration of thirty (30) minutes each.

After collection, the information obtained was transcribed, organized, selected and categorized, based on the proposed objectives and theoretical framework based on studies on school complaints, school failure, speech therapy and medicalization. In the selection and analysis of data, the concepts of statement and dialogic, by Bakhtin (2003), were also important. The analyzed statements, concrete and unique, given by the participants of this research, in a sphere of human activity (the interview), produced in a socio-ideological context (BAKHTIN,

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2003), were analyzed both from the point of view of the ideological content and the conditions of production.

The initial reading of the interviews made it possible for the data to be organized into two major categories of action with the school complaint: the moment of the evaluation and the therapeutic proposals resulting from the evaluation process. From there, nuclei of meanings related to the mentioned categories were organized, creating subcategories about the positions of each interviewee that allowed us to analyze the differences or proximity of positions between the interviewees or, still, the possible contradictions of positions within the same interview.

Results and discussion

After reading the material selected for analysis, some relevant points were observed in the statements of speech therapists regarding the performance of these professionals with the school complaint.

It was sought, in a careful and attentive way, to bring the interviewees' view of their therapeutic practices related to school complaints, more specifically, to their work with the child, family and school. It was also sought to identify how much this performance approached or distanced itself from practices that contributed to the process of medicalization of education. Two aspects of therapeutic practices were highlighted: assessment and therapy.

About the evaluation process

It is in the evaluation process that relationships between therapist, child and family begin, taking as a starting point the previous complaint that promoted this meeting. As in any other practice (clinical or not, evaluative or not), this meeting can be followed by medicalizing or non-medicalizing paths (GENTIL, 2016). From the statements below, it is possible to verify that the evaluation is a practice mentioned by almost all the interviewees, following different paths:

> *[…] the welcoming, which is a moment when we make an initial assessment, we already have the moment of qualified listening before he goes into therapy with the patient*. (P1, our translation)
>
> *We receive the child, make the assessment... I do some assessments, mainly neuro assessments, related to development and such to see what are the demands within Speech Therapy that she is presenting... Language changes, the beginning of reading and writing... so, like, it's starting to develop this part of reading and writing, right? How is this coherence, this cohesion? How*

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> *is this grapheme organization, phoneme? Today, here at the clinic, we work with global assessment. What do we do... we receive the child, go through all the professionals and from there we define if it is only for the psychologist, if it is only for the speech therapist.* (P2, our translation)
>
> *So, I usually start with the listening, hearing a lot to what this family brings, what are the characteristics it brings to this child so that I can make parallels and explanations of how many potentials they are unable to see, how many defects they have, they see much more than the characteristics of not learning, of behavior, anyway... So, first I listen to what they are saying and within the therapy I talk a little more with the child alone, I insert the parents into this... of therapy, so that I can show it like this "look at this, what a beautiful thing he did! He did it alone!"* (P3, our translation)
>
> *After my evaluation process, I thought everything... right? I closed the assessment, I go to school.* (P4, our translation)
>
> *I act, in the first place, accepting this complaint, accepting the demand of the subject, family, school and seeking to reframe this relationship of suffering of the subject with writing or with the educational process.* (P6, our translation)

It is noted, in the statements above, that the interviewees P1, P3 and P6 describe their evaluative practice as an instant of listening and welcoming, both with the family and with the patient, being the crucial moment to better understand the complaint and not for the identification of strictly speech therapy demands, as pointed out in the statement by P1: *"...they are children who are already in such pain at that school that it is a relief for the family to hear that it may be another the question, right?*" That is, qualified and welcoming listening breaks with the stereotypes marked in the complaint and enables new meanings and paths for the child and his family in the face of the school process, as can also be seen in the statements of P3 and P6 listed above.

On the other hand, it can be observed, in the interviewee's speech P2, an evaluation process more focused on the investigation of signs and symptoms that characterize a speech therapy demand (difficulties in writing, voice, orofacial motricity, hearing) and that may be associated with the process schooling. In an excerpt from P2's speech, it is possible to observe this practice: "*I make some assessments, mainly neuro assessments, related to development and such [...] we receive the child, make the assessment, see what the demands are within the Speech Therapy that she is presenting... see if it's just demand, if she's goes to the speech therapist*". The evaluation aimed only at identifying signs and symptoms is the result of the biomedical roots still impregnated in Speech Therapy, in which the subject becomes just a body that is mapped to identify characteristics that justify the therapeutic performance (GENTIL, 2016). Interviewee P4 mentions that she performs an evaluation, but does not provide any more

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detailed information about it. P5 does not mention the evaluation process at any time during the interview.

Another important highlight related to the evaluation concerns the difficulties mentioned by P3. The interviewee reports that the family arrives at the office requesting a specific assessment, of a specific symptom or disease, using a specific test. P3 talks about his difficulty in dealing with this family stance:

> *She came to me asking what the CAPD evaluation was like, 'How is this assessment? Do you make this assessment? 'I said 'oh, who forwarded it? How was that? What does she have? How are you feeling?', "No, like this oh, my daughter has something, I'm looking for that right? So, I want the CAPD evaluation!', I said 'ah, do you already know how the CAPD evaluation is? Let's explain how is the CAPD evaluation', I explained everything!* (P3, our translation)

For Amaral, Carvalho and Collela-Santos (2020), CAPD (Central Auditory Processing Disorder) "is defined as a deficit in the neural processing of auditory stimuli and can coexist or be associated with changes in language development and/or neurological conditions" (P. 2, our translation). Among the most frequent language disorders, mentioned as resulting from the CAPD, are reading and writing difficulties and Attention Deficit Hyperactivity Disorder (ADHD), considered a comorbidity. Oliveira, Harayama and Viégas (2016) highlight that the demand for the diagnosis of CAPD in school-age children has increased considerably, and the confirmation of the diagnosis "has served as a kind of opium that intoxicates the reflection on the complex processes involved in failure diagnosis of the diagnosed child" (p. 114, our translation). The authors also point out that "it has drawn attention that families, schools and even health professionals have claimed the diagnosis of CAPD and other disorders (such as ADHD and dyslexia), affirming it as a child's right" (p. 114, our translation). The family charges the therapist for a specific procedure, sometimes because it is guided by a doctor or another professional, but also because it is crossed by a medicalizing ideology - from which it has become very difficult to escape - and believes that that specific diagnosis can be as much the cure for access to quality education.

In addition, P3 mentions how the private system deals with different methodological approaches. Here is P3's comment:

> *I explained what was different from my approach, what my approach was and that I cannot do in a plan session. So, it goes beyond this private relationship that we end up falling into. Anyway, in this case it was a case like that, it was one of the most complicated ones, because it was a family that wants something else. So, to be able to bring other information is very difficult! If*

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> *the family already has a formed thought, some diagnosis in the objective evaluation, what that neuro said, what that professional or another said, what the read on the internet... so, when they already go with this solid idea, is very complicated for us to be able to show another point of view, to show another approach.* (P3, our translation)

The private health system operates not only on the diagnostic process, but also interferes with speech therapy practices in general, as pointed out by P3. The professional is limited to following the performance standards of the private health system, which often restricts the performance of the health professional to rules and protocols centered on the hegemonic model. If the speech therapist seeks to act differently, the system tensions him so that he cannot, as P3 points out. Both the public and private health systems can impose limits in relation to the choices and possibilities of professional performance with the school complaint, however, precarious bonds, in which "the employment risks are assumed mainly by workers and not by their employers or by the government" (EBERHARDT; CARVALHO; MUROFUSE, 2015, p. 19, our translation), can reduce the possibilities of facing the hegemonic perspective. To resist and exist within these systems, in a model that proposes to demedicalize health, education and life have not been an easy task.

The public system, despite all structural limitations, in management and working conditions, proposes views and experiences that can go beyond the ties of the capitalist system of private health services, placing professionals in situations that provide broader clinical care. Unfortunately, the reality of the speech therapist in the Unified Health System is still timid, with the Northeast region being the region with the lowest offer and expansion of the profession in the SUS (SOUSA *et al*., 2017).

About the therapeutic process

Regarding the focus of the therapeutic practices carried out with school complaints, it was observed that such practices are built from the data obtained in the speech therapy evaluation, and two points were highlighted in the performance of all interviewees: working with the family and the school.

Regarding the work done with the family, even though it is considered an important actor in the therapeutic process, different practices were observed. The interviewees P2, P3, P4 and P5 prioritized more verticalized, unidirectional and, sometimes, blaming practices, because they pointed the family as responsible for the therapeutic success or failure. Here are some excerpts from the interviews:

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> *The family has guidance. I make the family understand the process, what is being done, what is being worked on and what they can observe in the child, in the other context, at home, at school activities, at family meetings... the family is also taking all the therapy, of course, in a more relaxed way, not so therapeutic, not so professional, but to continue what we are already doing in the clinic. I try to meet with parents at least every month.* (P2, our translation)

> *So, with the parents it is essential, there is no way to have therapy with a child without including the parents, even more for this, even more for reading and writing "what do I see lately, more like this... parents who are skeptics, who do not believe in what I'm doing, because it's a lot of fun and they want activity or demands "where's it? He's not writing... now it's over, the difficulty is there, the teacher is demanding, everyone is demanding! Give me results!" We need construction and partnership. And then, many parents, many, many, I can raise awareness, like this, bring my approach, how do we insert it, with the parents I need to say the same thing twenty times so we can have this availability to have changes in their daily lives, which are so small... my interpretation with the parents is to be very patient, you need to have patience because, in fact, we need to repeat things a little.* (P3, our translation)

> *With the family all the time! From the beginning to the end. So there are mothers that I don't get out of therapy in the first three, four months of therapy and she stays in the room all the time. There are already others that depend a lot on the seriousness of the situation. You notice that the mother responds to the stimuli that we ask for only at the very end of therapy and I take her out and at the very end we call. If it's a mother who is very resistant, you realize that you're talking and she doesn't understand, or she's talking and doing it differently, she can't understand, she is in therapy to observe the moments that the child is doing, as we are acting for her to try to reproduce this at home in the best possible way.* (P4, our translation)

> *Success is completely linked to this and the family in any situation, which is she who is interested, right? Which will really promote the changes that we suggest and... show what is best for that child. If the family does not, it won't do any good, right?* (P5, our translation)

It is noted, in the statements of P2, P3, P4 and P5, that the work with the family prioritizes a very common practice called 'guidance', in which the professional, holder of knowledge, instructs the family on what to do (and how) for the child to improve. In this practice, the presence of a traditional biomedical, prescriptive, vertical and blaming clinic is observed. In this model of action, the different family structures and arrangements, socioeconomic conditions, the role of the caregiver - especially the mother (in general, crossed by a patriarchal model that overloads her) - and cultural and affective relationships are not considered, therefore, this model is based on a reductionist and medicalizing performance. In a medical clinic, issues such as family structure, family relationships, low purchasing power with precarious living conditions are related to the child's learning (FERRIANI; IOSSI, 1998) and serve only to justify not learning. The statements of P1 and P6 are configured in another perspective of performance:

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> *All sessions have this time to talk to the family at the end of the session. So, it's nice for you to show the mother and the family member the other side of the story too, of the child's potential for the family to see. Because sometimes the family only sees the difficulty... even from the discourse if you are going to analyze "look, you can't do it, you can't. You still don't get that". Then show the other side of the coin to the family too.* (P1, our translation)

> *So, yes, I accept this demand and try to reframe and build a new look with the family, [...] I always try to talk to the people who are part of the educational process of this child, this teenager, so that together we can build a new one perspective of this subject's relationship with language.* (P6, our translation)

It is observed, in the statements of the interviewees P1 and P6, practices based on more horizontal and dialogical relationships, a speech therapy activity that seeks to understand that the family is an essential part in the child's school process and that there are difficulties and potentialities in it. They emphasize the importance of attentive listening that welcomes anxieties and experiences, listening that can re-signify stigmas and stereotypes, capable of finding shared ways that lead to coping with the complaint of school failure.

As for the work done with the school, all the interviewees pointed out that the relationship with the school is very important for clinical practice, however, it is possible to notice differences and contradictions in relation to the way this relationship is built.

Interviewee P4, for example, points out that, after the child's speech therapy assessment at the clinic, her work starts to take place in the school space to observe the school and the child:

> *I closed the evaluation, I go to school, I always schedule the first visit with the school for observation. So, the visit that I will try to stay there at school just observing the behavior of that child in his class and break routine, with the other children.* (P4, our translation).

Then, P4 mentions that he returns to school to implement speech therapy strategies with the teacher and pedagogical coordinator, and also with the aim of listening more to the teacher and/or the coordinator:

> *I return to school to talk to the teacher and the pedagogical coordinator to listen to his demand and from there we sit down and think about joint strategies, if necessary, because there are children who need the teacher to adapt their pedagogical activities to demand of child* (our translation).

P4, in this statement, takes a stance that seeks dialogue and the joint construction of strategies that can help the child in the school process, affirms that it is necessary for the teacher to "*adapt his pedagogical activities to the child's demand*". When the researcher asks about the difficulties presented by P4 in her performance with the school complaint, some contradictions appear in her narrative:

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> *There are teachers who are extremely resistant to that work. there were teachers who asked me "listen here, but are you going to do my pedagogical work?" or else... I give my whatsapp a lot, everyone has my whatsapp, but he doesn't look for it, he doesn't have that return, he won't go, despite you being available. So if I'm going to tell you, half, half. Half I have had a good acceptance and the other half unfortunately not. [...] Most times we are with the child once or twice a week. The teacher stays every day of the week depending on whether it is a full shift and stays with the child all the time. And then he has a privileged role, which is this. If we know how to get together and make a good and interesting partnership, that teacher will be the multiplier and will help that child to enhance what we have been working on in therapy. So for me it is extremely important.* (P4, our translation).

When saying that teachers are extremely resistant to speech therapy work, there is a blaming of the teacher for the difficulty of speech therapist in accessing it. Interviewee P4 attributes this 'resistance' to the lack of knowledge of the speech therapist's work on the part of the teacher or a threat to the supposed possibility of the speech therapist taking on the teacher's pedagogical role. The teacher is blamed for not adhering to the proposed work and for not giving feedback or not contacting the professional. P4 continues his statement talking about the importance of the teacher, who has the privilege of being with the child all week and, therefore, can be a 'multiplier', in the sense of enhancing the therapeutic process. Gomes and Brito (2006) emphasize how much education professionals have been required to offer quality teaching, within a system whose material resources are increasingly precarious, low wages and overload of functions contribute to physical exhaustion and damage to health. Care must be taken in the partnerships we have with teachers so that our practices do not become an overload.

Some contradictions can also be seen in the statements of P5, when this interviewee deals with her relationship with the school and the difficulties faced in this relationship:

> *But for school there is a consultancy, on how I can help this child in the classroom. So, I'm going to help teachers understand that part. I think it borders on consulting and actually hearing what the real problem is, right? What is the child's real difficulty in that area. I think it's more or less around.* (P5, our translation)

> *The difficulty is too great! At school, I think it is necessary to put into practice what we advise because of the classroom dynamics, right? It is twenty students, three assistants, it is not possible to give special attention to a child, for example, who does not have a medical diagnosis... which is the majority of our children, right? Which comes to speech therapy diagnosis. I even went through it yesterday. So, like that, it's difficult... they face it differently. If diagnosed it is much better for them. They will put in 20% of the curricular adaptation right? The rate of is... of special children, whatever the diagnosis, it makes no difference. It may be an ASD, it may be an ADHD, but coming from a psychiatrist, for example, they can already use the diagnosis as a tool to adapt.* (P5, our translation)

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It is observed, in the statements, that the interviewee P5 understands her practice as a consultancy. P5 reports, at various times during the interview, her effort to be at school in order to understand the child's difficulties in this context. However, her look is medicalizing, for example, when she places herself in an asymmetrical position in relation to the teacher (and the school) who receives her orientations, assuming that her technical knowledge is superior. She is also medicalizing when she focuses her practice on speech therapy diagnosis related to a disease and not on the functioning of language, as well as when she relates the appointment of a diagnosis to access to quality and inclusive education.

Speech therapists P1, P3 and P6, on the other hand, point to a performance in which they are concerned with the partnership established with the school and with the need to rethink the posture of speech therapists in this relationship, as well as they are concerned with the subjectivity of the subject and with the suffering resulting from experiences with language in the school environment. P1's statement demonstrates its concern to build partnerships with the school and other professionals and rethink the position of Speech Therapy in this relationship:

> *This articulation with other professionals is... in other areas it is already important, especially in reading and writing as well. How to go to school, to know what attitude you will adopt at school too, because you will not interfere in the pedagogical conduct, but you can be a partner of this professional. So we can also rethink our posture in these spaces, which sometimes, our posture in these spaces makes these other professionals have another look at us, right?* (P1, our translation).

The interviewee P3, in her statement, points out the difficulties of making visits to the school due to her work routine and that of the school itself. It also brings relevant comments on the purpose of the visit:

> *So, normally, not as many visits to school are made as I would like. Both the routine of the school itself and our routine... if we think of the ideal service I would think of a much greater presence within the school. [...] This visit to the school, which aims to see how they are correlating, how the school material is, how the assessment is, what is happening inside... and I see if they need more support, I also provide material... and so... on pedagogy, on the literacy process, on the type of school base, so if it is constructivist... so, I think that this knowledge is lacking for us and I am also unable to evaluate this part... I cannot get very close to this theme about evaluation, about curriculum. I would like to go deeper in this area, in this part that involves the school, but still, I stay in a slightly more restricted part*. (P3, our translation)

In the statement of P3, it can be seen that the proposal to act with the school is also to understand its functioning, the routine and the didactic-pedagogical material. P3 points out that he has difficulty in building a relationship with the school in his routine and points out that the

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school routine can also be a complicating factor. Another relevant point in P3's speech is his concern with the restricted knowledge of speech therapy training in relation to educational knowledge, about the curriculum and assessments. Interviewee P6 goes in a more dialogical and de-medicalized direction and highlights that:

> *I think it is important that the speech therapist considers that a story that comes marked by a school complaint, is not a story that is isolated from the social context as a whole, you know. School is not an island in society, it is immersed in an unequal society, in a society that prioritizes a specific social class, where especially in our country, in our... in our region, in our state, not all have the best conditions to have access to culture, to have access to education. So, the speech therapist needs to know that his role is not only to consider biological issues, but to consider that this subject is inserted in a context, you know, and that context is social and historical. [...] In general, when someone comes to the clinic with a school complaint, I always keep in touch with the school, I always try to hold meetings with the pedagogical coordination, with the teacher, with the health professional who, suddenly, have it at school and follow the case. So, this is the way I find access to school today.* (our translation)

In his statement, P6, when defining the school as part of society and determined by socio-historical aspects, also questions the role of the speech therapist and his commitment to understand the school complaint as part of this historical construction, of a society marked by inequality and by class privileges - race privileges are added.

In general, P1, P3 and P6 presented practices that can be understood as being of a less (or not) medicalizing character, because they do not blame the apprentice, the family and/or the school for the school complaint or failure but understand the complexity of socio-history of each of these elements. Demedicalizing because they do not reduce the child to their diagnosis (whatever it may be) and present practices based on an intersectional and dialogical model, whose purpose is not to inform, guide, but to transform existing knowledge, to build shared and responsible educational practices that contribute, in fact, for a liberating education (FREIRE, 1996).

Final considerations

The school complaint is one of the main demands in the speech therapy clinic. Mainly marked by not learning, it invades the clinical space and mobilizes the speech therapist to go beyond the walls of his office and think about the school environment and all its functioning, structure and actors involved. Although speech therapy has germinated its seeds in the school environment, as pointed out by Berberian (1995), the corrective ideals and what is normal or

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pathological in the educational process are still sometimes configured from a biologizing perspective.

The analysis of the interview statements made it possible to observe that similarities, differences and contradictions crossed the narratives about the different clinical practices related to school complaints.

The moment of evaluation was pointed out by some of the participants as the moment of identification of symptoms/pathologies related to language, showing that the biomedical roots, supported by curative practices and rehabilitating human communication, still guide some speech therapy practices. On the other hand, other interviewees reinforced that this is the moment to welcome school experiences and the whole learning process of the child and his family, whether these experiences are linked to the child's difficulty or not.

The analysis of the statements presented in this article, marked by practices that are sometimes medicalizing, sometimes non-medicalizing, points out that there is still a long way to go to break with the ideological perspective of biomedical clinic. Many professionals have tried to break with the medicalizing logic and, sometimes, some are captured by the bonds of the system that suffocates and imprisons the subjects in their biologizing way of thinking about the clinic, education and life.

Breaking with the hegemonic biomedical and medicalizing clinic is an arduous and laborious task, requiring a continuous search for the path to be followed. The path of a demedicalization is composed of an incessant search to take responsibility for the transformation of life, without labels and stigmas that imprison and suffocate Brazilian children and young people every day.

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