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MEDICALIZATION OF LIFE AND ITS IMPACT ON CHILDHOOD

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Abstract: The present work aims to present a study on medicalization and its impact on childhood. Starting from the concept of medicalization, a historical review is made of its incidence in the Brazilian family from the 19th century onwards and how this process had as its main focus the creation of the child. Based on the author's experience in a children's CAPS in the city of São Paulo, we show that it is possible in the public service to offer children with developmental problems care that favors their psychic structure, as recommended by the Psychiatric Reform. The ideology that legitimizes modern barbarism, in its "scientific" and "biological" forms, favors the resurgence of medicalization, given that capitalism, in its most savage form – neoliberalism – aims to produce consumers and not the constitution of subjects of desire, creating conditions for the medicine industrial complex – pharmaceutical industry – hospital industry to operate with increasingly greater profits.

INTRODUCTION

The medicalization of life is not a contemporary phenomenon. It began simultaneously with the urbanization of Brazil, still in the Empire:

> Social medicine realized that urbanization forced the family to change and that the State, supporting the expansion of public health, had given it a certain trust that it was up to exploit as far as possible. The intervention in the house responded, in part, to this strategic movement. Taking charge of the hygienic transformation of the family continent, doctors gained ground, occupied empty spaces, tried to present themselves as useful, necessary, indispensable to the health of all physical and social places in the urban universe. (COSTA, 2004, p.113-114).

Child care, at this time, has gone beyond school and family, with medical discourse having been appropriated from it.

In modernity, the child is the stake for the future of civilization. Vorcaro states that, through new knowledge and new control modalities, it is necessary to know it from all aspects, take care in order to prevent all risks, optimizing their potential, (...) "they are imperative to ensure the control of uncertainties of the future of civilization and guaranteeing the stability of the social order." (VORCARO, p.220).

In the first half of the 20th century, the mental hygiene movement emerged, whose focus was the early detection of mental problems, particularly in childhood, beyond the walls of the asylum. In Brazil, this movement is influenced by Psychoanalysis, with Arthur Ramos and Durval Marcondes as key figures.

Established by Federal Law 10216 of 2001, the Psychiatric Reform changed the paradigm of care for children in distress. Children's CAPS arrive in the city of São Paulo, replacing day hospitals. This equipment, fruits of the Reform and indirect heirs of School Health services, have their fundamental pillars in the assumption of the subject and his uniqueness, in transference and in play, thus placing themselves in notorious opposition to psychiatric nosography, cognitive therapies -behavioral and medicalization.

However, capitalism, to achieve its ends, needs, in Oliveira's words, to destroy the intentions of autonomy, creativity and liberation. Quoting Paulo Freire, the author states that consumer society has a necrophilic tendency, that is, "(...) it does not need, does not desire and does not want living and desiring human beings, fighters and transformers. You need to robotize them, you need to destroy their hopes and direct their energies towards one goal: consumption." (FREIRE, 1970, apud OLIVEIRA, W., 2018, p. 15).

After the 2016 coup, we saw barbarism come out of the shadows and show its horrendous face. The attacks on the Psychiatric Reform and, consequently, on the CAPS model became virulent. Although they have not been successful in extinguishing this equipment, they do so in an insidious way, outsourcing and scrapping the services.

Thus, we see the circle closing, as the medicalization of life and childhood, which today has medicine as the organizing element of a larger structure, as Oliveira refers, and medicine is also appropriated by the structure represented by the medicine-industry industrial complex. pharmaceutical-hospital industry. And, the author adds: "(...) And, furthermore, this complex is a subsidiary of the capitalist political-social structure, with a mercantilist orientation." (OLIVEIRA, 2018, p 12)

CONCEPT OF MEDICALIZATION

Foucault - a fundamental author in understanding the process of medicalization-, through the historical analysis of the small powers acting in society, distinguished "the agents responsible for creating patterns of social behavior into *legal and normative* ones". (FOUCAULT, 1976, apud COSTA, J.F., 2004, p. 49)

The order of law, whose main mechanism is repression, is imposed through a punitive, coercive power, which acts by excluding and imposing barriers. The law is theoretically founded on the legal-discursive conception of power and historical-politically created by the medieval and classical State. The norm, on the contrary, has its historical-political foundations in the modern States of the 18th and 19th centuries, and its theoretical understanding explained by the notion of devices. These devices are formed by a set of discursive and non-discursive practices, employing a technology of subjection of its own.

> The discursive practices that integrate them are made up of "theoretical elements" that reinforce, at the level of knowledge and rationality, the techniques of domination. These elements are created from available knowledge – scientific statements, philosophical conceptions, literary figures, religious principles, etc. – and articulated according to the tactics and objectives of power. Non-discursive practices are formed by the set of instruments that materialize the device: physical techniques of body control, administrative regulations for controlling the time of individuals and institutions, techniques for the architectural organization of spaces, techniques for creating physical and emotional needs, etc.
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> It is from this combination of theoretical discourses and rules of practical action that the device derives its normalizing power and, through regulation, individuals are adapted to the order of power not only by the abolition of unacceptable conduct, but, mainly, by the production of new bodily characteristics, sentimental and social. (COSTA, 2004, p. 50)

For Foucault, the meanings of medicalization are linked to:

> 1) a process of sanitation, urbanization and, consequently, development of public and sanitary hygiene; and 2) the process of erasing the boundaries between medicine and life as a whole, that is, the *process of indefinite* medicalization. (ZORZANELLI, 2018)

The modern State, whose characteristic is industrial development, needed to have demographic and political control of the population and, with this purpose, created two types of normative intervention that, at the same time as defending the physical and moral health of the family, implemented the policy of State.

> The first of these interventions took place through domestic medicine. This medicine, within the bourgeoisie, stimulated population policy, reorganizing the family

> around the conservation and education of children. The second was aimed at poor families in the form of public moralization and hygiene campaigns.
>
> Philanthropy, social assistance and medicine worked together to manipulate the bonds of family solidarity and use them, when necessary, to retaliate against insubordinate and dissatisfied individuals. These demographic interventions, with the rich, and demographic-police, with the poor, allowed the proliferation and release of a politically docile workforce for free play in the labor market. The medical-philanthropic-assistance action led to private life without disrespecting the social pact. (COSTA, 2004, p 52)

The medical device was introduced into the family transformation policy, thus compensating for the deficiencies of the law. Medicine responded to hygiene, whose work developed in the 19th century was based on the idea that the health and prosperity of the family depended on its subjection to the State, starting to classify conduct that harms the State as unnatural and abnormal. One of the fundamental objectives of the hygienists was the conversion of the family universe to the urban order.

This exchange of favors between medicine and the State was guided by the same logical axis: the repertoire of feelings and behaviors, which were previously managed by the family, were taken over by medicine and, through it, returned to state control, to be reinserted into the fabric social, according to a given articulation.

> The family has converted from a large socioeconomic body into a *cell of society*. "By fracturing the relations of "caste", religion and property, medicine prepared the family to accommodate and participate in the creation of the values of class, body, race and individualism characteristic of the bourgeois State." (COSTA, 2004, p 151)

If in the 18th century the medicalization of cities was of paramount importance for social development, as highlighted by Foucault, the second episode, now more contemporary, of indefinite medicalization, becomes the target of interest, to the extent that, in the 20th century, medicine lost its borders and began to occupy the entire social field outside the subject's demand. "Medicine then became part of everyone's daily life, as an intervention without demand, incorporated into sexuality, schools, families and the courts." (ZORZANELLI, 2018). Thus, medical practices are everywhere, as health becomes an object of desire and profit, materialized in the individual cultivation of a healthy body, exalted as an ideal.

Added to this, we see, in Western societies, the increasing displacement of problems inherent to life to the medical field, transforming collective issues, of a social and political order, into individual, biological issues.

> Biologization, based on a deterministic conception, in which all aspects of life are supposedly determined by rigid biological structures and without interaction with the surroundings, removes from the scenario all processes and phenomena characteristic of life in society, such as historicity, culture, values, affections, social organization with its difficulties of insertion and access. This reduction of life, with all its complexity and diversity, to just one of its aspects – cells and organs, rendered static and deterministic – is a fundamental characteristic of positivism. Thus, life is removed from the scene. (MOYSÉS and COLLARES, 2018, p 155)

Based on this assumption, in which the future is determined from the beginning, the ground is prepared for medicalization, a phenomenon whose concept was proposed by Luz (1988) as:

> (...) process by which men's way of life is appropriated by medicine and which interferes in the construction of

> prescriptions – sexual, dietary, housing – and social behaviors. concepts, hygiene rules, moral standards and customs. This process promotes interventions in society, including political ones, articulated with knowledge, scientifically produced in a social structure. (LUZ, 1988, apud COSTA, 2018, p 12)

However, it is worth highlighting that, although medicine is seen as the organizing mechanism, it itself is appropriated by the larger structure represented by the medical-hospital-pharmaceutical industrial complex, a subsidiary of the capitalist political-social structure with a mercantilist orientation.

> The articulated set of industrial production actions, mobilization of key actors and cultural promotion through massive propaganda, led to a point where the machine acquired a life of its own and no longer strictly depends on any of these factors, such as doctors, to ensure excessive and unnecessary consumption of medicines. Through cultural production, patients themselves have learned to demand the use of these products and doctors who refuse to prescribe products that are specifically demanded are discriminated against as negligent or bad professionals. The voice of the medical-hospital-pharmaceutical complex is today diffuse, appearing in all media that, in an integrated and often non-explicit way, promote neoliberal capitalism as a whole. (OLIVEIRA, 2018, p 12-13)

MEDICALIZATION AND CHILDHOOD

In Colonial Brazil, knowledge, to maintain the solidity of property, came from the re-edition of domination formulas used by ancestors, transmitted through oral tradition, and through personal experience. Consequently, the old was more important than the new, insofar as useful information had its source in the past. The head of the house was, then, the spokesperson for this knowledge and, therefore, his interlocutors needed to be in a position to understand the legacy he was responsible for transmitting. The child, therefore, was excluded from this list, not deserving the same consideration as the adult.

> The family's socioeconomic organization and the past knowledge that structured it relegated the child to a kind of cultural limbo in which they remained until puberty. Cementing these two factors was the religious vision of culture. (...) The child, as a biological and sentimental being, was despised by religion. (COSTA, 2004, p 159)

Catholicism was interested in children only as a sign of purity and innocence, as a model of spiritual perfection, to serve as an example and correction to man's sinful soul. So, the child venerated by the church was the "angel", this image being the product of a dissociation from the child; that is, concrete life repressed for the benefit of supernatural life. However, it was in the cult of the dead child that the strength of this representation appears clearly.

> In the colonial period, the social and religious representation of children monopolized the meaning of their lives. The cultural roles of "incapable child" and "little angel" overlapped and obscured their status as a biological-moral stage in adult development. Children's lives persisted apart from the lives of older people, as if its core belonged to a second human nature. Imprecise, expectant nature, which remained in a larval state until the awakening of puberty. Between the adult and the child, the existing connections were of property and religion.
>
> Beyond that, a moat separated them. The "otherness" and discontinuity between one and the other were radical. (COSTA, 2004, p 162)

According to statistics, between 1845 and 1847, the mortality rate of children between 1 and 10 years old was around 52%. Faced with this alarming number, hygienists had a strong reaction: the dead child is no longer praised,

becoming a flag against this family system, considered to be harmful to childhood.

> The familial etiology of child mortality was evident. Parents handed their children over to ignorant slaves and allowed themselves to be assisted by unskilled midwives. Children were taken to doctors late. They dressed poorly and ate worse. Or, through the practice of consanguineous marriages and the age disproportion between spouses – common habits at the time – adults caused the stillbirth rate to skyrocket. Even more serious, tied to superstitions and religious archaisms, they considered the death of their children "happy". (COSTA, 204, p 163)

Hygienists, faced with the conclusion that the colonial family was harmful to children, saw that a new domestic organization was needed, in which the father's rights would have to be modified - as he was directly responsible for maintaining the survival of the habits of the past – with the consequent reduction of the asymmetry of power between the parental couple.

> This family ideal could serve as a summary of the objectives of domestic hygiene. Firstly, the father was situated within the family within very precise limits. He must be responsible for the material protection of his son. He therefore had to look for a source of income that did not conflict with the well-being of the children. Secondly, women gained an autonomous role within the home, as the initiator of early childhood education. Her role would not be that of a mere guardian of her husband's assets. Finally, thirdly, the roles of family and childhood were redefined in order to oppose the old family ethos. Children must be raised to love and serve "humanity" and not to love and serve their family. (COSTA, 2004, p 170)

The rights of the State then began to admit the rights of children. The couple must be the guardians, and no longer owners, of children whose property was owned by the State, the nation.

The idea of the family being harmful to children, unthinkable in colonial times, began to spread in the 19th century through hygiene. It can be seen as the great medical triumph in the fight for children's educational hegemony. Despite all the criticism from hygienists, it was not enough to propose that children be isolated from their family environment.

This way, the medical appropriation of childhood was carried out completely without parents' knowledge, with various theories demonstrating that they were obstacles to their children's health and even their own lives and, this way, teaching them the correct way to take care of the children.

Hygienists conceived of the child as an amorphous physical-moral entity. The pedagogical technique used was that of creating habits. That is, the imposition of good habits reduced the use of punishments, prevented bad inclinations, and their effects were long-lasting and practically invisible. Thus, this pedagogy also aimed to reach adults.

> Interest in the child was a step in creating a medically appropriate adult. Product of habits, this individual would not know when, nor how, nor why he began to feel or react the way he felt or reacted. Everything in his behavior must appear to his conscience as normal, in accordance with the law of things or the law of men. (COSTA, 2004, p 175)

Therefore, children, in the 19th century, found themselves used as an instrument of power, this time, against their parents, in favor of the State.

The moment this family began to adapt to this new state order, the accusations stopped. And, around the end of the 19th century, with doctors satisfied with the results of their work, the family could already take on the task of caring for their children.

> The set of medical-state interests came between the family and the child, transforming the nature and representation

> of the latter's physical, moral and social characteristics. The successive generations formed by this sanitized pedagogy have produced the typical urban individual of our time. Individual physically and sexually obsessed with the body; morally and sentimentally centered on his pain and his pleasure; socially racist and bourgeois in their beliefs and conduct; finally, politically convinced that the greatness and progress of the Brazilian State depends on the repressive discipline of his life. (COSTA, 2004, p 214)

It is worth noting that, in the history of childhood written, whether in Brazil or elsewhere in the world, there is a huge gap that separates the children described by governmental or non-governmental institutions from those in real life. The first includes the image normally associated with childhood, of laughter and games. In the second, children are oriented towards work, physical and moral training.

> In the first, he inhabits the ideal image of a happy child, carrying all the possible artifacts to identify him in a consumer society: electronic toys and tickets to Disneyland. In the second, the real, we see information accumulating about the barbarity constantly perpetrated against children, a barbarity materialized in the number on child labor, on the sexual exploitation of children of both sexes, on the filthy use that drug trafficking makes of underprivileged minors, among others. (PRIORE, 2013, p 8)

FROM THE ABNORMAL CHILD TO THE PROBLEM CHILD: THE MENTAL HYGIENE MOVEMENT AND THE INFLUENCE OF PSYCHOANALYSIS

Educators, in the 19th century, treated children in such a way that they had to adapt to a rigidly established plan, which was torturous for those who, because they had a disability and were unable to follow classes, and for those who, because they were more gifted, the content of the classes was of little interest to them.

But, back in the 16th century, a Benedictine priest, Ponce de Leon, took the first steps towards the education of deaf-mutes. And, practically three centuries later, several contributions enriched the education of children with disabilities: Itard and the savage of Avignon, Pereire and sensorial education, Pestalozzi and his intuitive and natural method and Séguin and his medical-pedagogical method.

> (...) Over time, men emerged who tried to humanize and personalize education. These men, of whom Professor Pestalozzi was an outstanding precursor, began to consider students as human beings who differed from each other by their ability, their inclinations, their ambitions and their emotional formation. (KANNER, 1971, p 28)

According to Ellen Key – Swedish writer cited by Ajuriaguerra and Kanner – the 20th century was the "century of the child".

In the first decade, psychometrics was introduced. In 1905, Alfred Binet and Theodore Simon published the first design of a scale to quantitatively measure children's intelligence. From a practical point of view, this method, concrete and safe, helped teachers adapt teaching to students' assimilation possibilities. Kanner states that Binet constituted, for the first time, "a successful attempt to prove the heterogeneity of human beings, at least with regard to their capacity to assimilate school education." (KANNER, p 30)

It was also during this period that the "Mental Hygiene" movement emerged. Hygienists proposed prophylactic measures to prevent diseases such as smallpox and tuberculosis. So, using this same reasoning, it would be possible to prevent and correct the conduct, even preventing these children from being sent to the asylum, a very common practice at the time. His motto was to prevent madness and delinquency.

> Mental hygienists have learned to care for children with dull personalities, taking measures *about* them and *for* them, but it was only in the fourth decade of the century that the way of working together with them was stipulated. Previously, children were placed in other environments, foster homes or boarding schools, which were more comfortable, in the face of other, less disturbing attitudes on the part of parents and teachers. But they were left completely aside when it came to therapeutic procedures. They generally faced their problems without their direct participation, ignoring them, as if to say "without the consent of the governed". The main characters of the work continued to be "seen, but not heard". (KANNER, 1971, p 37)

Ajuriaguerra, citing Kanner, puts the following scheme:

> (...) during the first decade there was greater attention to problems relating to children and, in particular, to their education; in the second decade, work was done in its favor, creating, mainly, community organizations; in the third decade, the action focuses on the family and school groups; Finally, during the fourth decade, we work directly with the child." (AJURIAGUERRA, 1983, p 4)

In 1926, the first work by Anna Freud, pioneer of child psychoanalysis, was published. She proposes an innovative approach to the examination and treatment of children - play - which, in addition to being a natural childhood device, enables the manifestation of symptoms and gives direction to the cure.

However, for hygienists, the idea of family harm culminated in the theses on mental alienation, with the family becoming one of the main determinants of madness and the isolation of the insane, one of the fundamental rules for their treatment. And this included child considered abnormal.

The "Hospício do Juquery", designed by Franco da Rocha, was opened in 1898, being the only psychiatric hospital in the city of São Paulo at the time. In 1922, the pavilion for "abnormal minors" was built; Until then, children were mixed with other patients in the different pavilions. In 1926, the first school for abnormal children was created inside what is now Hospital do Juquery. In 1929, a new building was built for educable minors and a nursing home pavilion for ineducable children. In other words, for those who cannot be educated, medical and hygienic care; for those who can be taught, corrective pedagogy.

> The fact is that most of these children will spend their lives in the asylum. They will leave the Pacheco e Silva School for the Asylum Pavilion, from there to the adult pavilions if they are busy or to the colonies if they are calm, according to Pereira. (CYTRYNOWICZ, 2002, p 32)

In 1947, the Division of Child Psychopathology had a men's section, divided into five clinics; a women's section, with five clinics and a specialized section, also with five clinics. Until 1980, all of these pavilions continued to operate.

> In his memoir about the Juquery, child psychiatrist Haim Grünspun recalls a four-year-old girl admitted to the children's ward in the 1950s: "A human rag who had come to the Juquery as a deposit of human rags. Due to his persistence [responsible psychiatrist] in the diagnosis, he found traces of humanity in this girl and insisted that they were autistic traits disturbing the mind of this unfortunate woman in life. Different, very different from the countless rags that crawled around in the courtyard and in the pavilion and even in the 'little school', where very little could be done for them." (CYTRYNOWICZ, 2002, p 32)

The doctor from Alagoas and great enthusiast of Psychoanalysis Arthur Ramos created in 1933 in Rio de Janeiro the Orthophrenia and Mental Hygiene Section of the Department of Education of the Federal District. The institution held child guidance clinics in schools with the aim of diagnosing and adjusting "problem children". This work

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made it possible to differentiate, in Brazilian education, between children with emotional problems and intellectual disabilities, previously treated indiscriminately as "abnormal children".

In 1938, Durval Marcondes, a disciple of Franco da Rocha and a supporter of Psychoanalysis, founded the Child Guidance Clinic of the Department of Education of the State of São Paulo, following the model proposed by Arthur Ramos, to assist poor schoolchildren. The results of this work, whose proposal was to assist children with learning difficulties through two interventions: carrying out multi-professional assessments and promoting environmental changes at school and in the family, were published in 1946, in the book "General Notions of Children's Mental Hygiene".

In Rio de Janeiro, in 1942, the Childhood Neuropsychiatric Hospital was opened in Engenho de Dentro and, in 1953, the Child Guidance Clinic was created linked to the Institute of Psychiatry of the National Faculty of Medicine of the University of Brazil.

> This institution, which was attended by Georges Heuyer [the first professor of Child Psychiatry in Europe] at its inauguration, demonstrating the influence of French-speaking psychiatry on its proposed work, it was under the direction of José Affonso Neto and was attended by the doctor and psychoanalyst Marialzira Perestrello, who was in charge of psychological guidance. The Clinic adopted a multidisciplinary orientation, with psychological and neuropsychiatric assessment, in addition to pedagogical guidance, which together demonstrated a psychodynamic orientation as a philosophical foundation to support the practice of child psychiatry. (ABRÃO, 2020, p 17)

In the 1940s, pediatrician Stanislau Krinsky stands out, a great scholar of Mental Disabilities and their etiologies, who shaped the multidisciplinary care at APAE- SP.

In 1956, pediatrician Pedro de Alcântara Marcondes Machado, professor at the Pediatric Clinic and Early Childhood Hygiene at FMUSP, created the Mental Hygiene and Child Psychiatry Service at Hospital das Clínicas. With a multidisciplinary team, which included Dulce Marcondes Machado and Oswaldo di Loreto, which "(...) focused not only on the clinical-outpatient treatment of childhood mental illnesses, but also on the adoption of preventive measures in mental health." (ABRÃO, 2020, p 17)

In 1961, the Child and Adolescent Psychiatry Service (SEPIA) began operating, linked to the Department of Psychiatry at FMUSP, coordinated by Eneida Matarazzo, whose actions were based on the descriptive proposal of psychiatric nosography and hospital intervention.

In Porto Alegre, the Léo Kanner Children's Therapeutic Community was founded in 1965, coordinated by Luiz Carlos Osório, the first institution of its kind created in Brazil, whose therapeutic foundations were the humanization of care and environmental therapy, without foregoing other interventions. psychotherapy or medication, if necessary.

In Diadema, in São Paulo, in 1968, Oswaldo di Loreto and Michael Schwarzschild founded the Enfance Therapeutic Community, which

> (...) comes up with this philosophy, inspired by the work of Maxwell Jones, a South African psychiatrist based in England, creator of the concept of therapeutic community.
>
> The practice developed in this institution aimed to insert the child into a healthy and carefully oriented social environment, so that environmental therapy was not just a humanized way of treating the patient, but rather a treatment mechanism, which was integrated with traditional therapies such as psychotherapy and drug administration. (ABRÃO, 2020, p 21).

Therapeutic communities represented a transitional milestone between a model of psychiatry supported by prolonged hospitalizations in large mental hospitals and the emergence of therapeutic proposals, based on the anti-psychiatry movement, which incorporated technical resources from psychodrama and psychoanalysis, with the main objective of reducing the social exclusion of patients.

> In turn, Psychoanalysis, as a theoretical system on child development and a psychotherapeutic method aimed at childhood, exerted a significant influence on Brazilian child psychiatry, with particular emphasis between the 1960s and 1980s. In a phase in which classical psychiatry, founded on a descriptive and organicist model, still had few resources to understand and treat children's mental illness, Psychoanalysis, based on hypotheses that found the origin of psychological suffering in childhood in the social and family environment, enabled the development of a environmentalist in Brazilian child psychiatry, which gained momentum, not only in relation to the etiology of mental illness, but also as a therapeutic resource capable of treating it, through psychotherapeutic approaches. The aforementioned psychoanalytic influence was fully in line with the philosophical movement called anti-psychiatry which, from the 1960s onwards, began to question the asylum and social exclusion model that characterized psychiatry at the time. This way, in the search for new references, child psychiatry found its identity in approaching psychoanalytic theory, a trend that lasted until the end of the 1980s, when an inversion of this perspective became evident, with the growing demand for psychotropic drugs. (ABRÃO, 2020, p 25)

PSYCHIATRIC REFORM AND CHILD AND YOUTH PSYCHOSOCIAL CARE CENTERS: A PARADIGM SHIFT

The process of Psychiatric Reform in Brazil began at the end of the 1970s with the Mental Health Workers Movement, not coincidentally concomitant with the redemocratization of the country.

> It is argued today that, just as psychiatry creates paradigms such as alienation, degeneration or even mental illness and advocates an inability of judgment, reason, social participation of the madman, it constructs as a therapeutic project nothing more than a space of exclusion: the asylum.
>
> Thus, the ideal of a Psychiatric Reform, after Basaglia, would be a society without asylums, that is, a society capable of sheltering the crazy, those suffering from mental suffering, the different, the divergent, a society of inclusion and solidarity! (AMARANTE, Memory of madness, MS)

Law, number: 10,216, of April 6, 2001, defines the fundamental principles and guidelines for the implementation of public mental health policy. Its approval was the result of a construction by several actors: health professionals, organized civil society and, mainly, the anti-asylum movement.

The Psychosocial Care Network (RAPS), in accordance with Ordinance GM/MS, number: 3088, has the following guidelines:

- Respect for human rights, guaranteeing people's autonomy and freedom;
- Promotion of equity, recognizing the social determinants of health;
- Combat stigma and prejudice;
- Guarantee of access and quality of services, offering comprehensive care and multidisciplinary assistance, under an interdisciplinary approach;
- Humanized care centered on people's needs;

- Development of activities in the territory that favor social inclusion to promote autonomy and the exercise of citizenship;
- Development of Harm Reduction strategies;
- Emphasis on territorial and community-based services, with participation and social control of users and their families;
- Development of the logic of care for people with suffering or mental disorders, including those with needs resulting from the use of crack, alcohol and other drugs, with the construction of a unique therapeutic project as its central axis.

Psychosocial Care Centers (CAPS) are strategic services for Psychiatric Reform. They have an open and community character, operating in the territories, precisely in the scenario where daily life takes place. Its mission is to guarantee the exercise of citizenship and social inclusion of users and their families. These are services that replace the asylum model and, as a result, represent a paradigm shift in the care of suffering and mental disorders.

And it is in this context that I want to report my experience as a child and adolescent psychiatrist at a CAPSi in the south zone of the city of São Paulo between 2001 and 2009.

In 2001, when I started my work at this unit in the south zone of the city of São Paulo, it was still a children's day hospital, heir to the school health clinics. As it was a "hospital", the presence of a psychiatrist was essential, even to keep the unit open. It was the psychiatrist who carried out the screenings and decided whether the case was eligible for care. In other words, a model centered on doctors and isolationism, as it recommended that children must remain in the service full time, from Monday to Friday. However, the team no longer worked this way, arguing that children needed to go to school, have time to play and socialize at home; In short, they must not be confined to a mental health service. It is noted here how the parallel training of professionals drove the transformation of the clinical approach, giving space and place for the subject to have the chance to attend each child. Parallel training in which, certainly, Psychoanalysis played a leading role.

In 2002, with the entry of SUS in the city of São Paulo, and in compliance with the Psychiatric Reform Law, the day hospital gave way to the Children's Psychosocial Care Center (CAPSi). And this was not just a name change, but a paradigm shift in the care of children, as the CAPS equipment guidelines were very clear, especially regarding the preparation of the Singular Therapeutic Project (PTS) and the proposal to include children in school and in social projects after school hours, within its territory – something that was already done by the team, now with the support of the law.

The CAPS model has, at its core, the horizontalization of relationships within the team. This means that the psychiatrist is no longer the voice in command and needs to learn to listen to and respect the opinion of other specialists, a task that is not easy for the professional whose training involves leading a team.

I already had a long experience of working in a multidisciplinary team at APAE-SP. This made my integration into the service much easier... However, there were other points of convergence between us: all professionals were influenced, in some way, by Psychoanalysis and attentive to the process of medicalization, avoiding pathologizing absolutely common childhood behaviors.

One of the main guidelines of CAPS, as we saw previously, is interdisciplinary logic. However, I can say that we had a transdisciplinary clinical practice, which certainly had a decisive impact on the

transformation of public institutional practices in the field of mental health.

> (...) It is in this interdisciplinary context where the specific support of a therapist is provided so that the other can intervene, taking into consideration, the possible mode of intervention in the affected function that is not their specialty. Such a way of approaching childhood psychopathology implies being willing to have a constant debate, case by case, to determine the prevalence of the series that, in such an opportunity, has a causal role. In this debate, discursive questions may arise that, sometimes, lead to concepts that are capable of operationally crossing different disciplines, and in this case, we are in the presence of a transdisciplinary concept. (JERUSALINSKY, 2018, p 138).

Although the Ordinance provided that the service was for children aged 0 to 12 for admission, children arrived around the age of six to eight, when they entered primary school and the problems became unavoidable. The vast majority of patients were referred by schools. However, it is important to highlight that the mothers had noticed that something was not going well since the child was still very young, especially regarding the acquisition of instrumental aspects.

They reported that their questions were invalidated by pediatricians and that, after much insistence, they managed to get a referral to a neuropediatrician; but this did not solve the family's anguish, as this consultation took a long time to happen and, in general, resulted in a request for an electroencephalogram and a tomography that took even longer. And the result, in the vast majority of cases, was absolutely normal. Then, the child, already older and having more difficulties, was referred to the childhood psychiatrist.

It must be noted that the purpose of the referral was not for a multidisciplinary assessment, but for the psychiatrist to follow the medication prescribed by his colleague, even if there was no established diagnosis.

The psychiatric evaluation, then, was a long anamnesis, not with the purpose of establishing a closed diagnosis, but of getting to know that little patient, his difficulties and, also, his abilities, an aspect that was very little valued, including by the family, who showed themselves to be very surprised by this question.

In order to be able to monitor the cases, it was necessary to establish the transfer.

> Parents seek treatment for the child because they are not resigned to their disability, and that is why they seek treatment; at the same time that they resign themselves to the fact that there is some limit at stake, otherwise they would not seek specific help.
>
> There is a paradox that presents itself in transference neurosis, initially due to the idealization of the therapist. At that moment, the parents become infantilized in front of the therapist, assuming that he has all knowledge. The unfolding of transference implies the passage from infantilization and initial imaginary identification to the unfolding of know-how; When the work has been completed, the parents resume their role with their child. (JERUSALINSKY, 2021)

Although the eligibility criteria are quite clear, the same is not true for different clinical conditions. The team meetings, which were mandatory to attend, were extremely rich, as all patients were discussed, not only upon entry into the service, but also during their stay. If we are talking about a subject of desire in structuring, we need to be aware of the displacements of the symptom that the therapeutic process will provide.

Furthermore, it is extremely important to be aware of phantom lesions, that is, as Jerusalinsky puts it:

> When the mark that a baby receives does not overflow the functioning of the function, if it does not erogeinize it, production may

> even occur, the functioning of the function may even occur, but it is a functioning that excludes the symbolic extension that the object may have. as a representative of the desiring bond with the Other. That is why a small autistic child (...) may present different instrumental acquisitions, but the way in which this instrument is placed in the exploration of the environment and in the encounter with others bears the mark of how he is psychically constituted – it bears *the mark of an exclusion demand*. (Jerusalinsky, 2002, p 159)

Older children were already arriving for treatment with this brand and, consequently, deprived of their knowledge. to the extent that the phantom injury eventually ends up producing greater damage than the real injury which, in these cases, was not apparent or even existed. So, the family group was a fundamental part of the work, with the purpose of making it possible to move the place given to the child and with the aim of supporting the maternal and paternal role.

The proposed treatment was, preferably, in small groups and with co-therapists. "The group functions as a potential for support and contact and, in addition, can allow an experience of re-supporting psychic development for those whose first support was insufficient or inadequate." (TOLEDO, 2021, p 401).

Through playing, both structural and instrumental aspects were worked on in groups and therapeutic workshops

Playing is fundamental as an assessment tool and as a therapeutic intervention in childhood. Jerusaleminsky states that:

> (...) playing is a constituent symptom of the subject in childhood. With it, the child produces a response to the temporal paradox he is confronted with: between symbolic anticipation – which locates, from the parental unconscious, his place in filiation, sexuation and identification – and the real immaturity of his body." (JERUSALINSKY, 2014, p 232)

> For S. Lebovici and R. Diatkine, play is a means of relating between children and adults. Therefore, it not only expresses the possibilities that the child has to oppose his dependence and acquire a certain autonomy; it can also symbolize or express positive relationships: it can be one of the most valid and constructive forms of relationships with adults. On the other hand, not only does the game play a role in structuring particular modes of object relations, but it directly expresses this relation. (LEBOVICI and DIATKINE apud AJURIAGUERRA, 1983, p 74 – 5)

However, this service carried a great difficulty: the end of the treatment. Regarding families, although discharge was a process that lasted a reasonable amount of time, the feeling of helplessness generated anguish and they tried to keep the children in care. On one occasion, all the children in a certain group, aged around 10 -11 years, started to have nocturnal enuresis. The team concluded that it was, in fact, one of the only symptoms that we could not dispute, much less investigate. We found the solution quite creative, it surprised us.

Teams that work with patients with serious developmental problems find it very difficult to realize that, at a certain point in the treatment, it will surely stop contributing to the patient's improvement, and it is not uncommon for some patients to remain in ineffective care for years.

> These are children, then young people, who may need treatment for many years of their lives. The important thing about this is that each therapist knows how to put an end to the phase in which they were required to intervene. If the therapist intends to accompany the child throughout his life, it will be because he does not want to give back to the child and parents the fullness of their relationship, with the limits that it may have.
>
> Treatments for this type of pathology have their recoverability limit and, therefore,

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> children always continue to give the impression that they need this or that thing more. At this limit of recoverability is the end of the treatment, there, at the cutoff, is where the therapist, child and parents resign themselves to what will never happen: total cure. (JERUSALINSKY, 2010, p 97)

This CAPSi, with this peculiar team, with work guided by ethics and respect for the patient and their family, was dismantled in 2009.

THE RESURGENCE OF MEDICALIZATION IN TIMES OF BARBARISM

The word barbarism, in the dictionary, means lack of civilization.

Philosopher Michael Löwy states that

> One of its most important aspects of the civilizing process is that violence is no longer exercised spontaneously, irrationally and emotionally by individuals, but it is monopolized and centralized by the State, more precisely, by the armed forces and the police." (LÖWY, 2010)

However, the philosopher states, citing Marx, that "barbarism has reappeared, but this time it is engendered in the very heart of civilization and is an integral part of it. It is leprous barbarism, barbarism as the leprosy of civilization." (MARX, apud LÖWY, 2010)

In the 20th and 21st centuries, it is a modern barbarism, which has the following characteristics:

- Use of modern technical means. Industrialization of homicide. Mass extermination thanks to cutting-edge scientific technologies.
- Impersonality of the massacre. Entire populations – men and women, children and the elderly – are "eliminated", with as little personal contact as possible between the decision maker and the victims.
- Bureaucratic, administrative, effective, planned, "rational" (in instrumental terms) management of barbaric acts.
- Legitimizing ideology of the modern type: "biological", "hygienic", "scientific" (and not religious or traditionalist) (LÖWY, 2010)

This State, which is the State of the ruling class, is basically maintained, according to Althusser, through two types of Apparatus:

> the State Repressive Apparatus (ARE), which comprises the Government, Administration, Army, Police, Courts, Prisons, etc. and the Ideological Apparatus of the State which are "a certain number of realities that present themselves to the immediate observer in the form of distinct and specialized institutions." While the ARE works mainly through violence, the AIEs work through ideology, which is that of the ruling class. (ALTHUSSER, p 43)

Modern barbarism has a legitimizing ideology which, in the case of childhood, is the school, one of the AIEs, which will exercise the function of establishing the norm.

> (...) by organizing itself based on health categories, whether consistent, dense, consolidated or not, education positions itself in a subordinate manner to movements in the health field. Now, a certain nosological entity can disappear, reappear, move, and be excoriated by the scientific community. Whatever the movement, education remains, in a more or less reflexive way, contributing to the institutionalization, the crystallization of certain aspects of health, even if Health itself creates new movements. Aside from the established anachronism, the category "global developmental disorder" is creating a kind of life of its own in education, with no scientific basis in either educational or health knowledge, starting to constitute itself as a mere ideology. And it is easy to see that the reproduction of ideology has no connection with the assumptions of inclusive education." (ANGELUCCI & RODRIGUES, 2018, p 107)

Since the 80s of the last centuries, we have witnessed the expansion of a psychiatry

inspired and formed by the processes of biologization and cerebrization of life, which increasingly contributes to the constitution of the perception that we are somatic and neurochemical beings. This nosography radically reduces the complexity of relational ways of feeling and acting and, this way, feeds the process of medicalization.

> (...) In the trajectory we are describing, this effort to see and listen to a subject, with all the difficulties he had to say, was erased, and was replaced by data ordered according to a nosography that erases the subject. This is how autism is transported to the realm of developmental disorders. This is how problems stop being problems and become inconveniences. It is an important epistemological transformation, and not a mere terminological transformation. A problem is something to be deciphered, interpreted, resolved; a disorder is something to be eliminated, suppressed because it bothers. (JERUSALINSKY, 2011, p 238)

Combined with this, the normalized existence that currently reduces the multiplicity of ways of being in the world to biological criteria, we see that, as Caliman (2016) puts it, in medicalization processes, care is linked to knowledge that has the norm as a central parameter.

Given the above, it is not difficult to understand why equipment such as CAPS and, consequently, the Psychiatric Reform, are the object of constant attacks by organicist psychiatry which, together with the current authoritarian government, will, through decrees spurious, removing funds from programs linked to the improvement and expansion of care for suffering individuals, to allocate them to therapeutic communities which, for the most part, do not have any point of contact with the Maxwell Jones model.

And this also applies to Psychoanalysis, as it assumes that the person who suffers is, despite and beyond the diagnosis, a subject of desire and also of rights, which is of little or no interest to capitalism, as it only needs consumers and not creative subjects.

FINAL CONSIDERATIONS

Medicalization, as we can see, is not a contemporary phenomenon. It has become more sophisticated over time so that, currently, through the media, the medical – hospital – pharmaceutical order is interfering in human existence, with the purpose of pathologizing what is outside the norm.

Berlinck, in 1988, wrote about Brazil: (...) "A miserable, ignorant, illiterate and, inevitable consequence of all this, pretentious and arrogant nation in which culture is worth little and, therefore, where the path to the word finds irremediably blocked." (BERLINCK, 1988, p 76). Despite more than thirty years having passed, this reflection is, unfortunately, atrociously current.

However, despite this Dantesque scenario, the clinic - carried out ethically and always assuming, in each patient we receive, a subject of desire and rights, respecting their singularity - is the way for the word to circulate and for the subject, even if buried by adversity and suffering, may arise.

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