A Patologização e Medicalização das Crianças é a Solução ou Problema?

Is Pathologizing and Medicating Children the Solution or the Problem?

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Resumo: um crescente número de crianças no Brasil está sujeita à prática terapêutica da medicalização excessiva. Isto tem levado a diferentes comportamentos e dificuldades, especialmente aqueles relacionados à escola, tidas como doenças, síndromes ou desordens. A lógica da patologização parece a cada dia dominar a perspectiva dos profissionais, tanto na Educação, quanto na Saúde. Este artigo reflete os mecanismos de controle social que promovem e sustentam esta lógica, considerando suas implicações para as vidas das crianças e adolescentes cujo destino é comumente caracterizado pela rotulação, discriminação e controle de drogas. Argumentamos que há uma necessidade urgente de reconsiderar este paradigma e desenvolver novas abordagens que busquem desmistificar a patologização da vida e prover alternativas viáveis.

Palavras-Chave: Educação; Medicalização; Patologização; Crianças; Hiperatividade.

Abstract: increasing numbers of children in Brazil are subject to a therapeutic practice of excessive medicalization. This is leading to different behaviors and difficulties, especially those related to school, being regarded as diseases, syndromes or disorders. This pathologizing logic seems to be increasingly dominating the perspective of professionals, both in education and in health. This article reflects on the social control mechanisms that promote and sustain this logic, considering its implications for the lives of children and adolescents, whose fate is often characterized by labeling, discrimination and containment by drugs. We argue there is an urgent need to reconsider this paradigm and to develop new approaches that seek to demystify the pathologizing of life and provide viable alternatives.

Keywords: medicalization; Pathologization; Children; Education; Hyperactivity

This article reflects on the social control mechanisms that promote and sustain the Pathological logic, considering its implications for the lives of children and adolescents, whose fate is often characterized by labeling, discrimination and containment by drugs.

A recent study in the Journal of Attention Disorders estimated that 5.6% of Brazilian children have Attention Deficit, Hyperactivity Disorder (ADHD), the authors say this is about the global average (1).

A letter to the editors of the Revista Brasileira de Psiquiatria in 2012 from a team of reseachers (2) raised the concern that ADHD is under-treated in Brazil, they said:

> Increasing awareness about attention-deficit hyperactivity disorder (ADHD) - whether related to campaigns sponsored by medical associations, patient self-help groups or pharmaceutical companies - is associated with a desirable progressive increase in the number of patients being diagnosed and treated. However, there are concerns about overtreatment, especially in children and adolescents, which is often addressed by the media in alarming ways.

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They concluded: "Concerns that an excessive number of individuals may be treated with stimulants for ADHD in our country lack any scientific basis. Further educational campaigns are needed to identify the significant proportion of untreated individuals affected by ADHD in Brazil."

A further study published in a psychiatric journal here in Brazil in 2015 states that over 250,000 children between the age of 5 and 19 from low-income families have ADHD and are being deprived of appropriate treatment. The authors claimed this is because the Brazilian state is not paying for treatment. Indeed the title of the article is *"The Brazilian policy of withholding treatment for ADHD is probably increasing health and social costs"* (2). Consequently, they claim the economy of Brazil is losing an estimated 2 billion reals a year. They argue that, *"if treatment was available this would save 1.8 billion reals."* The cost of the treatment 200 million Reals makes up the difference.

The treatment recommended by the article is Ritalin, Adderil and equivalents to be prescribed three times a day. At least once, by teachers I suspect. The researchers are very specific with their statistics. They state precisely 257,668 children are effected. This compares with the USA where 11% of children were diagnosed with ADHD in 2011, a figure that has risen by 43% in the last 8 years (3).

In our view the research article quoted above (2) is preparing the ground. It seeks to persuade policy makers to invest in a diagnosis and a treatment. To invest in treatments. Are they correct and who does this treatment benefit and at what cost?

The benefit of treating ADHD with stimulants rests on the premise that the disorder is a biological problem. A problem of the brain. Therefor stimulants will help the child overcome their brain development disorder and help it to develop more normally. In effect, the medication is claimed to be neuro-protective. That is to say drugs are good for the growing brains of children.

However, long-term studies have failed to find that the stimulants provide any benefit. One recent Canadian study entitled *"Do stimulant medications improve educational and behavioral outcomes for children with ADHD?"* (4) found that the increase in medication use is associated with increases in unhappiness and a deterioration in relationship with parents. There was also evidence of deterioration educational outcomes. Medication use is also associated with dropping out of school. It showed that children with ADHD treated with medication had worsening outcomes.

Indeed, this finding is part of a bigger picture. Increasingly, the effectiveness of all kinds of psychoactive medication is being contested. Anti-depressants, for instance when compared with placebos has a minimal or non-existent benefit for people with mild or moderate symptoms (5) Their popularity can be seen as a warning of a dangerously over medicated world. The question we want to address in this article is whether the growing tendency to regard a range of different behaviors and difficulties faced by children (especially when related to school) as diseases, symptoms or disorders is justifiable.

A similar picture emerges for other behaviors in children. The World Health Organization (WHO) estimates that worldwide 10 - 20% of children and adolescents experience mental disorders.

It seems, as the American science journalist Robert Whitaker puts it, we are in the midst of a psychiatric epidemic that is also impacting on children and adolescents. Whitaker sees that children are vulnerable to being prescribed a lifetime of drugs. As the author says, a psychiatrist and parents may give a child a "cocktail" to force him or her to behave. Then when this child reaches the age of eighteen, Whitaker says the child often becomes a disabled adult. In his book *"Anatomy of an Epidemic"* (6), he asks why the number of Americans who receive government disability for mental illness approximately doubled since 1987. Whitaker tries to answer that question and examines the long-term outcomes for the mentally ill in the U.S. He finds that overall the drugs do more harm than good. Whitaker found that studies published in prominent medical journals have shown that patients with schizophrenia do better off medication then on it. Children with ADHD who take stimulants, are more likely to be diagnosed with mania and bipolar disorder than those who go un-medicated.

In the USA the number of people on disability pensions has tripled in the last 20 years. Whittaker asks if psychiatric drugs are effective at preventing mental illness, why are more people unable to work? The pathologizing paradigm seems to have dominated professional thinking, practice and culture in education and health.

Why is it that human distress is being pathologized? Partly, it is the role of the American Psychiatric Associations Diagnostic Statistical Manual of Mental Disorders, now in its fifth edition (2013) and the alternatives such as the International Statistical Classification of Diseases and Related Health Problems (ICD), produced by the World Health Organization (WHO). The desire for a simple fix and a cure.

However what about social determinants and other possible causal factors such as the generational trauma, for instance the impact of slavery on the enslaved and the enslavers?

What are the social control mechanisms that promote and sustain this llogic and what are the implications for children and adolescents, whose fate is often marked by the label, discrimination and containment by drugs.

Psychiatry purports that there are objective disease states and therefore through psychiatric diagnosis it is able to designate social problems as medical ones.

By concealing the political nature of these responses to situations that are labeled as mental illnesses, psychiatric diagnosis prevents these responses from being questioned and scrutinized. Therefor it allows the state to delegate difficult areas of social policy to supposed technical expertise.

Psychiatric diagnosis, can be seen to function as a political device employed to legitimate activities that might otherwise be contested. Such as forced treatment, treatments that cause harm etc.

Behaviors such as boredom, low achievement, absence from school, suspensions expulsion, involvement with criminal justice system, child-care systems can now lead to a diagnosis. Leading to treatment with medications such as:

- Stimulants for ADHD (Ritalin, Addaril etc)
- Serotonegics for depression (SSRI's like Prozac and Zoloft)

- Neuroleptics for psychosis, mood swings, anxiety and aggression (Risperdone, Albify)

However, there is a great deal of evidence that trauma, loss, separation, bullying and abuse often lie at the heart of such difficulties, issues that are not in themselves amenable to medical treatment. These kind of behaviors are in themselves messages, we should not be seeking to silence the message but to understand its meaning.

How can we create new ways of thinking, a new culture and new practice? How do we demystify the pathologizing of life?

Not seeing these issues as being pathologies, deficits, disorders, dysfunctions but instead as part of the diversity of human reactions to stress and difficulty - or - as neurodiversity. Therefore Autism Syndrome, Asperger´s Syndrome, ADHD, Discalcula, dyspraxia, dyslexia are normal variations in the human genome and are not inherently pathological or necessitating a cure. Instead, they are authentic forms of human diversity and self-expression.

There is strong case to be made that it is not your genetic code that makes it likely for children and adolescents to have problems but morel likely it´s your postal code. What we mean by this is we need to recognize the importance of social and economic realities facing children. Research from the UK shows that children experiencing family break up and who live with one parent are twice as likely to be diagnosed with a mental illness.

Problems are very closely related to:

- Housing insecurity
- Food insecurity
- Job insecurity

This creates hopelessness and despair. We know the things that can help keep children and young people mentally well include:

- being in good physical health, eating a balanced diet and getting regular exercise
- having time and the freedom to play, indoors and outdoors
- being part of a family that gets along well most of the time
- going to a school that looks after the wellbeing of all its pupils
- taking part in local activities for young people.

Other factors are also important, including:

- feeling loved, trusted, understood, valued and safe
- being interested in life and having opportunities to enjoy themselves
- being hopeful and optimistic

- being able to learn and having opportunities to succeed
- accepting who they are and recognising what they are good at
- having a sense of belonging in their family, school and community
- feeling they have some control over their own life
- having the strength to cope when something is wrong (resilience) and the ability to solve problems.

On the other hand there are certain risk factors that make some children and young people more likely to experience problems than other children, but they don't necessarily mean difficulties are bound to come up or are even probable. Some of these factors include:

- having a long-term physical illness
- having a parent who has had mental health problems, problems with alcohol or has been in trouble with the law
- experiencing the death of someone close to them
- having parents who separate or divorce
- having been severely bullied or physically or sexually abused
- living in poverty or being homeless
- experiencing discrimination, perhaps because of their race, sexuality or religion
- acting as a carer for a relative, taking on adult responsibilities
- having long-standing educational difficulties.

As Paulo Freire wrote in "Pedagogy of the Oppressed" (1968):

> Education either functions as an instrument to bring about conformity or it becomes the practice of freedom, the means by which men and women (and children) deal critically with reality and discover how to participate in the transformation of their world (p. 34).

In the face of these social realities we need to consider how our values of equity, dignity and inclusiveness inform our thinking, practice and culture. We live in a time when collective solutions rooted in social justice and human rights are been replaced by atomized individualized solutions, but to whose benefit? What can we do?

- Being supportive and connecting adults
- Strengthening social and peer networks and family support
- Schools can be at the center of creating a whole life, whole community, whole system approach, playing a crucial role in supporting and maintaining strong communities, that support families and create resilient and resourceful citizens.

- Schools are and can be havens working to overcome the difficult situations children find themselves in.
- Developing resilience.
- Person centered.

Further, we specifically need to understand the different ways children learn through:

- Memory
- Visually
- Abstractly
- Verbally/linguistically
- Logically/mathematicaly
- Kinesthetically and movement learning through dance (people who have to move to think
- Playfully and gamingly

What can this mean for our work:

I recommend you watch the TED Talk by the British professor Sir Ken Robinson (8) in his short lecture he challenges us to:

- Acknowledge the unpredictability of the future
- Recognize the extraordinary capacity and resilience of children.
- Every child has strengths, however troubled, however challenging.
- Appreciate that intelligence is dynamic and interactive

Not to squander their talent, as Picasso said, "All children are born artists"

He provided this scenario

Teacher: "What are you drawing?" Child: "God"

Teacher: "But nobody knows what God looks like"

Child: "They will in a minute"

It's OK to be prepared to be wrong, to take risks.

Ken Robinson says we need to transform the role of education away from its roots in meeting the needs of industrialization and colonization and ask what is education for? Is it just to prepare for university or rather to prepare children for an uncertain future. Rosabeth Moss Kanter, A Harvard University Sociologist said: "*When we do change to people they experience it as violence, when people change for themselves they experience it as liberation".*

If we want to help people in a way that does them no harm to their capacities and their communities then the best place to start is to consider what is strong about them and their communities not what is wrong. We should start with capacities and abilities. What often happens though is that the focus and obsession is to start with what is wrong, what is broken and what is pathological in people. This is a paradigm that causes great harm to poor people and communities. Carmac Russell says the are four unintended harms that come from this paradigm.

1. Top down change, in trying to help people, defines them by their deficiences and their problems. Not by their capacities, and what they can bring to finding the solution.
2. Funding that is intended to go to the people that need help, goes instead to those people who are paid to provide services to those who need help.
3. Active citizenship, the power to take action and respond at the grassroots level retreats in the face of ever increasing technocracy, professionalism and expertise.
4. Entire communities and groups of people that are defined as deficient start to internalize this and start to believe that the only way that things are going to change for them is when the right professional with the right program comes to rescue them.

This is largely unintentional, as no professional means for these things to happen and no community needs these things to happen. Because they do not help - they just make things worse.

When we label people as vulnerable, deficient or problematic what we do is define them out of the community and redefine them as clients of a service system, no longer as friend and neighbor. When we do that we take some of the soul of the person. The alternative is to start with what is strong not what is wrong. We need to understand what do people do use to make change from the inside out.

Everyone who has been defined as having a problem has the right to redefine the problem for themselves. The solutions for the most difficult problems for people can be found by acknowledging:

- The stories of our shared lives
- The power of social networks
- The skills and knowledge of all people
- Resources from all sources

The Five Ways to Wellbeing are a set of evidence-based actions which promote people's wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give.

These activities are simple things individuals can do in their everyday lives.

Connect: With the people around you. With family, friends, colleagues and neighbors. At home, work, school or in your local community. Think of these as the cornerstones of your

life and invest time in developing them. Building these connections will support and enrich you every day.

Be Active: Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take Notice: Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savor the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

Keep Learning: Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Give: Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

The Five Ways have been used by health organsations, schools and community projects across the UK and around the world to help people take action to improve their wellbeing. They've been used in lots of different ways, for example to get people to start thinking about wellbeing, to develop organizational strategy, to measure impact, to assess need, for staff development, and to help people to incorporate more well-being-promoting activities into their lives.

"If you come to help me, you are wasting your time. But, if you come because your liberation is bound up in mine, then let us work together." Credited to 'Aboriginal activists group, Queensland, 1970s'.

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Notes

1. Further, the World Health Organization outcome study for schizophrenia patients were better for poor countries like India, Colombia and Nigeria than in rich countries. In the International Pilot Study of Schizophrenia (IPSS) (Schizophrenia: An International Follow-Up Study, 1979) for example, researchers find that after a five-year follow-up, India had the most success, with 42% of schizophrenia cases reporting 'best' outcomes, followed by Nigeria with 33% of cases. By contrast, the rich countries performed poor: 'best' outcomes were seen in only 17% of cases in the USA, and in fewer than 10% in the other developed nations.

2. The Determinants of Outcome of Severe Mental Disorders (DOSMeD) figures (1992) supported these findings with rates of complete clinical remission of 37% in low income countries and 15,5% in high income countries.

3. In the International Study on Schizophrenia (ISoS) (British Journal of Psychiatry, 2001) more than 1,000 people with schizophrenia from 16 centers around the world were followed up after the passage of 12 to 26 years. Most of them had participated in the IPSS and DOSMeD as well. The researchers concluded that the findings of this study confirmed the 'better prognosis hypothesis' of the 2 earlier studies. Countries where only a small percentage of patients receive medication.

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