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FROM PSYCHOSIS TO THE AUTISM SPECTRUM: A BRIEF HISTORY OF THE DIAGNOSTIC TRANSITION IN THE FIELD OF CHILD PSYCHOPATHOLOGY

DA PSICOSE AO ESPECTRO AUTISTA: UM BREVE HISTÓRICO DA TRANSIÇÃO DIAGNÓSTICA NO CAMPO DA PSICOPATOLOGIA INFANTIL

DE LA PSICOSIS AL ESPECTRO AUTISTA: UNA BREVE HISTORIA DE LA TRANSICIÓN DIAGNÓSTICA EN EL CAMPO DE LA PSICOPATOLOGÍA INFANTIL

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ABSTRACT

This article analyzes the historical and discursive transition between the diagnoses of childhood psychosis and autism from DSM-III to V, exploring the formulations in psychiatric manuals and the impact of epistemological changes since the twentieth century. The article proposes that the notion of spectrum articulates a new regime of recognition for difference, while incorporating tensions between control, standardization, and subjective resistance in the context of treatments and public health policies.

Keywords: Autism. Psychosis. Diagnosis. Child Psychiatry. Psychopathology.

RESUMO

Este artigo analisa a transição histórica e discursiva entre os diagnósticos de psicose infantil e autismo do DSM-III para o V, explorando as formulações em manuais de psiquiatria e o impacto das mudanças epistemológicas desde o século XX. O artigo propõe que a noção de espectro articula um novo regime de reconhecimento da diferença, ao mesmo tempo em que incorpora tensões entre controle, padronização e resistência subjetiva no contexto de tratamentos e políticas de saúde pública.

Palavras-chave: Autismo. Psicose. Diagnóstico. Psiquiatria Infantil. Psicopatologia.

RESUMEN

Este artículo analiza la transición histórica y discursiva entre los diagnósticos de psicosis infantil y autismo del DSM-III al V, explorando las formulaciones en los manuales psiquiátricos y el impacto de los cambios epistemológicos desde el siglo XX. El artículo propone que la noción de espectro articula un nuevo régimen de reconocimiento de la diferencia, a la vez que incorpora las tensiones entre el control, la estandarización y la resistencia subjetiva en el contexto de los tratamientos y las políticas de salud pública.

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Palabras clave: Autismo. Psicosis. Diagnóstico. Psiquiatría infantil. Psicopatología.

INTRODUCTION

In recent years, we have observed an important transposition to the scope of public policies of the historical clinical and epistemic tension between proposals of psychodynamic and reeducational origin for the treatment of the so-called "Neurodevelopmental Disorders" **(DSM-V and RT; ICD 10 and 11),**[3] assuming even more evident contours of dispute with regard to Autism Spectrum Disorder **(Machado, 2021)**. In the field of psychiatric psychopathology of childhood and adolescence, ASD is proposed as a broad category that also recognizes phenomena of suffering previously attributable to what was understood as "childhood psychosis". In adult-attributable psychopathology, there is still a categorical differentiation between ASD and Schizophrenia Spectrum Disorders and other psychotic disorders **(DSM-V, p.87),** with psychotic phenomena prevalent in the second category. As the diagnostic manual itself describes, the organization of the chapters is "*based on considerations about development and the life cycle*" **(ibid, p.40),** with the first categories described being those that have the most frequent manifestation from the beginning of life. Thus, the so-called "neurodevelopmental disorders" deal with the names attributable to the signs identified as pathological in the child, followed by "schizophrenia spectrum disorders and other psychotic disorders", which statistically are less frequent in childhood[4]. "Childhood-onset schizophrenia" **(ibid, p.58)** is a terminology that currently appears punctually in the aforementioned manuals, in both as a differential diagnostic note at the end of the detailed description of the ASD picture and in the field of "development and course" of the schizophrenia diagnostic picture.

This movement that makes this terminology fall into disuse in child psychopathology has been identified since 1978 and 1980, when both the DSM-III and the ICD-9 disappeared the "specific psychoses of childhood", and childhood autism was regrouped in the category of "Pervasive Developmental Disorders" **(Bursztejn, 2016).** In 1987, the French psychoanalyst and former president of the World Association of Psychoanalysis, Éric Laurent, noticed the increase in theorization about autism to the

[3] The formulation of public policies in the field of Brazilian public health makes use of epidemiological studies that are based on the criteria designated by the International Classification of Diseases **(ICD-10).** Both ICD 11 and DSM TR are the most recent versions of the diagnostic criteria used as a basis for identifying and comparing hegemonic health trends and statistics.

[4] In 1995, the estimated prevalence for this condition before the age of 13 was 0.9 cases per 10 thousand inhabitants **(Hafner, H, 1995)**; in 2004, studies on the prevalence of very early-onset schizophrenia estimated 1 in 10,000 and 1 in 30,000 **(Gonthier, M, 2004)**; in 2020, cohort studies by the National Institute of Mental Health (NIMH) estimated an incidence of 0.04% in the North American population **(Driver DI et al, 2020)**.

detriment of "psychosis" in psychoanalytic research, stating that the most prolific thing that had been produced in the field of psychosis took place until the beginning of the 60s - the author supposes that this decline was due to the fact that psychosis imposed important limits and impasses for psychoanalysis **(Instituto Sedes Sapientiae, 2024).**

Currently, we observe, through international epidemiological data, the increase in diagnostic rates related to autism and the very low statistical relevance attributable to conditions such as childhood schizophrenia or other psychotic disorders **(Maenner, 2023; Hafner, H, 1995; Gonthier, M, 2004; Driver DI et al, 2020),** we also observed in the country a series of normative interventions by the State in the care of autism, with bills of "directive and intrusive character in professional practices, without equivalents in other diagnoses related to psychic or somatic pathologies" **(Machado, 2021).**

If we discursively notice a greater adherence between the signifier autism and child, we cannot say the same about psychosis. Today we observe the conceptual weakening of the notion of childhood psychosis in the nosography that governs the recognition of psychiatric diagnosis, as well as an important cleavage between autism and schizophrenia attributable to the child. In the field of activism in the first person, movements that dispute psychiatric grammar, "psychosis" has not been in the field of childhood the term of greatest adherence for recognition and contemporary political mobilizations. With this in mind, we intend to investigate what remains of the articulation between "psychosis" and the "child", what are the advances and effects of this grammar for how we treat and narrate children today.

The present research is justified to the extent that the propositions that materialize in the discursive plane of public policies, activisms and the psychopathological nosography of social circulation concern the place produced and attributed contemporaneously to children in the social imaginary. To support this thesis, we make use of the understanding that such discourses produce possible representations about subjects and a retroaction in the way they are produced **(Butler, 1997; Machado, 2021; Hacking, 1999).** Thus, the focus of the proposed analysis starts from a discursive perspective, below we explain how the research methodology is based and justified.

METHOD

In this work, critical discourse analysis is adopted as a method to historicize and reflect on the contemporary diagnostic paradigm, as developed by authors such as Parker (2005), Dunker, Paulon and Milán-Ramos (2016), Lara Junior, Dunker and Pavón-Cuéllar (2019), in addition to Burman (2021). The corpus of the research is composed of fragments extracted from the manuals of the DSM series, from III to V, with the objective of analyzing how psychiatric diagnoses and their transformations are regulated and shaped by discursive crossings of a scientific, ideological and economic order, which directly affect the constitution of subjectivity and the modes of performance produced from these appointments in the field of public health. Accompanying such transformations is essential for the qualification of the debate and for the promotion of health policies and interventions ethically aligned with new evidence and activism.

DISCUSSION

Between 1952 and 1973, the DSM-II came under heavy criticism. Many saw the manual as the result of a problematic agreement between a traditional psychiatry, focused on the normalization of behaviors, and psychoanalytic theories - which together operated from an ideological scientism. The clinical operator "hysteria" was linked to "femininity", "homosexuality" to "egodystonia" and "perversion", and "autistic behavior" directly linked to the real and individualizing figure of the "mother". Thus, the DSM-II served as an institutional tool of the State, legitimizing practices of political repression through psychiatric-psychoanalytic discourses crossed by cisnormative and patriarchal ideologies. The manual has been used by educational, legal, and research institutions to individualize and pathologize social conflicts, segregate minorities, and neutralize forms of resistance **(Dunker, Kyrillos 2011).**

These criticisms of the DSM-II and psychoanalysis motivated changes in the APA and WHO classifications. Until then, the manuals had brief descriptions for children's paintings. From the 1970s onwards, with the publication of the ICD-9 (1975), autism began to be included as an autonomous category under the group of childhood psychoses, distancing itself from schizophrenia. In 1980, the DSM-III was launched, promoting a paradigmatic change by adopting a more objective and operational language, detached from psychodynamic terminologies, with 265 diagnostic categories. The term "psychosis" appears 187 times, but is no longer used in association with

childhood disorders, which are now specified under the group "Pervasive developmental disorders".

Thus, the terminology "psychosis" is no longer presented in the specific section related to developmental disorders, a category that encompasses mostly the most prevalent diagnoses currently in childhood. It is interesting to note that the signifier "development" also gains prominence in this edition of the manual, especially in the association with disorders that affect children.

The modern conception of psychological aspects, and even a psychology in itself of development, appears at the end of the nineteenth century - at the same time that the discussion about the terminology of psychosis begins to circulate and the children's disorders gain some space in psychiatric manuals - in order to answer questions related to the theory of evolution, anthropology and philosophy. Thus, from the outset, this field has been deeply linked to social movements explicitly linked to the comparison, regulation, and control of groups and societies – aligning closely with the development of psychometric tools, classification of skills, and the establishment of normative standards **(Burman, 2008).** Therefore, the field of developmental psychology has historically been involved, carrying in its own terms of reproduction, processes of transformation linked to late capitalism, the post-war period, and modern science.

The DSM-III is a synchronic re-edition of this restructuring of grammars of psychological and psychiatric knowledge, by ceasing to include relational and symbolic aspects, distancing itself from narrative and psychodynamic models, the APA defended a system that was allegedly atheoretical and more aligned with a science based on statistical evidence. This model allowed psychiatry to have, for the first time, a consensual stabilization of the empirical content related to each diagnostic category **(Dunker, Kyrillos 2011).**

Thus, an important break was made in relation to the previous theoretical model, now instead of evaluating child suffering and psychopathology based on narrative models and situated in the clinical experience with locally situated children - a model of individual clinical cases that unfold logics and dynamics of relationship with reality, although with a very restricted set - the new model chooses to quantify development and deviations as behavioral variables in a entire population, establishing the normal standard via statistical normality. At the same time, the analysis of the individual reaction was progressively replaced by a statistical analysis of the reactions of a

population to these stimuli, as well as of the correlation between risk variables responsible for chronic pathologies without a single causal element. Although the model still allowed the observation of human relationships as phenomena, it did not include questions about the mechanisms, reasons, or moments in which these relationships became pathological or deficient, especially in relation to children's capacities to imagine, hallucinate, or even fantasize **(Evans, 2013).**

Rodrigues (2017) points out that, although interest in the risks of illness in the population was already present since the constitution of public health, it was only in the second half of the twentieth century that this notion became central in biomedical research and health practices. During this period, the epidemiological transition occurs, marked by a change in the mortality profile: infectious diseases, previously predominant, give way to chronic and degenerative diseases, driven by technological advances and improvements in basic sanitation. This process was consolidated between the 1950s and 1970s in Europe, while in Brazil it intensified in the 1980s and 1990s.

This movement involving the epidemiological transition and the centrality of statistical studies involving children and psychosis was more strongly outlined in the 1960s and 1970s in Europe and the United States **(Evans, 2013).** A reference study in the field was conducted by the English psychiatrist Israel Kolvin (1971), who focused on analyzing childhood schizophrenia and its causes, excluding the possibility of hallucinatory phenomena in young children. Kolvin, in particular, tried to validate the hypothesis that psychotic disorders in children depend on the age at which they start. To do this, he divided the patients into groups according to the age of symptom onset and observed characteristics such as speech delay and stereotyped movements in cases of early onset. His method highlighted the need for clear evidence of hallucinations, dismissing reports of children lacking sufficient language skills to express them.

This focus led to a change in the understanding of autism, which became more articulated with the term "communication disorder" than "psychotic". Such opposition emerges as a discursive phenomenon that replaces previous productions associated with psychodynamic theories, however they fall back on a reductionist critique that supposes "psychosis" as a behavioral disorder detached from the dimension of subjectivation present in language. Such a strategy leaves out all the production of

knowledge that he had already associated since Bleuler, and especially in Lacan, psychosis, autism, schizophrenia and language alterations as fundamental for the understanding of the experiences in question.

Another important break occurs in 1978, when the English child psychiatrist Michael Rutter and the German psychologist Eric Schopler propose a new definition of autism, as a mental disorder unique and independent of schizophrenia. Both informed their theories from behaviorism and mechanistic structuralism, a conception that takes language as a pragmatic instrument of communication and that takes into account a methodological denial of intention or consciousness in the description of the message analyzed. Like these researchers, other psychiatrists have followed this differentiation in the nosographic picture of autism, as well as the exclusion of hallucinatory phenomena from the descriptive grid of the disorder, considering that unless children could verbalize hallucinatory experiences, they should not be considered hallucinations. This position was not due to the contrariety of these researchers in recognizing the possibility of phenomena such as hallucinations in infants and children, but assuming this dynamic in a way that did not include the verbal behavior of describing hallucinations, as in adult psychiatry, would compromise the accuracy of epidemiological studies **(Evans, 2013)**. This perspective transformed the approach of child psychiatry, prioritizing descriptions considered observable and measurable to the detriment of constructions based on relational dynamics, which took into account the relationship as a fundamental axis for any possible reading of the phenomenon**.**

As autism is no longer associated with hallucinations and fantasies, an important focus is now on deficits in language, cognition and imagination. This movement was directly influenced by the growth of the cognitive field in psychology during the 1960s and 1970s. Rutter studied the relationship between linguistic characteristics and sensory deficits prevalent in autistic children, where the axes "sensoriality" and its relationship with the body and "language" would be further explored. Studies on receptive language at the time demonstrated the reiteration of patterns such as echolalia and pronominal inversion in autistic children **(Rutter; Bartak; Cox, 1975).** These results reinforced the conception that autism would be primarily a "communication disorder", transforming - synchronously with the impasse between childhood hallucination, verbal description and epidemiology - significantly transforming the approach of child psychiatry in relation to this condition.

In 1979, psychologist Judith Gould and Lorna Wing conducted a study in which they argued that conditions previously called "childhood psychosis," "childhood autism," or "childhood schizophrenia" should be re-conceptualized as "social interaction" problems. Based on the characteristics of autism described by Rutter, they selected 132 children and developed the interview scheme to distinguish between autism and specific receptive and expressive language disorders **(Wing; Gould, 1979).** The authors argued that their system based on the severity of impairment of reciprocal social interaction—comprised of the triad of disability in the usual set of social skills, reciprocal language, and social imagination—offered statistically more significant associations with behavioral, psychological, and medical variables than previous systems.

Thus, in the DSM-III (1980), following this whole scenario of discursive reorganization of the object "autism", the term "psychosis" and any presentation of hallucinations or delusions in developmental disorders, or in other disorders in the broader category of disorders evident in childhood, is excluded. The hypothesis for such an event concerns the reaction to the psychoanalytic discourse presented in the DSM-II, the activisms of mothers of children diagnosed as autistic and schizophrenic, as well as the repositioning of scientific hegemony in Anglo-Saxon countries based on a functionalist grammar.

DSM III (1980)[5]

Disorders usually first evident in childhood, childhood, or adolescence

- **Other disorders of childhood, childhood, or adolescence**
  - **313.22 Schizoid Disorder of Childhood or Adolescence**
- **Pervasive developmental disorders**
  - **Childhood autism**
  - complete syndrome
  - Residual stage
  - **Pervasive developmental disorder beginning in childhood**
  - complete syndrome
  - Residual stage
  - **Atypical pervasive developmental disorder**

The schizoid disorder above has no relation to the typical presentation of schizophrenia, today the description present in the manual would be part of the current

[5] The authors freely translated the text in the box, based on the original document in English, available in the references.

autism spectrum, as well as the pervasive developmental disorders of this edition. Concomitantly, the traditional concept of autism, which previously played a crucial role in the diagnostic criteria for adult schizophrenia in the DSM-II, has been entirely excluded from the diagnostic criteria for adult schizophrenia in this edition. In this way, autism ceased to be a diagnostic key in adult schizophrenia, as it was originally thought, to become a specific category within pervasive disorders of child development **(ibid).**

This edition of the manual was revised in 1987 in the DSM-III-R, from this text the category "autism" is no longer immediately followed by the signifier "infantile", suggesting a new discursive turn with such suppression, emphasizing the fact that it is a pathology for life and not only childhood **(Bursztejn, 2016).** Six years later, the tenth version of the ICD-10 (1993) was published, followed by the DSM-IV (1994). "313.22 Schizoid Disorder of Childhood or Adolescence" is removed from the previous category, since it is similar and integrable to pervasive developmental disorders, such as Asperger's syndrome:

DSM IV (1994)

Disorders usually first evident in childhood, childhood, or adolescence

- **Pervasive developmental disorders**
  - Childhood autism
  - Rett syndrome
  - Childhood Disintegrative Disorder
  - Asperger's Syndrome
  - Pervasive Developmental Disorder Unspecified (Including Atypical Autism)

Asperger's Syndrome, recently added to the 94 manual, gains its name by association with the aforementioned work by Hans Asperger, published in 1944. This study was initially published in German and only became widely known in the English-speaking community after being translated and popularized in the following decades, most notably with the publication of the study "Asperger's Syndrome: A Clinical Report" **(Wing, 1981).** In this, English psychiatrist Lorna Wing proposes that autism be recognized as part of a broader set of disorders characterized by difficulties in the "development of social interaction", "communication" and "imagination". Wing's work has wide repercussions in the psychiatric field, giving rise to the expression "Asperger's syndrome". Here another discursive cut occurs and autism enters into series with the discourse of "cognitive deficits". The hypothesis for such a cut is once again articulated with the new grammar coming from cognitive theories, as opposed to the psychoanalytic tradition, as explanations for "communication disorders" - the bet was

that discourses more aligned with an "objective", "functional" and "pragmatic" science could reproduce a psychopathological paradigm without crossings of ideological scientism linked to social markers of difference. However, if the psychoanalytic discourse failed at numerous times in the pretension of talking about the phenomena of the world as if it were talking about nowhere **(Haraway, 1995)**, the cognitivist theories of the second half of the twentieth century and the beginning of the twenty-first century reiterated the same structure.

In Brazil, in 1999, Assumpção and Carvalho published an article that reviewed hospital psychiatric morbidity in the SUS between 1992 and 1997, showing how the Brazilian epidemiology of the time - still with the ICD-9 criteria in force - used the terminology of "psychosis" and "schizophrenia" in child psychiatry, fostering a "surrealist conception, without any link with reality" **(Assumpção; Carvalho, 1999 apud Lima, Caponi, 2011**). The authors identified from DATASUS that among young Brazilians, aged 0 to 19 years, from January 1992 to December 1997, 73 babies under 1 year of age were diagnosed as having "senile and pre-senile psychotics", and 2,120 babies with a diagnosis of "schizophrenic psychosis" (**ibid).** Rhode (2000), Assumpção and Carvalho (1999) read these data in such a way as to criticize an inadequate transfer of adult to child psychiatry, defending the need for specific training in child and adolescent psychiatry in Brazil. Lima and Caponi (2011) argue that such epidemiological data actually show the effects of careless completion of medical records based on mental disorders, which are not in fact able to convey the order of suffering in question that they aim to circumscribe pragmatically, with "surrealism" being an effect of the conventionalist grammar itself proposed in the manuals and their bureaucratic application. After all, in the previous nosographies "schizophrenia" (DSM I and II and "schizoform disorder" in III), "psychosis" (DSM I and II) and "dementia praecox", associated with states analogous to senility in children, were in fact terms that circumscribed phenomena in the psychopathological literature that were later reframed from the name autism.

In the following decades, with the publication of the ICD-10, there was an important diagnostic migration, in which the conditions named "psychosis" or "childhood schizophrenia" progressively began to refer to the new updated and internationally standardized nomenclature under the term "Pervasive Developmental Disorders (PDD)" - divided into subcategories such as: Childhood Autism, Atypical Autism, Childhood

Disintegrative Disorder, Disorder with Hyperkinesia Associated with Retardation Mental and Stereotyped Movements, Asperger's Syndrome, Other PDD, and PDD Not Otherwise Specified. Such categories present a reiteration of the rupture of the nexus with rationalities and nominations associated with psychoanalytic theories.

In 1997, a new publication by Wing gained repercussion and generated a new discursive cut important in relation to the previous series, which was later legitimized and widely reproduced in diagnostic manuals, with the concept of "autistic spectrum". This notion of spectrum had already been suggested in the child psychiatric literature, as a *continuum* that includes a great diversity of presentations and the possibility of transit between different points on the spectrum, and the difference between childhood autism and Asperger's Syndrome, as in the DSM-IV and ICD-10, is no longer necessary - all of which can fall under the concept of "autistic spectrum" **(Wing, 1997).** This notion was initially disseminated by Wing, but had already been similarly proposed in the field of child psychopathology by psychiatrist and psychoanalyst Elwyn James Anthony based on the idea of a continuity between severely psychotic children and those with milder or partial manifestations **(Anthony, 1958).**

The concept of spectrum, dealt with in the previous manuals, dismisses the categorical and linear model of diagnosis, replacing it with a dimensional one - in the latter logic the spectral style of combining traits prevails. Thus, the dimensional model proposes to encompass infinite combinations between a series of differences that a subject can present, suggesting a singular presentation in the last instance. Such repositioning has profoundly changed the meaning of autism, as well as the number of children who are now defined by these new classification criteria. And it is in the DSM-V, almost a decade later, that the concept of spectrum becomes a fundamental articulator for the hegemonic psychiatric understanding of autism and the displacement of psychosis in childhood:

DSM V (2013)

Neurodevelopmental disorders

- **Autism Spectrum Disorder - 299.00 (F84.0)**

Severity levels:

- Level 1 "Demanding Support"
- Level 2 "Requiring Substantial Support"
- Level 3 "Requiring very substantial support"

***Differential Diagnosis:**

Schizophrenia: Childhood-onset schizophrenia usually develops after a period of normal or

near-normal development. There is a description of a prodromal state in which social impairment, atypical interests and beliefs occur that can be confused with the social deficits found in autism spectrum disorder. **Hallucinations and delusions, defining features of schizophrenia, are not elements of autism spectrum disorder**. Clinicians, however, should take into account that individuals with autism spectrum disorder can be concrete in interpreting questions about key aspects of schizophrenia (e.g., "Do you hear voices when no one is around?" "Yes [on the radio]").

In this edition, the category "Autism spectrum disorder" (ASD) is now subordinated to the set of so-called "Neurodevelopmental disorders", replacing the previous terminology of "Disorders usually evident for the first time in childhood and adolescence". This substitution represents a commitment by contemporary psychiatry to incorporate childhood-oriented diagnoses within an explanatory model that links etiopathogenesis to neuronal development **(Klein, T, Lima, R., 2020)**. The neurodevelopmental approach is aligned with the recent guidelines of the National Institute of Psychiatry (NIMH), especially in the context of the RDoC project **(Cassey, Olivieri and Insel, 2014).**

In this same issue, the diagnostic criteria for autism are reviewed, and sensory behaviors encompassed in "restricted and repetitive patterns of behaviors, activities, or interests" are included as part of the new definition, and are significant for diagnosis to the extent that they cause "clinically significant impairment in social functioning" (p.50). Timimi (2020) points out that definitions of this order present a circularity of psychiatric thinking, to the extent that such diagnostic criteria are established by the specialists who apply them. This logic makes the concept of an "anomaly" of social interaction, communication and behavior not an objective datum, but rather a constructed defined and legitimized within the psychiatric field itself. In this way, it is the specialist who defines what characterizes a dysfunction and, at the same time, legitimizes himself as the only authority capable of recognizing it. This closed cycle prevents questioning about the very foundations of these classifications and naturalizes a model of normality that, far from being universal, reflects specific historical, social and cultural criteria.

With regard to the prefix "neuro", present in the edition, there is the mark of a new discursive slip, if not new, at least more explicit, of an emphasis from the point of view of the etiology attributed to such disorders and the movement of "cerebralization" of the understanding of ASD. The hypothesis in question suggests that processes related to brain development play a central role in the presentation of the disorder, in line with the cognitivist perspective, and based on multiple studies that indicate a

correlation between events occurring early, during intrauterine life or shortly after birth, as fundamental in the etiology of some cases of autism and also schizophrenia **(Akil & Weinberger, 2000; Brito, A., Franco, F., Brentani, H. et al, 2023).**

Lima and Klein (2020) argue that the use of the radical "neuro" in the conception of neurodevelopment has promoted significant shifts in relation to the modern idea of development. While the classical concept of development was aligned with a strictly "evolutionary" and "predetermined" logic, the modern developmentalist discourse articulated with the "neuro" - is differently linked to contemporary propositions of biology, such as epigenetics and concepts such as brain plasticity - suggesting a more "dynamic", "erratic" and "constant transformation" process **(ibid, p.111)**. Even so, according to the authors, the modern concept presents continuities in relation to the previous one, at the same time that it discontinues evolutionary and previously defined ideals, new normative ideals are also reiterated centered on this order of continuous transformation of the individual and on the technical interventions to achieve them.

Currently, ICD 11 unites all these diagnoses related to modes of functioning close to what was called - in psychiatric and psychoanalytic categories, antecedent to the DSM's and ICD's - hebephrenia and dementia praecox **(The American Medico-Psychological Association, 1918)** or even psychotic disorders **(APA, 1952),** under the broad category of Autism Spectrum Disorder with and without specification.

In diagnostic manuals, the semiology that separates ASD from the so-called early-onset (before 18 years of age) and very early onset (before 13 years of age) schizophrenia has overlaps, since in both conditions there are descriptions of significant alterations in the motor, language, and social interaction fields. However, while ASD is typically diagnosed in early childhood, characterized by restricted, repetitive, and inflexible patterns of behavior, interests, or activities, and by a difficulty in social communication, and the trend is toward a stable course **(ICD 11, 2019)**; early-onset schizophrenia is narrated as typically diagnosed in adolescence or adulthood[6], being preceded by "normal development" in early childhood, and characterized mostly by auditory hallucinations and delusions, tending to be associated with a functional decline "the longer the untreated psychosis" **(*Ibid*).** However, despite being conditions with different standardized descriptions, in recent systematic reviews, young people

[6] "The National Institute of Mental Health (NIMH) cut-off studies estimate an incidence of 0.04% and the prevalence studies of very early-onset schizophrenia estimate prevalence of 1 in 10,000 and 1 in 30,000" **(Melcop, Moriyama, Saldanha, 2021).**

diagnosed with ASD are three to six times more likely to be diagnosed with schizophrenia in adulthood, demonstrating a high comorbidity between one condition and another **(Jutla et al, 2022)**.

The current pathological model incorporates the logic of "risk medicine", prioritizing the early identification of pathogenic factors and early interventions, often dissociated from the subjective experience of suffering **(Rodrigues, 2017).** In line with this logic, recent research published in *JAMA Network Open* explores technologies such as "EarliPoint Evaluation", which uses eye tracking in babies aged 16 to 30 months to identify possible signs of autism, with the promise of reducing diagnostic time and eliminating the evaluator's "subjectivity" (Jones, W., Klaiman, C., Richardson, S et al., 2023; Jones, W., Klin, A., Klaiman, C et al., 2023).

These approaches emphasize body mapping and individualized surveillance, favoring high-cost technologies that disregard the relational factor in diagnosis. As Rose (2013) points out, the focus on body individualization in risk assessments shifts the debate from collective responsibility in care. Funding thus tends to focus on studies on biomarkers, fueling expectations of early prediction, despite their technical limitations and ethical implications **(Rodrigues, 2017).**

The descriptive inventories of current traits and symptoms (DSM and ICD), as well as such evaluations of bodily signs, do not seem to explore in a sufficiently satisfactory way the complexity of the phenomena once called "psychotic" in childhood - there is little or no space for discussion of important phenomena in the psychopathological tradition, and especially in the advancement of its critique, such as the relational and collective dimensions involved in delusions, hallucinations, fantasies, daydreams or imagination in children - also erasing specificities of a time, place and culture - categories so close to the basic elements of narrative composition, such as time, space and characters. That such diagnostic systems are hegemonic in children's psychopathological discourse is not without effects. Such diagnoses are based on statistical hypotheses of etiology, pathophysiology that lead to horizons of recognition and also exclusion of subjective processes marked by the collective dimension, as well as specific intervention models.

Treatments considered "gold standard" are discursively presented as superior in terms of scientific evidence for the population for which they are intended, in this cut the population diagnosed within ASD. By positioning themselves as the most effective

interventions in reducing positive and negative symptoms, they emphasize skills training and cognitive and social adjustment.

We observe how such treatment strategies have been discursively positioned as the only legitimate options to be chosen for mental health care - in the field of autism, if compared to schizophrenia, the current discussion focuses more on the dispute regarding therapeutic treatments than pharmacological ones

The imposition of a therapeutic approach as the only alternative to meet such diverse demands exceeds ethical limits in the promotion of public policies. The disputes involving the field of autism diagnosis are tributaries of a new repositioning and game of forces from the category of recognition promoted by ASD and its consequent growth in childhood diagnosis, with 1 in 38 diagnosed in Brazil, according to the most recent report **(IBGE 2025).**

Such numbers draw attention and produce different discursive mobilizations regarding this category of recognition of suffering in child psychopathology, either through discourses that deny its pertinence and validity, or through the defense of the importance of this form of naming as a political resource to guarantee rights, access to care and advance science, or through market discourses[7], and so many other crossings that govern the social field of autism dispute **(Machado, 2021).**

Conclusion

By historically resuming the path that begins with the signifier "psychosis" and culminates in the consolidation of "autism" as a central category in child psychiatry, it becomes possible to understand how these nomenclatures transited and reconfigured themselves within public health practices, differentially tensioning the discourses that sustain them. Along this path, we see how increasingly syndromic and operational classifications gain strength in the face of a diagnosis that becomes imperative — not only as a clinical instrument, but as an essential bureaucratic requirement for care management, whether in public or private contexts. The diagnosis becomes a condition for access to treatment, the allocation of resources, the institutional recognition of suffering and the validation of existence in normative health systems.

With this mapping, we seek to broaden the debate on the effects of these classifications on the constitution of subjectivities and modes of care. Resuming the

[7] For details, see more in The "industry" of autism in the current Brazilian context: contribution to the debate. Technical material available in the references.

history of such diagnostic categories is fundamental to denaturalize the discourses that today sustain practices and techniques that are apparently neutral, but deeply marked by political, ideological and economic decisions. For the field of public health, this resumption is essential, as it allows the ethical and relational dimension of care to be put back on the agenda, opening space for more plural practices, situated and sensitive to the experiences of the subjects concerned.

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