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ORIGINAL ARTICLE

Pharmacological Microcontroversies and Civilizational Grammars Around ADHD in Chile

Esteban Radiszcz[1] · Hugo Sir[2] · Juan Pablo Pinto[3]

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Abstract
This article examines pharmacological microcontroversies (PMC) surrounding attention deficit hyperactivity disorder (ADHD) in Chile, based on a comparative, multisited ethnography in four educational contexts with differing socioeconomic and territorial profiles. Drawing on science and technology studies, microcontroversies studies, and Norbert Elias's sociology of interdependence, the study conceptualizes ADHD as a situational configuration in which diagnosis and treatment emerge from interwoven relations among children, caregivers, educators, and health professionals. Data were collected through focused ethnography, open interviews, discussion groups, and triangular groups and analyzed via emergent content and sociological discourse analysis. Two axes structure PMC: (i) desired effect—stillness versus performance, and (ii) normative model—external conduct versus internal capacities. Across sites, pharmaceuticals were embedded in distinct "civilizational grammars" linking bodily regulation, moral expectations, and educational aims: from medication as protection against criminality to a "concentration pill" enabling hidden potential. These grammars mediate acceptance, rejection, or ambivalence toward medication crossed by other vectors as class and gender. ADHD-related debates thus constitute territorially situated normative arrangements, revealing how local trajectories and interdependencies shape diagnoses and the production of children's interiority.

Keywords ADHD · ADHD situation · Medication · Interdependence · Civilizational demands

Introduction

Since its initial inclusion in the third edition of the diagnostic and statistical manual of mental disorders (APA, 1980), attention deficit hyperactivity disorder (ADHD) has been a particularly contested nosological category (Parens & Johnston, 2009;

Extended author information available on the last page of the article

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Singh, 2008). Among the many points of debate, the medication of children has been especially controversial (Chang et al., 2019; Faraone et al., 2018; Ortega et al., 2018). Whereas the use of amphetamines for childhood hyperactivity in the 1930s appears to have raised little concern (Baumeister et al., 2012; Lange et al., 2010; Smith, 2012), over the past four decades, the prescription of psychostimulants to children has generated persistent disagreement (Bianchi et al., 2017; Rojas Navarro & Vrecko, 2017). The medicalization of children's bodies through ADHD has unfolded amid a wide range of disputes (Bell, 2024; Cameron, 2024; Ortega & Müller, 2020), ranging from claims about the facilitating (Sultan & Andresen, 2019), protective, or uncertain role of medication in relation to drug use (Chang et al., 2019), to debates over its negative or affirmative consequences for subjective and identity-related dimensions (Comstock, 2011; Haye et al., 2018; Leavy, 2013).

This article complicates current approaches by drawing on research conducted in Chile that examines the contested status of ADHD through its "microcontroversies." These are small-scale, situated disputes—limited in scope and typically confined to interpersonal domains—that unfold outside both public debate and expert arenas (Lemieux, 2018). While microcontroversies carry implicit principles of generalization—what we term civilizational grammars—these are not articulated as public or political claims. Instead, they take the form of complaints addressed to specific actors, or sets of equivalent actors, such as teachers, caregivers, and medical practitioners involved in the everyday management of the diagnosis.

Among them are those specifically concerned with the use of medication, which we call "pharmacological microcontroversies" (PMC). Their analysis underscores the importance of attending to the interdependent relations involved in the use of pharmaceuticals to discern their function, efficacy, and normative horizon. Indeed, when viewed in light of interdependence chains (Doblytė, 2022; Elias, 2009) and the interpretive frameworks that shape medication practices (Kirmayer et al., 2017), PMC become intelligible in more nuanced terms—less bound to moral or binary distinctions (good/bad; authentic/false; natural/artificial, etc.).

Indeed, psychotropic medications actively participate in shaping children's experiences, identities, and moral worlds within specific sociocultural contexts, giving rise to forms of interiority that emerge at the intersection of pharmaceuticals, social trajectories, cultural imaginaries, and institutional regimes of treatment (Jenkins, 2009). Thus, rather than functioning as passive recipients of diagnoses and prescriptions, children actively construct meanings around diagnosis and medication, integrating, reworking, or resisting them in their understandings of self, behavior, and everyday relationships (Carpenter-Song, 2009a, 2009b). This dynamic has also been described within the framework of so-called invisible disabilities, in which medication does not simply respond to a clinical category but mediates moral expectations concerning parenting motherhood, responsibility, and childhood normality in contexts of inequality (Blum, 2015).

In social research on ADHD, debates have often centered on normatively charged notions such as responsibility, authenticity, and moral agency (Koi, 2021; Singh, 2013a, 2013b; Sultan & Andresen, 2019). Much of this discussion has been shaped by critiques of medicalization approaches that conceptualize diagnosis as a sociocultural process through which behaviors and problems previously treated

as part of everyday life are redefined as medical issues (Conrad, 1975; Conrad & Bergey, 2014). Over the past decade, across both the Global North and Global South, this perspective has been reconsidered, expanded, and, in some cases, deemed at least partially obsolete (Bianchi, 2018; Faraone and Bianchi 2018).

On the one hand, some positions—drawing on the 'sociology of critique' and on 'science and technology studies'—emphasize the authenticity of the assemblages formed between children's bodies and nonhuman agencies such as pharmaceuticals (Rojas, 2018). From this perspective, it has been suggested that, rather than falsifying children's identities through the arbitrary medicalization of their behaviors, medication may instead open pathways for them to develop an authenticity not confined to the opposition between the natural and the pharmaceutical, but conceived as a process of self-construction with pharmaceuticals (Bergey, 2024; Bergey et al., 2018; Singh, 2013a).

On the other hand, some have argued that this very *logic of potential* (Ehrenberg, 2018)—that is, the perspective in which selves are seen as biologically perfectible and neurologically optimizable (Rabinow, 2010; Rose, 2007)—must be understood not only in relation to specific sociocultural coordinates, but also in terms of expectations and possibilities that are unevenly distributed across other forms of social stratification (Béliard et al., 2019; Cottet et al., 2023; Kirmayer et al., 2017). Our own contribution aligns with this latter position.

Specifically in Chile, several studies have shown that diagnosis and pharmacological treatment do not operate in a linear or homogeneous manner, but are instead locally reassembled through institutional and sociomaterial arrangements that produce multiple ADHD trajectories within the school setting (Rojas et al., 2018; Rojas-Navarro et al., 2022). Likewise, research has documented that children's and families' experiences of diagnosis and medication are shaped by ambivalences, disputes, and processes of identity destabilization, rather than by univocal logics of medicalization (Béliard et al., 2019; Cottet et al., 2023; Reyes et al., 2019).

Questions of responsibility, autonomy, and moral agency that pervade concerns and research on ADHD have been shown to be tied to contemporary notions of authenticity and self-control (Comstock, 2011; Haye et al., 2018; Lakoff, 2000) This linkage calls for a broader inquiry into the ideals, obligations, and experiences of individuality as differentially distributed across social vectors. This issue—relevant to social research on mental health more generally—is particularly acute in the case of ADHD, whose genealogy links it to forms of behavior historically deemed morally inappropriate (Berrios & Gili, 1995; Caliman, 2010, 2012; Comstock, 2011; Sir, 2023). From its earliest descriptions, the set of bodily and attentional dispositions identified through ADHD has been associated with demands and expectations that, especially within schooling, carry a civilizational dimension: explicit and implicit expectations involving, through the child, families, and institutions (Elias, 1998; Lakoff, 2000; Sir et al., 2019).

In this article, we argue that ADHD microcontroversies—particularly those concerning the use of pharmaceuticals—allow us to explore the civilizational dimension through the *language* and *modes* by which concerns about children's conduct and attention are expressed; that is, through the grammars mobilized in mutually addressed complaints. Reciprocal obligations, expectations, ideals, and

horizons are embedded in both the language and the modality of complaints. Should children take pills? Should they remain still? Should schools acknowledge and foster diverse ways of learning? Should caregivers seek to unveil the hidden potential of their children? Should teaching diversification require medical categories? A grammar can be understood simultaneously as the rules governing the use of language to elaborate criticisms and as the underlying principles for the normative generalization of those claims (Boltanski & Thévenot, 2006; Lemieux, 2009).

This set of uncertainties surrounding ADHD cuts across a diversity of actors, involving them in what we call an ADHD situation. In what follows, we show that while this situation is indeed modulated by different social vectors—such as class, gender, or race—it also varies according to local inflections. Different territories harbor distinct fears, expectations, and ideals regarding children's behavior, performance, and success. Nonetheless, as we will also show, there is no mechanical relation between a given local context and a specific civilizational grammar; rather, what varies are degrees of dominance and configurations among multiple grammars.

An *ADHD situation*, like other care-related issues, reaches a point at which it can no longer be dismissed, demanding action across the diverse actors involved (Garrau & Le Goff, 2010; Stefanidi et al., 2022). In responding to such situations, actors mobilize different *civilizational* grammars within a context of marked interdependence. Indeed, it is a highly interdependent context—where the outcomes of any aspiration or intervention depend on the coordinated yet differentiated actions of multiple actors (children, caregivers, teachers, health professionals, special educators, and others)—that gives grammars its civilizational character. A civilizational grammar therefore implies both sociogenetic effects, by shaping the ways society is organized and community life is inhabited, and psychogenetic effects, by modulating shared aspirations and modes of understanding human interiority, including that of children (Elias, 2003, 2009; Salumets, 2001).

In this way, we aim to show that PMC makes it possible to identify civilizational grammars that, in defining both the expected effects of pharmaceuticals and the sociopsychogenetic norms they convey, also project expectations of interiority demanded of and negotiated among individuals. To this end, after presenting the main methodological aspects of the study, we describe the PMC identified across the different sites and examine them through their prototypical conflicts (Hacking, 1998a, 1998b). Finally, we show how these conflicts bring into relief three civilizational grammars whose (a)synchronies and tensions help to characterize the specific value and meaning of pharmaceutical use across different ADHD situations.

Methodological Framework

This article draws on the results of a broader research project conducted between 2020 and 2024. Methodologically grounded on the situational standpoint about ADHD in Chilean school and upon insights from the civilization process Eliasian theory (Ampudia, 2008; Lutz, 2014; Paulle et al., 2012), the fieldwork was distributed by proximity to the main metropolitan area, the capital. Thus, we

conducted multisited ethnographic-inspired class observation, interviews, triangular, and group discussions in four sites:

- Two districts in *the capital* with contrasting socioeconomic profiles (**W**, characterized by middle- or lower-middle-income households; and **Y**, recognized for its affluent neighborhoods);
- A *mid-sized city* in the south of the country (**X**, notable for its established middle-income groups and the strong presence of agroindustrial activity); and
- A *rururban locality* (**Z**, substantially more exposed to poverty).

The sites differed by their proximity to the metropolis (capital, mid-size, rururban), and within the capital also between the socioeconomic profile of the territory. Nonetheless, to ensure comparability, we flattened the social profile of the four schools. Consequently, four educational institutions—one per site—were selected based on their similarity in:

(i) The implementation of the School Integration Program (PIE, Spanish acronym), in line with the national strategy on educational inclusion and disability (MINEDUC, 2025), which provides specific state funding to schools to establish specialized professional support units. These units—comprising special education teachers, speech therapists, psychologists, occupational therapists, among others—offer in-class support and individualized assistance to students with Special Educational Needs (SEN), including ADHD; and

(ii) The reporting of a Multidimensional Vulnerability Index (IVM) score for the first stage of primary education within the medium range (40–45 points), as defined by the Ministry of Education of the Government of Chile (JUNAEB, 2021).

Once in the field, the research began with focused ethnographic-inspired observations (Trundle & Phillips, 2023) conducted in a multisited fashion (Santos-Fraile & Massó, 2017) over a short duration (four months) in the fourth-grade classrooms (typically children aged 9–11) of each school, with records kept in Field Notebooks (FiNo). This was followed by open interviews (Gordo & Serrano, 2008) with twelve children (three per school), selected based on information gathered during the ethnographic observations, ensuring diversity in gender, diagnostic trajectories, treatments, and participation in the PIE. The main caregivers of these children were also interviewed, along with other actors involved as education specialists or health professionals. Finally, the study included six Discussion Groups (DG) (Gordo & Serrano, 2008; Ibáñez, 1979)—three with children aged 9–11 diagnosed with ADHD and three with their primary caregivers—as well as nine Triangular Groups (TG) (Gordo & Serrano, 2008; Ruiz Ruiz, 2012): three with primary school teachers, three with PIE professionals, and three with health specialists.

We now present a table that concisely outlines both the different procedures used to collect relevant information and the main characteristics of the participants involved (Table 1).

Table 1 Characterization of data collection strategies and of the participants involved

Sites	Educational institutions	Ethnographic observations	Interviews–children	Interviews–caregivers	Interviews–others	DG	TG
X Mid-sized city (south)	Private school (state-funded) IVM = 39.99	4th grade, 22 students (teachers, PIE)	**Ac** (*No dx; No PIE*), **Au** (*ADHD dx; medicated; In PIE*), **Ja** (*ADHD dx; In PIE*)	Ac's father (technical degree), Au's mother (professional), Ja's mother (homemaker)	Va (Spec. Educator), Pa (Speech Therapist)	7 boys, 3 girls (ADHD dx) 6 mothers, 2 fathers (children ADHD dx)	3 Homeroom teachers 1 Child psychiatrist 1 Familiar doctor 1 General doctor 1 PIE coordinator 1 Special educator 1 Psychopedagogist
W Metropolitan district (middle strata)	Public school (municipal) IVM = 42.67	4th grade, 29 students (teachers, PIE)	**Lu** (*ADHD dx; med. Stopped; In PIE*), **Ag** (*ADHD dx; No medicated; In PIE*), **Le** (*No dx; No PIE*)	Lu's mother (unskilled), Ag's mother (technical degree), Le's mother (technical degree)	Su (PIE Coord.), Ur (Spec. Ed.)	5 boys, 2 girls (ADHD dx)	4 Homeroom teachers 1 Familiar doctor 1 Child neurologist 1 Pediatrician
Y Metropolitan district (affluent)	Private school (state-funded) IVM = 45.95	4th grade, 19 students (teachers, PIE)	**Ma** (*ADHD dx; medicated; In PIE; Psychologist*), **Fa** (*ADHD dx; med. Stopped; In PIE*), **Cr** (*No dx, In PIE*)	Ma's mother (professional), Fa's mother (professional), Cr's mother (professional)	Ca (Psychologist), Ig (PIE Psych.), Jo (Teacher)	7 mothers (children ADHD dx)	1 PIE coordinator 2 Special educators

Table 1 (continued)

Sites	Educational institutions	Ethnographic observations	Interviews–children	Interviews–caregivers	Interviews–others	DG	TG
Z Rururban city (higher poverty)	Public school (municipal) IVM = 43.71	4th grade, 15 students (teachers, PIE)	**Na** (*ADHD dx; medicated; In PIE*), **Ga** (*ADHD dx; medicated; In PIE; Psychologist*), **Da** (*No dx; No PIE*)	Na's grandmother (homemaker), Ga's mother (unskilled), Da's mother (unskilled)	Ik (PIE Coord.), Di (Psychologist), Em (Spec. Educ.)	4 boys, 1 girl (ADHD dx) 5 mothers, 1 father (children ADHD dx)	3 Homeroom teachers 2 Pediatricians 1 Child neurologist 1 PIE coordinator 2 Special educator 1 Speech therapist

The analysis followed a dual strategy: a descriptive approach, through "emergent content analysis" (Bryman, 2004), and an interpretive approach, through "sociological discourse analysis" (Ruiz Ruiz, 2009, 2014). The aim was thus not only to identify and describe the various microcontroversies surrounding ADHD, but also to discern the different configurations assumed by their distinctive moral grammars (Lemieux, 2017).

The research project received ethical approval from an accredited Research Ethics Committee. Informed consent (adults) and assent (children) were obtained for all data collection modalities. Participant anonymity was ensured through data anonymization; audio recordings were deleted after transcription, and photographic materials excluded or blurred identifiable features. Protocols were in place to provide emotional support, professional assistance, or rights protection when required, particularly given the inclusion of children. Study results were shared with participants through workshops in each territory, using freely available adapted written and audiovisual materials.

Pharmaceuticals in Conflict

The difficulties triggered by an ADHD diagnosis—at school, within families, and in social contexts—do not depend solely on individual behavioral or cognitive characteristics but, as we show, on the configuration of an ADHD situation shaped by the interplay of its actors. The situations examined here are not intended to represent entire field sites, but to illustrate how specific arrangements of an ADHD situation bring into sharper focus what is taken as a prototypical conflict. Here, prototype is used in contrast to paradigm, following Hacking's (1998a) distinction between "paradigm, to refer to the initial model of a disorder, and prototype, to designate the characteristic and typical example of a patient once the disorder has become an established diagnosis" (p. 202). In our use, the prototype refers not to the diagnosis itself but to the salient, situated conflictivity that emerges around ADHD within the school context.

Thus, an important finding concerns the polysemy of both the diagnostic category and its modes of management. The plasticity of the ADHD diagnosis has been widely noted, particularly in relation to gender, contexts, and trajectories (Bergey et al., 2018; Bröer & Agyekum, 2021; Cottet et al., 2023; Santah & Bröer, 2022). In line with this literature, research in Chile shows that normative expectations surrounding ADHD are neither class- nor gender-neutral, but articulated through differentiated mandates of discipline, emotional self-regulation, and academic performance (Béliard et al., 2019; Rojas et al., 2018; Uribe et al., 2019). Our fieldwork further shows that, beyond class and gender, territorial histories introduce additional tensions shaping these expectations.

In this way, even the physical and social settings of the schools observed offer valuable clues for exploring the variants of ADHD's polysemy, reflecting distinct sociopsychogenetic contrasts across the research sites. In this regard, the symbolic and semantic distance between **X** and **Z** is particularly illustrative of the different civilizational grammars applied to both the diagnosis and the use of pharmaceuticals.

Z: Between Salvation and Abandonment

Shaped by agricultural activity, **Z** is a small city which, like many others in the country's central zone, exhibits characteristics that, given their mismatch with the traditional rural/urban distinction, could justify—for some—the term *agropolis* (Canales & Canales Cerón, 2013). This label is less tied to the tacit primacy of the urban, which, in line with a presumed trend toward metropolization, would persist even within the more common administrative category of "rururban" (Ruiz Rivera & Delgado Campos, 2008).

In **Z**, the selected school was located, as the earliest FiNo notes record, "almost at the boundary between the urban and the rural," positioned between the city proper and a sector referred to as a "bad neighborhood"—the last link before fully rural spaces. These are characterized by "high territorial dispersion" and by the difficulty of reaching them with the limited resources available, a concern that weighed heavily on the school and local institutions, especially during the pandemic. In this context, the school presents itself as inclusive and capable of accommodating differences—both between social classes and between rural and urban conditions—as well as those recognized as SEN, addressed through the PIE.

This self-understanding fosters in the support teams a sensitivity to the local conditions shaping what diagnoses means. During the third month of observation, in a conversation with the ethnographer, the PIE coordinator—after noting the existence in the area of "high levels of domestic violence"—asked, "A child who suffers violence, or neglect from their parents, is that really ADHD?" She went on to add that "violence within families is a serious problem affecting many students in the school," a factor she believed was overlooked by psychiatrists and neurologists, who, in her view, "neglect psychosocial problems [and] fail to take a comprehensive approach to the issue; they just diagnose ADHD on the basis of a standardized test" (FiNo, **Z**).

Yet, beyond appearances, this is less a straightforward denunciation—aligned with more classical perspectives on medicalization (Bianchi, 2016; Conrad, 1976)—than a recognition of a conflict that plays out through diagnosis and its treatment approaches, including the use of pharmaceuticals. No matter how distant the relationship with medical practitioners, their expertise, and their authority may seem, it is never only oppositional. Rather, the relationship with the medical profession varies in ways deeply shaped by the fears circulating in the territory.

The main distrust toward the diagnosis arose whenever it was suspected that behind a student's behavioral difficulties, disobedience, opposition, or absenteeism lay trajectories or situations of violence: "In many schools there is an overdiagnosis of the disorder (…) where children who are considered problematic are given the diagnosis in order to make teachers' work inside the classroom easier" (FiNo, **Z**). Social and family violence marks the prototypical conflict that gives intelligibility to the diagnosis and to pharmaceutical treatment in **Z**. In this sense, and with reference to **Na**, one of the students later interviewed, the ethnographer noted:

> "Strongly marked by violence at many levels. [**Na**] lives with her grandparents, whom she calls her parents, as she has been raised by her

grandmother because her mother lives in environments shaped by drug trafficking and crime, which meant the girl was exposed to high levels of violence from a very young age. The girl has an ADHD diagnosis, takes Methylphenidate and Risperidone, and her treating physician is the only child neurologist working in the public health network. [Her grandmother] is a woman of rural origins who has also lived a life deeply marked by violence since childhood, and she has set out to 'save' her granddaughter." (FiNo, **Z**).

This strongly normative idea of "saving" a child permeates the conflict that unfolds around the diagnosis and the pharmaceutical in **Z**. More than aiming for the child to "perform"—an expectation the PIE professionals explicitly reject—the concern lies in recognizing the different levels of violence to which families, and thus their children, are exposed and/or which they reproduce. These would manifest as bodily restlessness, aggressiveness, disobedience, "negative" leadership, and so forth, and are framed primarily as a behavioral dimension—in which the external manifestation of bodies and actions is placed under surveillance, rather than internal skills or states.

This concern with behavior is also evident in a large share of the recurrent complaints and difficulties expressed by children during the respective discussion groups, particularly in relation to behaviors—whether their own or others'—perceived as disruptive, transgressive, or violent.

D: "Because… but the kids don't… not really… because [the moms] say […]: 'Behave yourselves!' And the kids don't behave well, they talk with their friends… the other day they told me it was something I had done."
[…]
E: "I have two classmates who are messy in class. There's one who's really copuchento [gossipy], because when the teachers are talking he goes, 'yes, yes, miss, that happens.' And they repeat the same things they tell the teacher, so they gossip. When the teachers are talking, […] they start gossiping about what the teachers are saying."
[…]
D: "I go to the psychologist a lot, but *for me it helps* […]. *Because sometimes I hit my brother*."
(DG-children, **Z**).

It is thus possible to identify an expanded concern with aggressive behavior and violence in the management of ADHD situations. In this light, Na's grandmother did not oppose the ADHD diagnosis; on the contrary, she perceived both the diagnosis and the medication as an opportunity to "save" her granddaughter from her own inclinations and from a family history marked by hardship. Neither the diagnosis nor the pharmaceutical was understood as preventing Na from expressing herself, being herself, or developing; rather, they were seen as enabling the hope of interrupting a tragic trajectory—by helping Na to become more tranquil, calm, and still.

Na herself echoed her grandmother's view, noting that before the medication,

> "I was very restless, I was going from here to there, from there to here, and I *behaved badly*, I did *worse things*. One day […], with the scissors, I cut the seat of the van. And then, it was like, yeah, I kept *behaving badly*, and I tore a book. I did many things, many things I did *wrong, wrong*."

By contrast, she explained that

> "all of a sudden *I'm calmer with the pills* […], I calm down, I'm calmer, like I suddenly sit down and think, suddenly I think that *it's better for me to behave well* because that way I can pass the grade, I reflect on my homework." (Interview, Na, **Z**).

At the center of **Na's** ADHD situation was, in fact, a struggle against the repetition of her mother's history, which was described as marked by an attraction to "criminal activities," "drugs," "sexual–affective relationships," and "reggaetón" (FiNo, **Z**). "So, Na already comes—comes with her mother's mentality" (Interview, Na's grandmother), a formulation that made the prevention of school abandonment or expulsion imperative. More generally, this case illustrates how, in site **Z**, both the diagnosis and the use of pharmaceuticals are linked to a prototypical conflict deeply rooted in the moral history of ADHD: the perceived risk of violence, crime, and deviance (Honkasilta & Vehkakoski, 2019).

In this sense, the grandmother experienced her situation as a salvific mission that directly extended to the school, whose location at the boundary between urban and rural areas metaphorically condensed its role as a last civilizational bastion. The neurologist's work and the effects of medication were, in turn, understood as preventing a definitive detachment from the modern educational institution—what administrative jargon designates as "school dropout," and what, as **Na** and her grandmother knew well, regularly precipitated the feared intervention of the state child protection agency in place at the time, the National Service for Minors (SENAME). For this reason, the grandmother would warn her granddaughter about SENAME's possible arrival as the consequence of a negative trajectory, adding:

> "**Na**, now you're seeing a neurologist, you have *your medicine*, *your pills*. You *have to change*, **Na**. So, what's the point, I say, of going every month with you to the neurologist, and the neurologist checks you, measures you, weighs you, asks me 'how are you doing?' and nothing else. That's all the neurologist does. (…) And he tells me that on June 1st, I have to bring him a report from the school and your grades. So, they base everything on that. If they see that your grades are good, maybe they'll keep you on the same medication. However, if they see that your behavior has been bad lately (…), then he'll probably take other measures—maybe give you another medication—because *that's the only thing the neurologist does*." (Interview, Na's grandmother, **Z**)

Not without ambivalence, then, the pharmaceutical appeared as a possibility of salvation, while at the same time signaling another form of abandonment or reduction—where that "it's the *only thing the neurologist does*" also represents the *only thing done* to prevent the grim fate inscribed in the history of social and family violence.

X and the Plus of Concentration

X is a mid-sized city in southern Chile, where the openly modernizing drive of the local elites has gone hand in hand with ambivalent attitudes toward large cities, especially the capital (Weibel Fernández, 2021). As characterized by the strong presence of the agroforestry industry, it also has a significant service sector and non-manual wage employment which, being less monopolized by agricultural activity, shape an economy more like that of metropolitan areas (Mac-Clure et al., 2014).

The contrast between **X** and **Z** was evident even before classroom observation began. While, in **Z,** the research team had been received with enthusiasm and openness, in **X**, there was a more pronounced sense of distrust and a somewhat defiant attitude on the part of caregivers and school actors. This distant reception, though it softened over time, reflected local critiques of metropolitan expertise and professionals which, as an expression of a broader tension with central authority, foreshadowed distinctive ways of articulating controversies over the ADHD diagnosis and the use of pharmaceuticals.

In fact, the PMC in **X** and **Z** differed visibly regarding the expected effect of the medication. In **Z**, the pharmaceutical aimed at achieving bodily stillness, intended to ward off the worst predictions surrounding criminality; in **X**, the concern of caregivers, practitioners, and teachers instead leaned toward fostering greater concentration to enable the expression of children's potential. In this sense, in line with the shared—though not uncontentious—interest of various actors in recalling and cultivating children's intelligence, the priority given in **X** to the internal modulation of conduct stands in contrast to the external bodily control more characteristic of **Z** and of some metropolitan ADHD situations.

Thus, while in **Z**, after being caught taking photos during class, a boy was severely reprimanded in front of all his classmates—with repeated scoldings "even though he's no longer doing anything"—for a long time (FiNo, **Z**), a very similar incident in **X** led to very different warnings:

> "[The teacher] looks toward the class and replies that she's going to speak with him [the one who took the photo] during recess, together with [the principal] and [another teacher], because '*he's* very intelligent and he knows what the rules are; he doesn't need us scolding him all the time. *If* he's intelligent, he'll put his mask back on' [and won't take photos again]." (FiNo, **X**)

This is, of course, another way of achieving ultimately similar ends: that the child does what they are supposed to do. Yet there is a whole world of difference—both in terms of the intended sociopsychogenetic norm and the desired effect—between the pathways taken in one setting or another. In this way, the demand for self-control and self-regulation seems to become stronger in contexts where there is an explicit aim to move away from disciplinary control.

In any case, this did not prevent children in site **X** from protesting against parental or school measures aimed at channeling their behavior, nor from denouncing what they perceived as inappropriate conduct by their peers. Thus, in addition to voicing complaints about teachers' anger when they felt their reactions were misunderstood (Interview, **Au**), restrictions on access to certain spaces (DG-children), limitations

on cellphone use in the classroom (Interview, **Au**), or demands to maintain domestic order (Interview, **Ac**), they also expressed annoyance at "noises… annoying noises, or paper-ball wars" during class (Interview, **Au**), insults, fights, and acts of aggression they witnessed (DG-children; Interview, **Ac**), stones being thrown in the schoolyard (Interview, **Ja**), or pushing during recess (Interview, **Au**).

Beyond condemning insults and violence as such, however, their concern with conduct often served to point out the inconvenience of such behaviors considering how they interfered with the deployment of their capacities and preferences. In this sense, **Ac** complained that "sometimes they start playing and *they distract me* […] they take a sheet of paper and make a little airplane, and they start throwing it at each other" (Interview). For his part, **Ja** regretted being scolded by his mother "when I do something wrong," since "that way *I don't understand anything and, I don't know, I get nervous*" (Interview). Likewise, while one participant in the discussion group linked aggression toward his brother to his hyperactivity, he nonetheless clarified that he only becomes aggressive "when they *bother me"* (DG-children, **X**).

In fact, for children in site **X**, the difficulties encountered at school were less understood as the result of their own problems, behaviors, or abilities than as the outcome of neglectful or indifferent affronts—sometimes even detrimental—to their skills and interests. In this sense, the (un)desirable effects of medication were notably absent from the children's discussion group, in contrast to what was observed in other sites. This absence is consistent with a local framing of pharmaceuticals that is less oriented toward conduct and more deeply rooted in their effects on performance. As both **Au** and his mother point out, medication is less associated with "behaving well" (in the sense of allowing the class to proceed without interruptions) than with the possibility of achieving the expected level of performance, facilitated by what they referred to as the "morning concentration pill" (Interview, Au's mother, **X**).

Thus, the PMC in site **X** reflected a prototypical conflict that, while emphasizing the importance of children's intelligence and abilities, crystallized around two distinctive dimensions. On the one hand, a concern with knowledge that translated into a polyphonic *critique of ignorance*; on the other, a growing *expectation of horizontality* that challenged relations both with the metropolis and with official knowledge (Araujo, 2022). Horizontality, defined as "the hope that an interaction involving the management of asymmetries will be based on recognition of a basic equality between the participants" (p. 24), reinforced suspicions toward metropolitan official knowledges, fostering disagreements among different actors over the diagnosis, its management, and the behaviors of diagnosed children.

In this sense, several parents in **X** expressed their dissatisfaction with practitioners who, in their view, lacked the specific knowledge and skills needed to adequately attend to the singularity of their children. For some, this was the reason enough to adopt modes of involvement that went beyond the more common level of interest most displayed regarding relevant knowledge, extending to engagement in advocacy initiatives aimed at facilitating access to information and specialized treatments (FiNo, **X**).

At the same time, while voicing complaints about what they saw as the inadequate capacity of parents to properly fulfill their roles, practitioners also criticized schools that, in their view, delivered ready-made diagnoses and erected a "monument to

medication" as a way of securing bodily and behavioral control over students in their classrooms (TG–practitioners, **X**). Amid these cross-cutting criticisms, PIE professionals experienced a certain sense of isolation in their work, which, in their opinion, had to confront the growing demands and expectations of families within the constraints imposed by *scarcity*—both in terms of having enough specialists and in providing a greater variety of approaches beyond pharmaceutical treatment.

The pressure on institutions in **X** fostered forms of cooperation and competition that gave the diagnosis, its management, and the use of pharmaceuticals a distinctive character. This was expressed in a search for *horizontality* in the ways that the diversity of students with SEN could achieve expected, desired, or required levels of performance. Less aligned with fears of detachment and criminality, the main concern regarding ADHD was, instead, related to anxieties over the neglect of abilities and, therefore, the difficulty of attaining the concentration needed to perform. In this way, the relationship between pedagogical and clinical functions was particularly intertwined, as seen in the account of a teacher describing what she calls a *screening checklist*:

> "For example, in my school we have a *screening checklist*, a checklist where you—as the homeroom teacher, especially those of us who are there for all the subjects—go over certain characteristics the children have that might raise *some suspicion* about something. Then you share this with the special education teacher, and from there the request is sent to the PIE coordinator, who sends you this checklist to fill out. Once that's done, you meet with the child's guardian and suggest that they be taken to the neurologist (…) When the guardian can't take the child to the neurologist because of the cost (…), what the school does is that the school itself *subsidizes*, in this case, the neurologist's fee. And on top of that, when the child goes to the neurologist, they go with a report, obviously, also prepared by the integration program." (TG–teachers, **X**)

Now, this overlap of functions was not so much about compelling a particular guardian to act in relation to a child at risk, but rather about facilitating the attainment of a benefit. In this sense, rather than the mere fulfillment of some duty (as in, "I have to medicate the child so they won't be expelled"), it was a matter of responding to a request grounded in a belief about a benefit. In this regard, concerns about the 'stillness' effect of the pills, expressed repeatedly by different actors in **Z**, were particularly revealing, as they were absent in **X**.

> "And you"—said a teacher, "regardless of how many children there are, you always do everything humanly possible. And I feel that, with the medication, a little… they stop being children; *they become like a robot*, so to speak, and they kind of lose all, suddenly, their essence of who they are, because of the medication (…). Although the change, obviously, with medication is like night and day." (TG–teachers, **X**)

This ambiguity occupied a particularly relevant place for **X**, as it revealed the different coordinates along which the relationship with the diagnosis and

the pharmaceutical operated. In **X**, unlike in **Z**, the background defining the danger was not a school dropout—deep and definitive—capable of leading to the traditionally described criminal trajectory, but rather a double tension: on the one hand, the performance mandate on the plane of knowledge; on the other, the expectation of *horizontality*, which imposes new demands regarding the manner and channels prescribed to respond to that mandate.

Indeed, even while reproaching the "monument to the pharmaceutical," practitioners' assessments in site **X** were not free from concerns about negative effects on other important dimensions, such as bodily regulation. All the same, the *desired effect* of pharmaceuticals was most strongly aligned with a normative expectation that, less concerned with bodily or moral stillness, focused instead on *concentration*. Even so, the desired effect of pharmaceuticals was strongly aligned with a normative expectation that was less concerned with bodily stillness and instead focused on children's concentration. Notably, diverse actors referred to the medication as the 'pill for concentration'.

> "So, we looked into the matter to try to help him find a solution, to have more concentration, and to be able to kind of balance his disorder. (…) The solution he gave us was to give him a pharmaceutical so he could (…) achieve concentration. He started taking it around the second semester of second grade, and from then on (…) he changed drastically. He began catching up with his classmates, started paying attention." (DG–caregivers, **X**)
> "Last year, the neurologist had him on *pill for concentration*, because he still wouldn't focus in class—he'd sit down, then get up and wander off." (DG–caregivers, **X**)

This concern is better understood not as an abstract preoccupation with authenticity (Singh, 2013a, 2013b) but rather as part of a civilizational grammar, with its own specific expectations and demands. What in the quotations is referred to as "essence" can be understood within a particular modulation of what is expected and encouraged in children. This very tension between orders of knowledge appears to be driven by the greater elaboration of expectations of *horizontality*, which would characterize mid-sized cities like **X** in Chile, while also fueling their tense relationship and demands vis-à-vis metropolitan agendas. In **X**, the association of the ADHD diagnosis (and of Autism Spectrum Disorder, ASD) with the grammar of hidden potential (Béliard et al., 2019; Ehrenberg, 2018) acquired particular relevance and was explicitly labeled as a *"plus."*

> "As an anecdote," recounted to the ethnographer the father of a girl diagnosed with ASD, "when people first started hearing about Asperger's—when Walt Disney came out, when Chino Ríos came out, when the guy who made Facebook came out (…). Then everyone wanted to be Asperger [laughs]. Chileans like to imitate. In this city, here in **X**. So how did [my daughter] take it? 'Ah, ok… And what does this mean?… Ah, right, got it' (…). I made her see it not as something bad, but as a *plus*." (FiNo, **X**)

There was, of course, agreement on the drastic nature of the change and on how beneficial the pharmaceutical could be insofar as it allowed for a *plus* in concentration and, consequently, improvements in performance. However, this same grammatical modulation also accommodated, in parallel, criticisms of medication when it was seen as turning children into mere obedient robots—critiques that, while clearly contrasting with **Z**, nonetheless reappear, as we will see, in different ways in the metropolitan sites.

Unease and Concentration, or on the Pharmaceutical in the Metropolis

The observation of metropolitan ADHD situations included two schools that differed both in administrative terms (a public institution under municipal management and a private school with state funding) and in their respective locations, with distinct socioeconomic levels. In one case, the school was located in a recently gentrified residential neighborhood that, although still bordering impoverished, densely populated areas, belongs to **Y**, a wealthy capital district with high quality-of-life indicators. In the other case, the school was situated in a traditional neighborhood known for its opposition to the dictatorship and its strong community organization, in **W**, an older central district well connected to the city and characteristically inhabited by middle and lower-middle strata. Despite these differences, both institutions enrolled predominantly students from middle-class families—more affluent in one case, more economically precarious in the other—where at least one parent had technical or professional studies.

Although there were variations in nuance and intensity, both metropolitan sites showed a comparatively higher frequency of positions adverse to medication and, more generally, to the ADHD diagnosis. These were most often adopted by parents who, despite the school's suggestions, avoided seeking medical consultation for their children, refrained from initiating medical treatment, or discontinued medication after a time. For them, their children's school difficulties, bodily restlessness, and lack of concentration were matters inherent to their age that would diminish as they grew older. This, they noted, had happened with other family members similar to them, without the need for medications that change children and are then required for life. Thus, the mother of **Lu** (a student in **W**), after two years of medication, decided to stop it:

> "The thing is, I'm not into pills. And I prefer that he learns in line with his age. (…) Because it's like it only lasts for a little while; **Lu** would take his pill in the morning and (…) when he left [school], it's like **Lu** just went back to normal. The pill is only for a little while (…) just for coming to school (…). Not at home (…), because I've always let them have their freedom."

She then added,

> "Because I said he didn't need them [the meds]. Because my older son was like that too, and my older son is super intelligent (…). The thing is, my husband (…) **Lu** is just like him when he was a kid!" (Interview, Lu's mother, **W**)

Likewise, the mother of **Ag** (also in **W**) chose not to take her son—then 5 years old—to the doctor, despite his teachers' suggestion that she do so because they considered him too restless. In fact, even a year later, when she finally decided to consult a neurologist, she still refused to give her son the medication prescribed following a hyperactivity diagnosis, opting instead for what she saw as more appropriate supports offered through the PIE.

> "[The neurologist said] that he needed medication. Because, of course, you take him there and he's all over the place, he doesn't stay still. But, of course, that's not going to be forever. It will go away. It's normal for him to be restless. And it has gone away, because when he was little, he was restless (…). But not anymore. Now he knows what's good, what's bad, what he should do, what he shouldn't do (…). And another thing is that maybe he'd be on that medication his whole life. So I refused to give it to him, and like me, I think many parents have made that decision (…). Because he wasn't going to be like that his whole life (…). It's normal for a healthy child to be like that, because in the end if you want a child to be like a statue, then you have a child who's sick (…). I'd rather take care of him and limit him if he's restless—hold his hand, warn him. I'd rather have a restless child than a child who's sick for life." (Interview, Ag's mother, **W**)

Other mothers and fathers also voiced similar concerns, which were likewise expressed by several caregivers in the corresponding DG, even though many of them stated that they valued medication. Parental contestation was, in turn, confirmed in the TG of practitioners, who (except for the pediatrician) criticized the reservations frequently raised by parents, which, in their view, were based solely on prejudice and misinformation. In contrast, metropolitan physicians emphasized—partly as in the case of **Z**—the dimension of risk which, in line with the behavioral maladjustment associated with ADHD, could lead to deleterious later outcomes (accidents, life failures, addictions, criminality). Timely diagnosis and its treatment, they argued, contributed considerably to preventing such outcomes.

> "Kids with attention deficit and hyperactivity, *per se*, have a lot of risks that come in the package. They're at risk for problematic substance use; they're at risk for not persevering in different areas like work, studies, relationships, uh… if you go and assess the prison population, it's full of people who (…) you could have diagnosed (…). So when moms ask me, 'And my child won't become a drug addict because he's going to take pills? (…),' I tell them, 'Ma'am, look, your child already has a high risk of addictions because of this, this, and this. If I treat him today, when he's 8, 10, 12 years old, that risk goes down—it will never reach the level of the general population—but, well, the child has a particular condition; he has an attention deficit.'" (TG–practitioners, metropolitan districts)

Between these two extremes, both teachers and PIE professionals expressed, in their respective TG, intermediate positions. On the one hand, parental resistance was also for them a source of reproach that—without pointing to specific risks, as

practitioners did—was directed instead toward what they interpreted as parents' neglect in addressing their children's difficulties. On the other hand, teachers and PIE professionals also voiced their frustrations with medical practices they considered highly problematic, particularly the excessive use of medication and hasty diagnoses.

> "And (…) when I worked in a state-subsidized private school and in the PIE, all the kids were medicated. In the end, I didn't know the real child. I wasn't doing work where you could really include that child, because, in the end, he was completely medicated—meaning, the *mummy* I had in the classroom was purely because he was medicated." (TG–teachers, metropolitan districts)
> "The pill doesn't work magic either, but it's like a constant in education, because I feel that, unfortunately, the pharmaceutical issue is something people think is magic." (TG–PIE, metropolitan districts)

Yet, beyond their obvious contradiction, both the resistance and its counterarguments were generally expressed in ways that privileged the behavioral dimension of children's activity (appropriate, inappropriate, legitimate, fictitious, risky). This arrangement, however, was not the same when, on the contrary, it came to the positive appraisal of the medication by other mothers and fathers who—distancing themselves from such reservations—emphasized its benefits. In a manner similar to **X**, they did so in terms related to the performance and concentration achieved by their children.

> "I had a lot of doubts about whether to give it [the medication], but (…) rather than being something counterproductive, it helps him completely (…). With concentration. Like, he manages to finish what he starts. To be able to self-regulate. What else does it help with? Things like that." (Interview, Ma's mother, **Y**)
> "Well, that's why I agreed, too, (…) to give her the medication, and because she told me she was able to concentrate much more. And, indeed, her grades went up. It was really impressive!" (Interview, Fa's mother, **Y**)

It is not that the behavioral dimension was entirely absent from positions favorable to the medication. As one participant in the DG of caregivers noted, the medication allowed her daughter to "self-regulate" and, thus, "when the decibels came down a bit," it became possible "to work with her," "to create a routine." In other words, *the effects of the medication on children's movement were valued in light of their impact on the (primarily school-related) children's productivity.*

In fact, this same articulation also appeared in the aims put forward to support the benefits of medication, voiced both in the TG of teachers and PIE professionals and in the TG of practitioners, where the consideration of the behavioral dimension was subordinated to a selective focus on performance and concentration. In this sense, one of the practitioners in the TG suggested comparing medication to the use of eyeglasses, without which "it's going to be harder for me to learn to read," "it's going to be harder for me to do other things."

Thus, when "they have the glasses on"—that is, while the medication is active—efforts should be made to ensure that the child "learns as many skills as possible to allow them to function later on without the medication."

Indeed, even some children—just like their parents—who were favorable to medication also described its benefits in terms of its impact on concentration and performance.

> "[With the meds] I concentrate more, I study more, I behave better (…). In class I stay calmer, and in soccer (…). [And without the meds, I feel] like a different person (…). Like someone crazy, distracted (…). Restless, like: I want to go to recess! (…) [With the meds, I feel] like an intelligent person (…). Focused, without anyone bothering me." (Interview, **Ma**, **Y**)
> "For example, in the school I used to go to, they gave me *the pill* (…) [With them,] like I could get more energized (…). When I took them, I was calmer and could concentrate better, and when I didn't, it was like I was a rabbit." (Interview, **Fa**, **Y**)
> **D:** "Yeah… it's good, it's good. I like the meds because then I can study more."
> **C:** "Uh-huh, because I'm… very…"
> **D:** "Himperactive [sic]"
> **C:** "Himperactive, and like when they don't give me *the pill*, I get distracted (…) or people start talking to me or bothering me. And when I take *the pill*, then I stay more focused and if they talk to me it doesn't bother me." (DG–children, metropolitan districts)

Although with small differences in emphasis—more resistant to medication in **W** and more favorable in **Y**—the metropolitan sites reflected grammars articulated along axes related to both productivity and behavior, which had already been identified in the non-metropolitan cities. Yet in metropolitan sites, the predominance of concerns with stillness or hidden potential shows a markedly pragmatic distribution. Medication tends to be supported when performance is prioritized and to be rejected when behavior lies at the core of caregivers' worries. In this sense, what appears prototypical in the metropolitan city is the dispute over what is most relevant in a given situation: fostering productivity or protecting what is thought to be the conduct of the "real child."

Psychosociogenetic Entanglements: Final Reflections

Throughout this article, we have sought to extend and complicate debates around the social and subjective effects of mental health categories and approaches—particularly, in this case, pharmaceutical ones. Our perspective holds that categories are not merely labels externally imposed on people, but constitute genuine *looping effects* (Bradley, 2021; Hacking, 2006; Navon & Eyal, 2016), in which what people come to understand about themselves is intimately tied to these categories, while also modifying them. In this sense, what the analysis of ADHD allows us to foreground—through the expectations and fears elicited by the use of stimulant

medication among children aged 9 to 11 in different schools and regions of Chile—is a set of dimensions that remain largely unexplored in research on ADHD in school contexts.

On the one hand, we emphasize the situational character of the diagnosis. By speaking of an ADHD situation, we underscore that what is labeled an attentional problem depends less on individual traits than on the situation in which it emerges. It stems from the (mis)encounter of perspectives that endorse, pursue, or contest the category—perspectives that, beneath the apparent homogeneity of the label, carry divergent and sometimes contradictory concerns, ideals, and expectations.

We identify two axes that organize this variability: (i) *desired effect*—stillness versus performance, and (ii) *normative model*—external conduct versus internal capacities. These axes range from an emphasis on bodily stillness, with little concern for interiority or potential, to the rejection of stillness in favor of enabling the development of inner capacities. Acceptance or rejection of diagnosis and/or medication may occur at different points along these axes; as observed in metropolitan schools, the same actor may support medication to improve concentration while avoiding it when it flattens behavior—sometimes within the same family or even within the same day. The ADHD situations examined here show how microcontroversies mobilize distinct ways of conceiving children's interiority, autonomy, and social development, and invite a rethinking of diagnostic and treatment policies from a situated perspective attentive to local trajectories and conditions.

> On the other hand, this leads us to propose that the nature of situational looping effects is *civilizational*, in the sense reworked here from an Eliasian perspective. That is, they operate through grammars involving demands, obligations, ideals, and expectations regarding both institutional and societal configurations, as well as interior modes of response to their symbolic and functional requirements. Rather than ideals being simply "internalized," ways of experiencing interiority are shaped through perceived and felt demands. Complaints and controversies thus offer a privileged site for examining how these socio-psychogenetic processes are strained, negotiated, and reconfigured.

In this sense, when the desired effect attached to medication tends toward improved performance, what is explicitly or implicitly required of children's interiority tends toward a more reflexive, self-optimizing, and dynamic mode. Medication is more easily perceived as strengthening children's agency or autonomy, enabling them to develop a "hidden potential." This pole resonates with contemporary discussions on the increasing emphasis on self-control, autonomy, and self-optimization under neoliberal pressures in the United States, Europe, and Latin America (Cohen, 2009; De La Fabián et al., 2025; Ehrenberg, 2018; Martin, 2009; Rose, 2007).

However, exploring civilizational grammars through situated microcontroversies also reveals the simultaneous persistence of different kinds of worries, expectations, and demands, linked to more traditional concerns surrounding ADHD, such as criminality and other moral problems. Here, in turn, what is required of children's interiority tends toward a more classical

disciplinary form of docility. This does not appear as a residual civilizational framework destined to disappear, but rather as an integral component of the differentiated civilizational work unfolding in Chile.

Thus, our findings show that understanding the uses, meanings, and limitations of medication in the case of childhood ADHD requires closer attention to everyday microcontroversies involving children, families, schools, and professionals, in which psychotropic medications operate within differentiated civilizational grammars according to territorial and institutional frameworks. Departing from approaches that seek to make visible the agency of specific actors—such as children (Rojas, 2018; Singh, 2013a, 2013b) or mothers (Blum, 2015)—the microcontroversy framework developed here highlights both the interdependence among diverse actors and the singular ways in which diagnosis is understood and managed across territories.

This approach does not exclude other vectors, such as gender, social class, or race, whose relevance to ADHD is well documented (Béliard et al., 2019; Bröer & Agyekum, 2021; Uribe et al., 2019). Rather, diverse civilizational grammars, and their relation to territories, contexts, and situations, add a further layer of complexity and specification to these variables within a particular nation-state. Therefore, medicalization does not appear as a homogeneous or unilateral process, but rather as a normative arrangement articulated around territorial demands, forms of risk, and value horizons concerning childhood. Contrary to binary positions, medication is inscribed in relations of interdependence, through different configurations of what we term civilizational grammars, reflecting diverse concerns with self-control as well as performance, protection, and recognition, according to the territories in which the phenomenon unfolds.

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Declarations

Competing interests The authors declare no competing interests.

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Authors and Affiliations

Esteban Radiszcz[1] · Hugo Sir[2] · Juan Pablo Pinto[3]

✉ Esteban Radiszcz
eradiszcz@uchile.cl

✉ Hugo Sir
hugo.sir@upla.cl

Juan Pablo Pinto
juan.pinto@uacademia.cl

[1] Faculty of Social Sciences, University of Chile, Santiago, Chile

[2] Department of Mediations and Subjectivities, Playa Ancha University of Educational Sciences, Valparaiso, Chile

[3] School of Psychology, Faculty of Social Sciences and Education (FACSE), Academia de Humanismo Cristiano University, Santiago, Chile