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Articles

The ADHD epidemic: medicalization, the market, and the expansion of psychiatric diagnoses

A epidemia de TDAH: medicalização, mercado e a expansão de diagnósticos psiquiátricos (abstract: p. 16)

La epidemia de TDAH: medicalización, mercado y la expansión de diagnósticos psiquiátricos (resumen: p. 16)

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This study analyzes the diagnostic expansion of ADHD in the context of the medical-industrial and financial complex, highlighting contemporary medicalization and its economic and social engines. It explores how diagnostic elasticity, driven by DSM editions and by players such as the pharmaceutical industry, biomedical technologies, and the managed care model, has expanded diagnostic categories and social medicalization. Based on theoretical references and epidemiological data, the study discusses how these dynamics have made ADHD become one of the most diagnosed conditions. The findings indicate that hypermedicalization results from the interrelationship of various players (including the state), whose unequal forces influence the definition and expansion of mental disorders. The conclusion is that understanding these dynamics is essential to promoting care practices that prioritize unique needs and tackle health access inequalities.

Keywords: ADHD. Adult ADHD. DSM. Medicalization. Medical-industrial complex.

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Introduction

The contemporary medicalization of everyday life represents a complex sociocultural phenomenon that transcends the simple expansion of medical influence over human behaviors and experiences. Arguing that such a phenomenon does not bring only negative aspects to society, Conrad[1] defines medicalization as the process by which non-medical problems come to be treated as diseases or disorders, in a collective dynamic that involves multiple social actors, including movements, interest groups, the media, the pharmaceutical industry, and the medical-industrial complex.

In the field of mental health, medicalization assumes particular characteristics due to the greater diagnostic elasticity (the expansion and contraction of diagnostic criteria) of psychiatric categories compared to other medical specialties. Attention-Deficit/Hyperactivity Disorder (ADHD) constitutes a paradigmatic example of this process of elasticity and social medicalization.

Currently considered one of the most common mental disorders of childhood, ADHD is characterized by dysfunctional patterns of inattention, impulsivity, and/or hyperactivity that can lead to functional impairment in various life contexts[2]. However, its historical trajectory reveals significant conceptual transformations that reflect not only scientific advances but also broader social, economic, and political dynamics.

The analysis of the ADHD expansion becomes particularly relevant when considered in the context of what Vianna[3] calls the Medical-Industrial and Financial Complex (MIC/MFC). This concept refers to the interconnection between the pharmaceutical, biotechnology, and medical device industries and health services, and highlights that financial capital has come to regulate and finance these sectors. In Brazil, although there are specificities related to the Brazilian National Health System (SUS) and the supplementary health model, these dynamics also unfold, albeit in ways that differ from the North American managed care model.

Recent epidemiological data have revealed the magnitude of this diagnostic expansion. A 2023 umbrella review that included 588 primary studies with 3,277,590 participants demonstrated a global prevalence of ADHD in 8.0% of children and adolescents[4]. In the United States, a 2024 report from the Centers for Disease Control and Prevention (CDC) indicated a prevalence of 11.3% in children aged 5 to 17 years[2], while approximately 15.5 million adults (6%) received the diagnosis[5]. In Brazil, analyses based on the Outpatient Information System recorded 229,872 outpatient consultations for children diagnosed with ADHD in 2022 alone[6].

Given the scenario of increasing ADHD diagnoses and their expansion to different age groups and contexts, the present study sought to complexify the debate on the medicalization of life. To this end, it analyzed the diagnostic expansion of ADHD within the context of the Medical-Industrial and Financial Complex (MIC/MFC), focusing on the intersections between economic interests, social demands, and health practices. The question guiding the analysis is whether the increase in diagnoses and prescriptions reflects only a higher clinical prevalence or whether it stems, in part, from diagnostic elasticity processes mediated by market interests and institutional arrangements. The study is based on a critical review of the national and international

literature on medicalization, the MIC/MFC, and the medicalization of childhood, which provides the main theoretical frameworks for the analysis.

Methodology

This is a theoretical and critical study based on a narrative literature review in databases such as SciELO, PubMed, and Google Scholar, using descriptors related to ADHD, medicalization, methylphenidate, and the Medical-Industrial Complex. Recent studies and classic references were prioritized, without a rigid temporal delimitation. The central references include Conrad, Vianna, Camargo Jr., and Mendonça. Complementarily, normative documents (DSM), institutional reports, and SUS data were examined.

The phenomenon of medicalization

Although the understanding of the medicalization phenomenon has advanced significantly over the past five decades, its definition has not always been properly formulated. Many researchers believed that it was linked to the transfer of life issues to the medical field. In fact, the first studies on medicalization associated it with the idea of social and political control of individuals by medicine[7,8].

Nevertheless, for the purposes of this discussion, Conrad's definition[1] is adopted: medicalizing does not correspond merely to defining a problem in medical terms, using medical language, interpreting it through a clinical framework, or treating it through a medical intervention. It is, above all, a complex sociocultural process that: a) transcends the simple hypermedicalization of a condition; b) may or may not directly involve the medical profession; c) may result in both social control and indispensable treatment; and d) may derive from the deliberate expansion of the influence of medicine in society[9].

Thus, the engines of medicalization are not restricted to the medical sphere; they result from a collective dynamic that may involve lay people, user organizations, family members, social movements, interest groups, organizational and interprofessional activities, the media, and the pharmaceutical industry. Therefore, medicalization can be driven by external pressures, as occurred with Post-Traumatic Stress Disorder (PTSD), which was included in the DSM-III after mobilization of Vietnam War veterans seeking treatment for their emotional difficulties[1].

However, according to the author, there are indications that these engines are undergoing transformations. Such changes would be linked to the growing influence exerted by the pharmaceutical and biotechnology industries, potential consumers, and managed care organizations. In his view, these players are becoming increasingly decisive in the inclusion, maintenance, or exclusion of medical categories in the social fabric.

Because the theoretical frameworks on medicalization have been developed primarily in the North American context, their application to the Brazilian case

requires specific considerations regarding the particularities of the national health system. Brazil is characterized by a hybrid system that articulates the SUS, which is based on the principles of universality, comprehensiveness, and equity, with a rapidly expanding supplementary sector. This hybrid configuration creates specific medicalization dynamics. While the SUS is guided by the principles of the Psychiatric Reform and psychosocial care, prioritizing territorial and multidisciplinary approaches, the supplementary sector is aligned with the managed care model, favoring rapid diagnostic practices and pharmacological interventions[10,11].

Therefore, the analysis of medicalization in Brazil must consider both the universalist dynamics of the SUS and the market logics of the supplementary sector, as well as their interactions and contradictions. As will be explored below, the case of ADHD clearly illustrates these tensions and specificities of the national context.

Similarly, Conrad[1] conceives the notion of medicalization "degrees", and one of its dimensions is the elasticity of medical categories, that is, their capacity to expand and contract. In this sense, once a diagnosis is established, its definition, threshold, and corresponding boundaries can be extended to encompass new, similar problems or to incorporate additional populations, going beyond the groups initially delimited in its original formulation. As will be observed in this study, this notion explains why ADHD has become one of today's most common mental disorders.

The creation of the category

The diagnostic category of ADHD, with roots in the beginning of the 20th century, evolved from terms such as "hyperkinesis" and "Minimal Brain Dysfunction" to its current definition, focused on hyperactivity and attention deficit. Initially seen as a childhood problem that would be overcome in adolescence, ADHD has become a school diagnosis, as the classroom is the main environment in which children's self-control and tenacity are demanded[12,13].

In the logic of the disorder, those who fail to meet expected performance standards are often classified as having the condition, and this classification within diagnostic criteria may take place independently of the psychosocial context. As a result, ADHD has gained prominence in the expansion process of child psychiatry, being the most frequently diagnosed behavioral condition among school-aged children[13,14].

From this perspective, there is a search for a mental disorder, which becomes the exclusive cause of school difficulties, while the institution's role in recognizing and responding to the unique demands of each student is neglected. Such an approach reveals a lack of accountability regarding the commitment to implement an inclusive education that promotes autonomy[15].

In the Brazilian context, this dynamic manifests itself in a particularly intense way. Recent analyses indicate that the expansion of ADHD is strongly linked to the school context, with children aged 5 to 9 years representing 49.32% of the cases[6]. This pattern suggests that difficulties related to attention, performance, and discipline are progressively interpreted as indicators of a disorder, favoring referrals for psychiatric evaluation and diagnosis legitimation.

There is also the argument that the diagnosis will provide the proper guidance for school actions. Although it is valid to enhance our understanding of neurodiversity forms and the tools available to professionals, diagnoses derive from descriptive snapshots of nonspecific signs and symptoms. Such descriptions, designed to be universal, fail to capture the complexity and uniqueness of each individual.

Thus, even if someone presents symptoms similar to those listed in the diagnostic manual, each person has a unique combination of characteristics, experiences, and needs that cannot be fully explained by a generic diagnosis. Therefore, what will be decisive for good development is a pedagogical/therapeutic project that adapts to the individual's needs, and not to the diagnosis itself.

Very young children, for example, can be overwhelmed by labels that do not correspond to their individual reality and reinforce the false idea that they are limited, based on a way of being that is defined by a set of characteristics present in diagnostic manuals. This not only affects the child's self-esteem but also leads to the creation of rigid and reductionist expectations about their skills and capacities. Thus, when labeling someone with a diagnosis, especially an individual in the early stages of development, there is a risk of imposing a performance expectation based on what is presumed of someone with that condition.

In addition, parents demand diagnostic explanations and drug therapy to treat their children's difficulties. In this process, family/patient associations gain influence and exert pressure for access to diagnoses and psychotropic drugs, reinforcing predominantly biological interpretations of mental health problems. This dynamic intensified in the 1990s, when the descriptive shift inaugurated by the DSM-III (1980) and the expansion of the use of psychostimulants strongly impacted children's mental health. According to Lima[13], this movement - often described as 'remedicalization' -, coupled with a distancing from psychoanalytic and social currents, has shaped a child psychiatry characterized not so much by a maturation of knowledge, but by diagnostic inflation, by the incorporation of aspects of normality into diagnostic criteria, and by the consequent increase in conditions amenable to pharmacological intervention.

Beyond the explosion of diagnoses in the child population, Conrad[1] argues that one of the aspects explaining the expansion of ADHD in society, especially in light of the broadening of its diagnostic criteria in the latest editions of the DSM, is that adults have begun to be diagnosed with this condition. The social impact of this manual is so great that Frances[16] states, for example, that the DSM-IV has contributed to the existence of three major false epidemics of childhood mental disorders: attention deficit disorder, autism, and bipolar disorder.

The expansion of ADHD and the version for adults

A series of longitudinal studies with children originally diagnosed with hyperactivity began to be published in the late 1970s. These studies showed that, in some children, hyperactive symptoms persisted throughout adolescence and adulthood[1]. At this point, a path of possibilities opened up for the existence of hyperactive adults in society, that is, hyperactive children who, even after growing up,

were unable to overcome their symptoms. For this reason, the dominant thinking of the 1980s was that all adults with ADD were hyperactive children who grew up.

According to Conrad[1], another factor determining the defense of this perspective was the update that came with the DSM-III, which facilitated and reflected an interest in thinking about hyperactivity beyond childhood. As the manual tended to focus more on the description of symptoms, to the detriment of the search for the etiology of the disorders[13], it reclassified the disorder based on its primary symptoms: hyperactivity or inattention.

With its association to attention deficits, the diagnosis came to encompass two major subtypes: Attention Deficit Disorder "with" Hyperactivity (ADHD) and Attention Deficit Disorder "without" Hyperactivity (ADD), considered less severe. With the DSM-V, the age criterion for the onset of symptoms was extended from 7 to 12 years, which significantly expanded the target audience of the diagnosis[1,13].

Despite this variability, the different manifestations of the disorder were believed to be caused by a single "neurocognitive defect" that had not yet been identified. Furman[14], however, argues that there is no pathognomonic sign in neurocognitive tests that necessarily justifies diagnoses of ADHD. The author adds that cognitive deficits found in individuals diagnosed with the disorder are also observed in other neurological and developmental disorders.

The change in criteria, followed by the consequent expansion of the number of people classified within the ADHD diagnosis, was not an isolated event. Something that has become evident with the rise of "modern" psychiatry is the frequent modification of diagnostic criteria for various disorders with each revision of the DSM. Horwitz[17] illustrates this by stating that the revision of the third edition added a considerable number of new diagnoses and modified many of the existing criteria, making it easier to receive a psychiatric diagnosis. The DSM-III-R came to contain 292 diagnoses compared to the 265 diagnoses found in the DSM-III.

Regarding ADHD, the existence of two types of ADD allowed a change in the course of the disorder. At that time, either all symptoms would persist through adolescence and adulthood, or only some signs would continue to affect the individual for life, even without the incidence of, for example, hyperactivity.[1] It can be argued, therefore, that the reformulation introduced with the DSM-III expanded the diagnostic criteria for ADD in such a way that it enabled the persistence of signs and symptoms into adulthood.

With the advent of the new version of ADHD, hyperactive and impulsive children, even if less inattentive, could equally meet the diagnostic criteria. As a consequence, 50% more children were diagnosed based on these criteria, which also proposed changing the term "hyperactive adult" to "adult with ADHD". The latter is the individual who did not receive a diagnosis during childhood but showed symptoms during their first years of life. In addition, the 1987 revision of the DSM broadened the context in which inattention or impulsivity symptoms occur, encompassing both the classroom and the workplace[1].

Here, an important change in diagnostic criteria is observed. In the 1980s, adults with ADHD were considered problematic children who remained problematic. In the 1990s, however, the diagnosis of an adult with ADHD was not restricted to mere remnants of symptoms coming from a hyperactive child. Therefore, the existence of a specific dynamic of signs and symptoms of the disorder in adults became possible.

For this reason, Conrad[1] did not limit himself to the restricted view of early studies on medicalization – social control by the medical institution – and, when analyzing the spread of adult ADHD, observed other dimensions and forces that equally influenced the social medicalization of the disorder, that is, the engines of medicalization.

Self-diagnosis

Another engine for the expansion of ADHD in adults is self-diagnosis. Unlike children, who are referred by parents or the school, among adults, self-referral is the norm. Many adults seek professionals already with a diagnosis in mind, based on their identification with what is described about the disorder, and expect the physician to confirm their "new identity". The "hunt for a diagnosis" is a characteristic of the emergence of adult ADHD, and this form of self-labeling fuels the social engine that medicalizes certain adulthood problems. According to Conrad[1], without this, adult ADHD would be much more limited.

This search for a diagnostic identity reflects the rise of what Rose and Novas[18] call the "biological citizen": individuals who form groups based on their physical, genetic, or pathological characteristics. This new "biosociality"[19] results in identities influenced by biomedical classifications and shapes relationships with health professionals and authorities. With the support of new technologies such as the Internet, the dissemination of scientific knowledge and diagnostic categories has become central to shaping contemporary identities, allowing these groups to play an active role in the formulation of public health policies[18].

Groups of interest

Alongside the favorable context for the dissemination of diagnoses, various stakeholders have emerged with a particular focus on ADHD in children. Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), one of the largest support groups for people with ADHD, experienced a significant growth in the 1990s, largely resulting from actions of its adult members, especially those diagnosed with the disorder[1].

The organization helped expand the ADHD category to the adult public. Furthermore, it established as one of its missions the support and education of adults with this condition, sponsoring events nationwide in order to address the topic more incisively. In addition to lobbying for specialized educational services for children with the condition, CHADD advocates for legislation that provides workplace protection for adults with ADHD, viewing it as a medical condition – a neurobiological issue – instead of a psychiatric or behavioral disorder.[1]

Another organization interested in the agenda was the pharmaceutical company Ciba-Geigy, the institution that, in 1955, launched Ritalin (methylphenidate), the most prescribed medication for the treatment of ADHD. It is important to mention that Ciba-Geigy was involved in the classification of hyperactivity and ADHD as a medical issue. In the 1970s, Ritalin accounted for up to 15% of Ciba's gross profits and, although the drug's original patent has expired and methylphenidate is currently available in generic formulations, Ritalin is still the most prescribed medication for ADHD.

The expansion of the pharmaceutical market has directly accompanied the expansion of diagnoses. For illustrative purposes, the amount of methylphenidate manufactured in the USA increased by approximately 700% between 1990 and 1999[1]. In Brazil, between 2000 and 2006, national production jumped from 40 kg to 226 kg, in addition to increasing imports, consolidating the country as one of the largest markets for psychostimulants in the world[20].

With the redefinition of ADHD as a "lifelong disorder," it became possible for children and adults to remain on medication indefinitely. In this context, Conrad[1] highlights that the increased use of stimulants in recent decades in the USA is directly related to this continuity of treatment, in which pharmacological intervention begins in childhood, extends through adolescence, and can last into adulthood.

Stakeholders – interest groups and pharmaceutical companies – work both independently and in partnership. According to Conrad[1], Ciba-Geigy allegedly provided significant financial assistance and a variety of support mechanisms for adults with ADHD, including financial support to CHADD and a video produced for the Office of Special Education Programs (OSEP). The media and the public soon began to question CHADD's neutrality and, in its 2004-2005 annual report, the organization claimed that 22% of its revenue of nearly $4.5 million came from pharmaceutical companies through unrestricted educational grants.

As the diagnostic framework evolved, more behavioral variations were included in the late 1990s. Successful adults with high levels of inattention in interpersonal and recreational relationships began to be classified within the disorder. With the expansion of the DSM-IV criteria, some professionals suggested eliminating the requirement for a retrospective reconstruction of ADHD in childhood, allowing behavioral problems in adulthood to be sufficient for the diagnosis. This further expanded the identification of the disorder in adults.

Epidemiological data illustrate the magnitude of the expansion of adult ADHD. In the first decade of the 21st century alone, prescriptions for ADHD drugs increased by 90% among people aged 19 and older in the United States, with adults then accounting for one-third of all prescriptions issued[1]. A recent systematic review and meta-analysis estimated the global prevalence of ADHD in adults at 2.58% for persistent cases (with childhood onset) and 6.76% for symptomatic cases (regardless of childhood onset). These estimates translate to 139.84 million and 366.33 million affected adults globally, respectively[21].

Managed Care and Supplementary Health

The Managed Care model consolidated in the United States in the 1980s, marked by the logic of cost rationalization and controlled use of health services. In this arrangement, health insurance companies delimit the number of consultations, psychotherapies, and examinations that can be authorized, while favoring the prescription of medications, often reimbursable. This mechanism has direct implications for psychiatry, as it favors rapid and pharmacological diagnostic practices to the detriment of psychosocial approaches. Conrad[1] argues that, although managed care did not create adult ADHD, it functions as an important vector for its diagnostic expansion by structuring forms of care that privilege the biomedical framework of mental healthcare.

In Brazil, although there is no managed care model like the North American one, supplementary health has operated through similar regulatory mechanisms. According to Bahia and Scheffer[10], supplementary health in Brazil has expanded through state incentives, financialization, and the increasing segmentation of the system. This reinforces structural inequalities and solidifies the perception that the SUS provides care for the poor, while private plans play a central role in the care provided for the middle and upper classes. This dynamic, by aligning care with the logic of the market, has become similar to the North American managed care model, in which the regulation of access and the pursuit of efficiency take precedence over the principle of comprehensiveness.

In this context, the coding of diagnoses and procedures is extremely important; that is, the mandatory assignment of standardized codes (such as those of the ICD) justifies consultations, examinations, and treatments, being a necessary condition for authorizations and reimbursements. At the same time that this mechanism rationalizes costs, it creates incentives for the formalization of diagnoses as a strategy for access and coverage. Similarly to what happens in the United States, this logic may foster an increase in psychiatric diagnoses in Brazil, not only as a clinical expression of suffering but also as an administrative requirement, thus intensifying the risk of social medicalization.

In contrast, mental healthcare in the SUS is organized by the Psychosocial Care Network (RAPS), in which Psychosocial Care Centers (CAPS) constitute strategic points for territorial care and the replacement of the hospital-centric model[22,23]. Unlike the managed care logic, these services seek to provide continuous psychosocial support in articulation with families, schools, and territories[24]. However, Ribeiro et al.[6] found that both the Psychosocial Care Centers (CAPS) and the specialized outpatient clinics within the SUS also face difficulties in establishing a consistent line of care for individuals diagnosed with ADHD, and services frequently offer only diagnostic assessment and prescription.

Furthermore, the authors found that regional inequality, limited resources, and staff overload often hinder the effective implementation of the psychosocial care model[6]. This contrast reveals the tension between two rationalities: on the one hand, the market logic of the supplementary sector, similar to managed care; on the other

hand, the universal project of the SUS, which seeks to resist the reduction of mental health to diagnoses and prescriptions, but which also faces concrete obstacles.

The state can play the role of mediator, or even facilitator, of the market logic; however, its central responsibility in reducing structural inequalities that impact health cannot be overlooked. In the Brazilian case, the SUS was conceived precisely as a response to historical inequities in access. The principle of universality was adopted as a strategy to overcome the segmentation between those who can pay and those who depend on public healthcare. However, obstacles to the implementation of universal policies, deriving from chronic underfunding or from the coexistence with a supplementary sector strengthened by state incentives, reveal the tension between these two roles. Thus, discussing medicalization and diagnostic expansion also implies questioning how the state can effectively assume its regulatory and protective function, strengthening policies that address class, race, territory, and gender inequalities instead of reinforcing them. In this sense, the challenge is not only to contain private interests but to ensure that public policies succeed in producing healthcare equity, in consonance with the constitutional principles of the SUS.

Medical-Industrial Complex (MIC) and Medical-Financial Complex (MFC)

The case of ADHD helps to understand how the greater elasticity associated with psychiatric diagnoses in the last half-century may have fostered an environment conducive to the emergence of other epidemics. Furthermore, the presence of various agents, including the state, with their interests – especially economic ones –, influences the diagnostic expansion of certain disorders.

The Medical-Industrial Complex (MIC) and the Medical-Financial Complex (MFC) are concepts that help to understand how economic and industrial dynamics influence the health sector. Both Complexes are historical products of the capitalist development in the field of health, where private practices and market interests have come to dictate the rules of the system[3,25].

The MIC began to be studied in the 1970s, inspired by the concept of "Military-Industrial Complex", and gained importance with the increased integration between industry and the medical system. In Brazil, public health expert Cordeiro[26] was one of the first to analyze this interconnection, arguing that the pharmaceutical industry and medicalization policies have reduced health professionals' power of intervention. The MIC includes a wide range of players, from drug and equipment manufacturers to hospitals, physicians, and patients, all interconnected by a market logic that prioritizes profit over equitable access to healthcare.

The MFC, on the other hand, emerged as a response to the increase in medical costs, driven by the constant introduction of new technologies and by industrial competition. To mitigate financial risks, financial capital began to regulate the healthcare sector through models such as Managed Care, which seek to reduce costs and promote the intensive use of expensive technologies. This dynamic strengthens

the commodification of healthcare, transforming patients into consumers and medical services into market products[c].

[c] For an in-depth discussion on the historical development of MIC and MFC, see Maldonado[27].

MIC and the new engines of medicalization

Even without explicitly mentioning the concept of the Medical-Industrial and Financial Complex, Conrad[1] also recognizes that the main engines (protagonists) of the escalation of social medicalization are undergoing transformations. In the past, medicalization used to be driven by physicians, social movements, and interest groups. Today, the main players are the pharmaceutical industry, biomedical technologies, and managed care entities – and why not supplemental health companies? –, which shape health practices according to commercial and market imperatives. In short, the author states that the contemporary forces driving medicalization seem to be more significantly influenced by commercial and market imperatives than by professional advocates.

In this context, individuals come to be seen as potential consumers, and health becomes a market competition arena. It is also interesting to note that the state, intervening through public incentives, regulations, and subsidies, ensures the continued profitability of the health market even in the presence of external pressures, such as increased medical inflation or loss of the coverage guaranteed by companies, as observed in the USA[3].

Therefore, it is pertinent to ask to what extent public health policies can be influenced by private interests, especially by companies in the pharmaceutical and insurance sectors. Although this dynamic is widely observed in countries whose health systems are based on the logic of the market, such as the United States, it is important to analyze its manifestation in Brazil, a country that has a universal healthcare system. When the Brazilian state provides incentives for supplementary health and allows the increasing financialization of the sector[10], this may end up favoring the logic of the market to the detriment of the principles of comprehensiveness and equity. Thus, reforms that appear to serve the public interest may, in practice, reinforce structures that guarantee the profitability of economic groups, contributing, as observed, to the expansion of social medicalization and the explosion of psychiatric diagnoses such as ADHD.

Furthermore, another question related to the market logic is whether the financial capital has been shaping not only the care of illness, but also its very definition. That is, the medical industry, by redefining what is considered a "treatable" condition, shapes the recognition, the treatment, and even the "cure" of diseases, reflecting the relationship between the capitalist advance in healthcare and the medicalization of everyday life.

One example from the present study was Attention-Deficit/Hyperactivity Disorder (ADHD) in adults, whose medicalization is closely linked to the market of cognitive performance medications (methylphenidate, lisdexamfetamine) and therapies, following a market logic that prioritizes the creation of a demand for pharmacological interventions to the detriment of the real needs of individuals.

Thus, by introducing the notion of the Medical-Industrial and Financial Complex, the intention was to show that decisions about what is considered treatable, curable, or innovative are intrinsically linked to market forces, which prioritize financial return over the health needs of the population. Furthermore, by intervening or allowing these dynamics to develop, the state strengthens this market logic and reinforces inequalities in healthcare access, instead of mitigating them. State interventions, often justified as necessary to contain medical inflation or improve efficiency, end up being subsumed by the interests of financial capital, perpetuating a system in which health is a commodity and market value surpasses social value.

Final remarks

The present study sought to complexify the debate about the medicalization of life, analyzing the diagnostic expansion of ADHD within the context of the Medical-Industrial and Financial Complex and revealing the intersections between economic interests, social demands, and health practices. The analysis showed that contemporary medicalization is largely driven by market forces, such as the pharmaceutical industry, biomedical technologies, and managed care schemes, which shape not only access to care but also the definitions of health and illness. Medicalization and the diagnostic elasticity of ADHD, coupled with the actions of interest groups and the pursuit of biomedical interventions, exemplify how health needs can be relegated to a secondary position in the face of the imperatives of capitalist accumulation. In this scenario, state action can further reinforce these dynamics by sustaining the health market without addressing structural inequalities. It is concluded that understanding medicalization as a social, political, and economic phenomenon is essential to rethink healthcare models, so that practices that prioritize subjects' genuine demands over market logics can be promoted.

Data Availability

The contents underlying the research text are included in the manuscript.

Authors' contribution

Maldonado MM participated in the study conception and design, conducted the literature review, data analysis and interpretation, drafted the manuscript, and performed the final review. Camargo Jr KR participated in the study conception and design and in the discussion of the results, carried out a critical review of the intellectual content, and contributed to the theoretical and methodological improvement of the manuscript. Both authors approved the final version of the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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Este estudo analisa a expansão diagnóstica do TDAH no contexto do complexo médico-industrial e financeiro, destacando a medicalização contemporânea e seus motores econômicos e sociais. Explora como a elasticidade diagnóstica, impulsionada pelas edições do DSM e por atores, como a indústria farmacêutica, tecnologias biomédicas e o modelo de atenção gerenciada, ampliou categorias diagnósticas e a medicalização social. Por meio de referenciais teóricos e dados epidemiológicos, discute-se como essas dinâmicas moldaram o TDAH como uma das condições mais diagnosticadas. Os achados indicam que a hipermedicalização resulta da interrelação de diversos atores, incluindo o Estado, cujas forças desiguais influenciam a definição e a expansão dos transtornos mentais. Conclui-se que compreender essas dinâmicas é essencial para repensar práticas de cuidado que priorizem necessidades singulares e enfrentem desigualdades no acesso à saúde.

Palavras-chave: TDAH. TDAH adulto. DSM. Medicalização. Complexo médico-industrial.

Este estudio analiza la expansión diagnóstica de TDAH en el contexto del complejo médico-industrial y financiero, subrayando la medicalización contemporánea y sus motores económicos y sociales. Explora cómo la elasticidad diagnóstica, impulsada por las ediciones del DSM y por actores tales como la industria farmacéutica, las tecnologías biomédicas y el modelo de atención administrada, amplió categorías diagnósticas y la medicalización social. A partir de referenciales teóricos y datos epidemiológicos se discute cómo esas dinámicas moldearon el TDAH como una de las condiciones más diagnosticadas. Los hallazgos indican que la hipermedicalización resulta de la interrelación de diversos actores, incluyendo el estado, cuyas fuerzas desiguales influyen en la definición y expansión de los trastornos mentales. Se concluye que comprender esas dinámicas es esencial para repensar prácticas de cuidado que prioricen necesidades singulares y enfrenten desigualdades en el acceso a la salud.

Palabras clave: TDAH. TDAH adulto. DSM. Medicalización. Complejo médico-industrial.