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Original Article

Tired therapists: from employment precarity to precarious care in the autism industry[1]

Terapeutas cansadas: da precariedade do trabalho à precariedade da assistência na indústria do autismo

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Abstract

The model of specialized therapies for skill acquisition in children, particularly autistic children, has been expanding under neoliberal logic. Healthcare professionals experience employment precarity, with repercussions for both their own health and the care provided to children and families. To deepen the understanding of these aspects, this qualitative, retrospective documentary research analyzed 131 therapists' reports from a social media platform. The results are presented in two themes: (1) the precarization of work and (2) the assistance provided to children. The discussion explores how the relationship between employment precarity and precarious care in the "Autism Industrial Complex" affects professionals, children, and their families. To overcome historically institutionalizing practices and promote effective care, the involvement of all stakeholders is urgently needed in the search for dignified solutions to the severity of the issue, including the expansion of regulations and public policies.

Keywords: Child Care, Adverse Childhood Experiences, Neurodevelopmental Disorders, Job Security.

Resumo

O modelo de terapias especializadas para aquisição de habilidades para crianças, especialmente autistas, tem crescido sob a lógica neoliberal. Profissionais da saúde vivenciam a precarização do trabalho, com repercussões tanto para sua própria

[1]Although Autism Spectrum Disorder (ASD) is the most widespread term used to refer to autism, it is understood as a nosological classification based on a biomedical perspective. Thus, considering the field in which this study is situated, the terms autism and autistic people/children were chosen, acknowledging autism as a condition within the framework of neurodiversity.

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saúde como para o cuidado das crianças e famílias. Para aprofundar a compreensão desses aspectos, esta pesquisa documental e retrospectiva, de abordagem qualitativa, analisou 131 relatos de terapeutas em uma mídia social. Os resultados são apresentados em dois eixos: (1) o trabalho e sua precarização e (2) a assistência prestada às crianças. Discute-se como a relação entre trabalho precário e assistência no "Complexo Industrial do Autismo" afeta profissionais, crianças e suas famílias. Para superar condutas historicamente institucionalizantes e promover um cuidado efetivo, é urgente o envolvimento de todos os interessados na busca por soluções dignas diante da gravidade do problema, incluindo a ampliação de regulamentações e políticas públicas.

Palavras-chave: Cuidado da Criança, Experiências Adversas da Infância, Transtornos do Neurodesenvolvimento, Precarização do Trabalho.

Introduction

This study aims to shed light on crucial issues in contemporary healthcare for autistic childrenand their families, addressing topics such as social normativity, the capitalization of care in neoliberal society, and the ethical and technical responsibilities of professionals who work with this population. A critical analysis was conducted of reports from therapists published on an anonymous Instagram® profile, emphasizing the importance of developing future care practices that do not succumb to the productivist economic model or the normalization of children.

It is understood that the concept of childhood is not static and, as noted by Ariès (2006), has been historically constructed. The state's responsibility for children, particularly those with disabilities or psychological distress, emerged late (Fernandes et al., 2020; Taño & Matsukura, 2015). In the Brazilian context, only in the 19th century did new ways of understanding childhood begin to take hold, closely tied to the perspective of social control. The first state-led framework was characterized by a tutelary, disciplinary, and institutionalizing model (Lima et al., 2019).

For children classified as "intellectually abnormal," "minors affected by physical-psychic anomalies," and "disabled," care was primarily provided by the education and social assistance sectors, through special schools, psychology clinics, psychiatric hospitals, and shelters. Couto & Delgado (2015) discuss how this care was authoritarian and disciplinary, aiming to turn these children into subordinate and passive adults. According to Taño & Matsukura (2015), institutionalizing care practices were widely used, representing the main response to existing social problems.

Starting in the 1970s, a movement of mothers, fathers, and families of children with intellectual disabilities gained momentum in Brazil, leading to the creation of various philanthropic institutions to provide educational and therapeutic assistance (Lima et al., 2019) in response to the state's neglect. With the enactment of the 1988 Federal Constitution, the Brazilian State began to recognize children and adolescents as subjects of rights, especially with the creation of the Statute of the Child and Adolescent (ECA) in 1990 (Couto & Delgado, 2015). That same year, the Brazilian Unified Health System (SUS) was established, transforming the concept of health by incorporating

social and political dimensions. In line with the Sanitary Reform, the Psychiatric Reform process and the Anti-Asylum Movement began to establish new approaches to mental health care (Lima et al., 2019). However, despite challenging asylum-like, institutionalizing, and normative practices, these movements did not prioritize care for children (Taño & Matsukura, 2015).

Because of the state's failure to provide adequate care for children, particularly autistic children, private and philanthropic institutions organized by families began to import different care approaches for this population (Lima et al., 2019). Professionals, researchers, and families contributed to the formulation of laws, the development of medications, the creation of screening and diagnostic tools, and the expansion of increasingly specialized treatments (Grinker, 2019). This social movement, legitimate in its search for care solutions, resulted in the specialization of care, culminating in what the literature has termed the "Autism Industrial Complex" (Broderick, 2022), which commodified everything related to autism. Autism began to serve economic purposes (Grinker, 2019; Broderick, 2022; Rios & Fein, 2019), integrating into a growing economic sector. Health care became another market niche, where profit takes precedence and mediates care relationships (Bezerra et al., 2023).

From this perspective, according to Cascio et al. (2019), the social inclusion of children with disabilities depends more on acquiring individual skills through structured therapies than on psychosocial interventions developed in collective and community spaces. Overall, these therapies help reduce symptoms and develop socially acceptable behaviors, and while they are based on scientific evidence, they are not always applied according to established protocols (Lima et al., 2019).

In contrast, efforts to impose normative developmental standards on autistic children began to be challenged in the 1990s by autistic sociologist and activist Judy Singer, who developed the concept of neurodiversity. Neurodiversity emphasizes that atypical neurological connections, such as those present in autistic individuals, are not diseases but natural variations, different and intrinsic to human diversity (Sadzinski Junior et al., 2020). The need for therapeutic and/or pharmaceutical interventions for neurodivergent individuals is not denied; however, the focus should not be on normalizing behavior but rather on fostering autonomy and independence while respecting everyone's particularities, considering both their challenges and their potentiality (Alencar et al., 2022).

It is understood that health care practices centered on normative standards of body and behavior align with the patterns dictated by the capitalist system and neoliberal thought (Benevides, 2017). In neoliberal ideology, a "successful" individual is one who can adapt to the productive challenges imposed first by the educational system and later by the labor market, securing socially prosperous positions. Such an individual must be versatile, increasingly qualified, rapid, well-connected, productive, and responsive to market demands (Antunes, 2002).

These characteristics suggest a preference for health interventions focused on adjusting behaviors deemed "inappropriate" rather than preserving human diversity, culture, and individuality. Furthermore, the insistence on adaptation to productivist standards has historically led to physical and mental health issues, revealing the flaws of the capitalist system and exposing its frequent incompatibility with human life (Souza, 2021; Franco et al., 2010). This reality is problematic since, although there are many

ways for people to relate to the world, much of human uniqueness is rejected by society and classified as pathological (Canguilhem, 2005).

Given this scenario, it is essential to discuss the inclusion, working conditions, and organization[2] of professionals who operate in normative care services. Many of these services offer, on the one hand, a menu of quick solutions to families and, on the other, what Krein (2018) calls a "menu" of contracts for workers. These include multiple contractual options marked by a lack of rights and social protection, governed by outsourced, intermittent, "zero-hour," or "on-demand" contracts. The workload continues to increase, neglecting workers' own health and professional development, as they opt for increasingly fast and superficial training programs.

The employment precarity and deterioration of working conditions in today's capitalism affect various professional categories. However, multiple studies discuss the specific issues of employment precarity in the health sector (Souza, 2021; Franco et al., 2010), as its impacts affect both the workers and the users of these services.

Franco et al. (2010) define several dimensions for analyzing employment precarity, such as employment contracts and relationships; work organization and general conditions; workers' health; social recognition and symbolic appreciation; and collective representation and organization. Using different terminology but following the same epistemological foundation, Vargas (2016) points out that employment precarity can result from conditions related to job status (disregard for labor laws), objective aspects (work environment, resources, and organization), and subjective aspects (workers' awareness and experiences, depending on satisfaction levels and their effects on professional activity).

In Brazil, employment precarity involves both a lack of adequate material conditions and the weak symbolic recognition of the suffering caused by work. With increasing deregulation, job insecurity is intensified, particularly due to outsourced contracts (Anjos et al., 2011). In this context, the reality of work—what is actually experienced in daily practice from the workers' perspective—when shared through reports of violence and suffering, can offer insights into transforming the profession and critically assessing precarious care models.

Thus, based on reports of complaints published by therapists on social media (Instagram®), this study seeks to understand aspects of employment precarity and precarious care within private and specialized clinics for autistic children[3] in Brazil.

Method

Type of study

This study is characterized as a documentary and retrospective research (Gil, 2002), with its primary source being reports from professionals previously published on an

[2]It is understood that working conditions encompass not only physical, environmental, and instrumental aspects but also the subjective dimension and the relationships tied to forms of employment and remuneration (Oliveira & Assunção, 2010). Work organization, on the other hand, refers to the ways in which an activity is conducted, including the norms, procedures, and rules involved. Every work organization has characteristics aligned with the prevailing economic order and productive system (Resende, 2020).

[3]It is observed that, although it is not possible to determine with absolute certainty in 100% of the reports whether the population served in these clinics refers specifically to autism, the majority of them do mention it. This reflects the current reality in the Brazilian context, given the expansion of diagnoses.

Instagram® social media profile. It is a qualitative study aimed at understanding aspects of work and care provided to children, considering them as social processes that remain largely unexplored within this context (Minayo, 2014).

It is noteworthy that, as this topic and debate have become more prominent in recent years—because of the increasing prevalence of autism and, consequently, the rise of what has been termed the autism industry—there are currently no Brazilian studies that directly address this issue. While some works provide a general overview of aspects that intersect with this emerging problem (Lugon & Andrada, 2019), no investigations have delved into it specifically. Thus, this study aims to present and reflect on the issue based on an existing database that gathers therapists' reports on their lived realities. It is hoped that this study will serve as a starting point for future research to further develop this discussion.

The use of social media platforms such as Facebook®, Instagram®, Twitter®, and WhatsApp® for data collection in health-related scientific research had already been growing significantly, even before traditional data collection methods such as interviews and focus groups migrated to online environments during the COVID-19 pandemic (Araújo et al., 2019).

Ethical considerations

The study was approved by the Research Ethics Committee for Human Subjects of the Federal University of São Carlos (UFSCar) under protocol no. 6.057.453. Since this is a documentary and retrospective study, the Informed Consent Form (ICF) was waived, as any registered Instagram® user can submit reports, view the profile, read its posts, save them, and share them with other users on the platform. Additionally, all reports were published anonymously, ensuring the confidentiality of the individuals who submitted them and preventing the identification of any person or location.

Data collection

The data used in this study consist of 131 anonymous reports from therapists, published between November 2021 and September 2022 on the news feed of a public and anonymous Instagram® profile titled *@terapeutascansados*. Instagram® is a social network offering multiple interaction features, centered on photo and video sharing. Anonymous accounts are public and registered with e-mail addresses that do not contain personal user data. The news feed is an interaction feature where users post photos and/or videos (reels) to their page, which are then viewed by other users (Instagram, 2023).

The profile used for data collection aims to serve as "a space for therapists in Brazil to vent and unite in order to change the reality of our (their) professional categories" (Bio of the *@terapeutascansados* profile). Additionally, a tone of denunciation is evident, as many therapists who posted reports stated that they were unable to expose these issues in other spaces or institutional settings for various reasons, as discussed later in the results section.

In some posts, it is possible to identify that the authors of the reports are occupational therapists, speech therapists, psychology educators, and psychologists. However, the term "therapist(s)" was retained to encompass this professional diversity and remain faithful to the profile's approach.

The page consists exclusively of reports published on the news feed, following a standardized structure: report number, report text, and a digital image with child-themed illustrations. To submit reports, any Instagram® user can access the link available in the profile bio (Bio Personalizável, linktr.ee/terapeutascansados) and complete a form. This is a Google Forms® online form that states that submissions are completely anonymous, ensuring that the user's identity is not revealed, even to the profile administrators. The form includes a specific field for writing the report.

The reports were collected in November 2022. All were fully extracted by the principal researcher, stored in a text document, and numerically organized according to their publication date.

Data analysis

For data analysis, thematic analysis—a methodology frequently used in content analysis for research—was employed (Minayo, 2014). After organizing and thoroughly reading the collected data, the analysis began with the identification of recording units, followed by the definition of intermediate thematic categories. Finally, the material was grouped into broader and structured themes.

In this final stage, material organization was guided by hypotheses, reflections, and critical analyses of literature. The first analysis axis focused on employment-related issues, covering themes such as working conditions (social, objective, and subjective aspects), dimensions of employment (contractual arrangements, work organization, workers' health, social recognition, and collective representation), and employment precarity (Souza, 2021; Franco et al., 2010; Vargas, 2016). The second axis addressed care for children, encompassing themes related to violent and rights-violating practices, institutionalization, and the precarious relationships between therapists and families.

Results

This study is based on the premise that the 131 reports published do not allow for generalizations about a singular reality. However, they were considered representative examples of a specific reality in which the relationships between employment conditions and care provision are intertwined, revealing situations of violence and suffering.

The results are presented in two analytical axes to provide greater visibility to the findings, even though they are directly interconnected. Excerpts from the reports have been corrected solely for grammar and spelling, without altering the original writing style, including capitalization and punctuation. Additionally, they follow the numbering from the profile page, where they can be accessed in full.

Axis 1 – Employment

Precarization of employment contracts and work relationships

The repercussions of service contracts, whether as self-employed professionals or legal entities, were present in the reports, highlighting the loss of labor rights or the inability to exercise them in the real working world. Among these rights, references were made to paid

rest periods, annual paid leave, and the recognition of a formal work schedule. Additionally, reports identified salary reductions and the elimination of indirect benefits, such as health insurance, transportation assistance, and meal allowances.

> [...] *demands for professional development courses without salary increases, financial support, and with deductions since the therapist had to be absent to complete them* [...] *as self-employed* [...] (Report 09).

> [...] *"Oh, but being* [a legal entity or self-employed] *means you set your own hours, you have the autonomy to organize yourself." LIES! This type of work only strips away more of our rights, masks how ridiculous our salary is, and shifts the responsibility onto us so they don't have to pay deductions* (Report 14).

> [...] *I worked for two and a half years at a clinic under a formal CLT contract. During that time, my FGTS (social security) deposits were never made, and during the pandemic, several therapists were let go with a so-called "partnership request" to have FGTS paid in installments. Nothing was ever paid, and we had to take legal action to claim what was rightfully ours* (Report 32).

> [...] *After finishing our physical work at the clinic, we come home and are still required to attend supervisions, meetings, write reports, develop Individualized Therapeutic Projects, respond to countless patient groups, talk to parents, and take professional development courses constantly* (Report 37).

> [...] *They say we are self-employed, but we are not allowed to become sick, to choose our working hours, and sometimes we cannot even reschedule for a course. At least under a CLT contract, we have vacation, a year-end bonus, and absences are not as critical. Even so, under CLT, we earn little, and moral and psychological abuse is constant* (Report 71).

Precarization of work organization and conditions

The reports grouped under this theme highlight the multiple exposures of workers to both environmental conditions and work organization factors that contribute to distress and illness. Among these conditions, reports emphasize workdays exceeding 10 hours, inadequate environments in terms of furniture, ventilation, and lighting, as well as a lack of essential work materials.

> [...] *I found myself trapped in an exhausting work cycle (11 straight hours with a 2-hour lunch break that I had to fight hard for). Tiny chairs and desks, where our legs remained cramped all day, and our backsides barely fit on the seat* [...] (Report 19).

> [...] *Not even the bare minimum was provided (for example, toilet paper in the bathroom, printer paper at reception, ventilated and soundproof rooms)* (Report 21).

> [...] *We worked in windowless rooms with damp walls, no ventilation, and sessions were conducted in pairs, meaning two children and two therapists in the same space* (Report 22).

> *My report is just a fragment of the many inadequate conditions I experienced in these workplaces. I worked at a clinic where we had to continue working for two days without electricity due to a storm. A tree fell in front of the clinic, and they even did not cancel appointments while waiting for* [Electricity Provider] *to resolve the issue* (Report 29).

> *I worked at a clinic (***)*[4] *where, around October, the owner sent out a notice stating that no basic hygiene supplies would be purchased until January, so we had to ration supplies. Yes, we had to ration toilet paper and soap.* [...] *The workplace was unbearably hot, and we had to take turns using fans because there weren't enough for all the rooms* [...] (Report 79).

Precarization of workers' health, mental illness, and the medicalization of life

The reports in this section reveal physical and mental deterioration among workers, resulting from therapists' experiences with their actual working conditions. These accounts expose various health issues, particularly mental disorders and burnout syndrome.

> [...] *I needed a lot of therapy to realize that* [...] *I was suffering from burnout syndrome* [...] (Report 02).

> [...] *Working while on the verge of a nervous breakdown as well. I had anxiety attacks* [...]. *The situation is bleak: it was not uncommon (in fact, it was routine) to see colleagues crying in the room after a difficult session, already having to attend to another child* [...] (Report 03).

> [...] *Therapists quit, therapists fell ill, became aggressive, therapists lost their mental health, therapists had crying fits during patient sessions, therapists take antidepressants, therapists abandoned their sessions, therapists forgot their techniques because of exhaustion, therapists lost their love for the profession, therapists are exhausted, therapists left the profession because they couldn't handle it anymore, and the cruelest part is that these therapists are doing their best to care for CHILDREN (Report 31).*

> *I had panic attacks, anxiety attacks, and now I am still battling depression, relying on medication* (Report 52).

Precarization of social recognition and symbolic value

The reports from the tired therapists contain deeply distressing accounts, exposing abusive situations that lead to a loss of career perspective. They mention dismissals, the desire to leave the profession, job abandonment, and a sense of worthlessness, which impact both professional identity and self-perception.

[4]The page itself removed the names of clinics and any identifying characteristics of workplaces, replacing them with (***) to ensure anonymity.

> [...] *Every day I try to find strength where there is none, and I constantly question whether I should just give up everything. Love for the profession alone is not enough to make up for it* [...] (Report 04).

> [...] *Sometimes I felt like the clinic owners thought they were doing me a favor by giving me a job* (Report 12).

> [...] *Owners who called us "little girls" as we walked through the halls* [...] (Report 19).

> [...] *I think about quitting the profession and throwing away seven years of study and dedication. It's very frustrating!* (Report 23).

> *I have a story about a clinic (***) that almost made me resign and abandon my career (quitting the professional council, as many exhausted therapists jokingly say)* (Report 41).

> [...] *Therapists' personal lives were constantly controlled. We were not allowed to have friendships outside of work. Contact with therapists who had already left the clinic? Never* [...] (Report 103).

Precarization of collective representation and organization

This theme illustrates the weakening of mechanisms to confront degrading conditions, insecurity, and lack of protection, resulting in various reactions and consequences. The reports describe situations of harassment and coercion, as well as a lack of trust in institutions for filing formal complaints.

> [...] *The clinic owner used to brag about having a group with all the other clinic owners, saying that anyone who "crossed her" would never find a job anywhere else!* [...] (Report 25).

> *Today, the clinic owner where I work gathered everyone who followed the page and* [...] *said they were keeping an eye on everyone who liked the posts* [...] (Report 30).

> [...] *The worst part is knowing that our professional councils' recommendation is always: file a formal complaint! Well, we've heard* [...] *that all the clinic owners and coordinators are close friends with the people who work in those councils* [...] (Report 108).

In this context, the *@terapeutascansados* profile ended up playing a role in building a new form of collective organization, as was explicitly stated in its description: "a space for therapists in Brazil to vent and unite to change the reality of our professional categories" (Bio of the @terapeutascansados profile). Faced with coercive situations and failed attempts to file formal complaints, the possibility of telling their stories, venting, and sharing their experiences with other therapists was perceived by participants as a

form of resistance, a cry for help, and a hope that a collective—albeit anonymous—could bring visibility to their denunciations.

> *There is a light at the end of the tunnel! Your reports are anonymous because of the dictatorship imposed by some clinics (NOT ALL) but know that we are not anonymous in our patients' families or our own families!* [...] *Together we are stronger!!!* [...] *This page is a cry for HELP!* (Report 97).

> *I own a clinic* [...]. *I saw some therapists asking if this page only exists to dismantle clinics* [...]. *I can tell you, with absolute certainty, that it is not necessary. The dismantling begins when management* [...] *fails to consider the well-being of its team* [...] *Does all of this affect clinic managers? I assure you it does not.* [...] *Are the professional councils not taking action?* [...] *Do not let this Instagram® page die. Parents need to know about this, the Public Prosecutor's Office needs to know about this, the National Health Agency needs to know about this. Unite* [...] (Report 98).

Axis 2 – Care

Practices of violence, neglect, and violation of children's rights

The reports from professionals reveal practices adopted by clinics or recommended by managers that exceed ethical and moral boundaries, violating children's rights through mistreatment, the use of physical force, and aggression, all under the technical discourse of behavior control.

> [...] *not to mention that when children/adolescents had crises, we were instructed to use force and restrain them. Many times, we were also told to threaten them with punitive measures* (Report 70).

> [...] *not to mention the punitive practices used with children who were acting disruptively* (Report 75).

> *Children were frequently subjected to punishments and the infamous "just ignore it" strategy* [...] *What they were doing was not even remotely Applied Behavior Analysis (ABA) or any othe*r [...] *intervention* [...] *that might work in the short term but would have terrible consequences for the children in the long run* (Report 94).

> *They claim to follow conduct protocols, but when things get difficult, they call in some big guy* [...] *to forcibly restrain the child!* (Report 130).

> [...] *We were instructed to use aversive methods that caused pain to the children.* [...] *When restraining them, we had to do it forcefully, in a way that hurts, so they would not reinforce their inappropriate self-harming behaviors.* (Report 131).

Institutionalization of children

In this section, the reports denounce the excessive therapy hours imposed on children and their consequences, inextricably linked to the violence exercised in these services.

> *They pile therapy sessions on children even though they know the children cannot handle the demand!* (Report 66).

> [...] *The exhausting routine of many children—20 hours a week—many would fall asleep during sessions or become disorganized from fatigue, but we were not allowed to call their parents* (Report 107).

> *On a very hot day, while one of the therapists was holding a child* [...] *who fell asleep during a session* [...] *the owner* [...] *took the child from the therapist's arms, shook them, and threw cold water on their face so that* [...] *they would continue therapy, in front of several people* [...] (Report 102).

Precarization of relationships with families and the "fraud" in therapy sessions

Therapists also report that, many times, parents or guardians are unaware of how therapies are conducted. They mention that managers or other professionals misrepresent what is offered as care, from preventing professionals from providing information to parents to selling therapies with specialists in a specific technique or approach while delegating the practice to interns or unqualified professionals.

> [...] *It was not allowed to discharge patients, even if they had already achieved all the proposed goals... we were told* [...] *to "create" a new demand so the sessions would continue.* [...] *You sell a service that is not actually provided, you promise parents a thousand things, but the truth is that we are all being deceived and becoming hostages of this corrupt system* (Report 42).

> *Parents sign off on therapy sessions that never took place,* [...] *they are not informed when therapists are sick, exhausted, or injured, or are simply given an excuse because the therapist cannot take it anymore* (Report 122).

> *Parents pay for specific therapies, yet very few therapists actually have those qualifications. For example, method X—there was no staff member with that certification. The only one who had the certification was no longer at the clinic, and they still sold that therapy. Sensory integration therapy was conducted by therapists with only basic courses, without certification* (Report 128).

> *Parents often do not know that speech therapy and occupational therapy sessions are performed by ABA interns and that when a professional leaves, the directors do not allow follow-up sessions to occur* (Report 129).

> [...] *Interns cover for absent therapists, multiple children are treated in the same room at the same time, and parents have no idea who is actually working with their child. They lie to parents, claiming to provide specialized services* [...] *but in*

> *reality, the child just spends eight hours sitting at a desk, repeating instructions and pointing at pictures* (Report 130).

Discussion

The two dimensions of analysis, employment, and care are inseparable poles, connected by care and management practices embedded in neoliberal capitalism. In Brazil, within the global context of autism diagnosis expansion, there has been a growing advocacy among professionals, families, and researchers for intensive treatment of this population. The multimillion-dollar and highly profitable Autism Industrial Complex has been widely discussed, driven by service and pharmaceutical interests and funded both by private insurance agreements and political lobbying (Broderick, 2022).

In this scenario, our findings also reveal that time is money. The reports highlight processes of physical and mental deterioration among workers, driven by misguided cost containment efforts and attempts to maintain control over therapists' work processes, a characteristic of contemporary labor (Franco et al., 2010). Faced with productivity targets and accelerated work rhythms, strategies to increase efficiency are often employed, compromising both labor conditions and workers' health (Silva & Franco, 2007).

For children, the return of institutionalization is evident as they are removed from school to undergo intensive treatments in clinic-schools for 20, 30, or even 40 hours per week, justified by the severity of their condition and the weaknesses in the inclusion process. As a result, these children are deprived of numerous opportunities, such as socializing with their peers, engaging in free and spontaneous play, and expressing themselves outside the controlled and disciplinary context of therapy sessions.

Many are harmed. Incorporating the profit-driven logic of the capitalist productive system into healthcare is incompatible with human life, given its historical capacity to produce physical and mental illness (Franco et al., 2010). In this sense, therapists' reports demonstrate the close connection between employment precarity and the precarization of life itself (Souza & Lussi, 2022), affecting both workers and the individuals they assist.

Therapists, regardless of whether they are formally employed under the CLT regime or providing services as independent contractors, belong to the category of so-called "autonomous" healthcare professionals. However, our findings indicate that contractual choices and work organization in the clinics under scrutiny compromise fundamental aspects of professional autonomy, impacting workers' identities (Seligmann-Silva, 2001). In this context, autonomy serves only to perpetuate the lack of social protection and exempt companies from responsibility for investing in workers' well-being and the quality of services provided.

The narratives analyzed indicate that self-employment or freelance work is the predominant reality in terms of contractual arrangements, primarily materializing through the process of "*pejotização*" (outsourcing through personal legal entities). However, for the therapists in this study, the intense time pressure, combined with increased control or fear of job loss (including under direct threats), results in a lack of work breaks and compromised rest and recovery. These conditions pose risks for both workers and the children and families they assist, having no real connection to autonomy or freedom in the workplace.

Thus, it becomes evident that the supposed "autonomy" and "freedom" associated with self-employment or "*pejotização*" are, in reality, narratives promoted by the market, aligned with neoliberal rationality, rather than genuine advancements in quality of life and work. The profit of contracting entities is, in part, derived from employers' withdrawal of responsibility for their workers, as "*pejotização*" drastically reduces labor-related tax costs (Michelin et al., 2024).

Sennett (1999) highlights that the existence of different types of employment contracts has negatively impacted personal and professional development projects, particularly among young workers. This occurs, among other reasons, because companies can avoid investments in health and safety, shifting the negative consequences of work onto employees without any legal repercussions for the companies. This stance reflects a denial of the value of protecting health and life.

The disintegration of social relations among professionals, driven by a competitive neoliberal logic and structural unemployment, directly influences the weakening of collective efforts that could politically and legally challenge labor precarization. As a central element of adult life, work, when socially weakened and permeated by the insecurity we have reiterated throughout this study, affects various dimensions of human life, including workers' mental health (Franco et al., 2010; Silva & Franco, 2007).

Grounded in an understanding of the distortions in the use of approaches and techniques aimed at behavioral control and normalization, the limitations of professional training, and the supposed scientific evidence supporting certain practices (Silva & Camargo, 2023), professionals have produced reports denouncing numerous practices adopted by clinics or recommended by managers that exceed ethical limits and violate children's rights. These reports allow us to grasp the depth of the problem, which is not confined to the Brazilian context (Ortega, 2019; Broderick, 2022).

Once again, the rise of clinics specializing exclusively in autism diagnosis is noteworthy. In these clinics, technical team professionals are summoned to correct and socially adjust the "problem child" or the "difficult child" (Grinker, 2019), making them targets of various power technologies (Lockmann & Mota, 2013). Under a new guise—that of specialized intervention conducted by numerous professionals using their techniques and approaches—yet still sustained by intolerance toward deviation (Canguilhem, 2005), childhood remains a victim of violence, oppression, and exclusion in a pervasive scenario of pathologization and medicalization of life (Cascio et al., 2019).

Despite setbacks and disinvestment under the Bolsonaro administration, as well as the commodification of autism (Fernandes et al., 2020), Brazil has achieved some progress in healthcare assistance, resulting from the development of public policies driven by the movements for healthcare and psychiatric reform, disability rights advocacy, and more recently, the neurodivergent movement. However, our findings indicate that there is still a long way to go in transforming children's care.

Ortega (2019) emphasizes that what is at stake is not the individual and their care but rather who claims ownership of knowledge and, consequently, the market. Transforming this reality requires involvement and shared responsibility among multiple actors (Duarte & Kantorski, 2011). By prioritizing an exclusively capitalized and individualized care model, the risks identified in this study are disregarded. There is, therefore, an urgent need to move forward and ensure children receive comprehensive and genuine care, encompassing social participation, education, housing, and

citizenship, as many of the issues described today stem from historical practices that remain unchanged (Taño & Matsukura, 2015).

Confronting this reality and contributing to more effective care, integrated with lived experiences and everyday demands, requires the engagement of all individuals involved in this issue. The collective whisper of therapists on the anonymous platform, even if it does not directly lead to formal complaints or regulatory actions, serves as a record of violence—both in care and labor conditions. These records can support the formation of organized collectives that advocate improvements for both the professional categories involved and the quality of care provided. We hope that our analysis contributes to expanding this visibility, encouraging researchers from various fields to further investigate the multiple issues emerging from this study and prompting society to seek dignified solutions for a problem of this magnitude.

Final remarks

This study presents a critical analysis of therapists' reports published on a social media profile, highlighting the connections between employment precarity—in its multiple conditions and dimensions—and the precarious care provided to children and their families. It addresses issues of normativity, productivity, and the capitalization of care in neoliberal society.

The primary limitation of this study concerns the source of data used, as additional information would allow for a more precise characterization of the population of therapists who submitted their reports and enable an analysis of potential biases. Moreover, the methodological design of this study does not allow for generalization about a singular reality but rather reveals aspects of a specific reality in which employment precarity and precarious care conditions intertwine, exposing situations of violence and suffering.

A critical exploration of this material suggests several directions for future research, such as the need to understand the current landscape of the Autism Industrial Complex ore comprehensively, including its operations within public services, and to develop political and care strategies that could help overcome the reality presented here.

We hope that this article contributes to expanding the visibility of this issue, mobilizing all those interested in developing ethical, technical, and political solutions for this population.

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