

Security devices, psychiatry and crime prevention: the TOD and the notion of a dangerous child

Dispositivos de segurança, psiquiatria e prevenção da criminalidade: o TOD e a noção de criança perigosa

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Abstract

The article analyzes the growing tendency to multiply psychiatric diagnoses in childhood, which finds legitimacy in the argument that, if childhood psychiatric disorders are not properly treated, it will be highly probable that in adult life there will be serious irreversible psychiatric problems, problems associated with crime and delinquency. The example of oppositional and defiant disorder, known as TOD, is analyzed insofar as, according to DSM-5, this pathology supposes a high risk for the development of antisocial personality disorder, a condition that presents clearly juridical connotations and criminological. These diagnoses are analyzed in a critical perspective from the Foucauldian concept of “safety device”.

Keywords: Security Device; Crime; Foucault; DSM-5; TOD.

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Resumo

O artigo analisa a tendência crescente da multiplicação de diagnósticos psiquiátricos na infância, que encontra legitimidade no argumento que indica que se as patologias psiquiátricas da infância não forem devidamente tratadas, será altamente provável que, na vida adulta, surjam graves problemas psiquiátricos irreversíveis, assim como problemas associados à criminalidade e à delinquência. Analisa-se o exemplo do transtorno de oposição e desafio, conhecido como TOD, na medida em que, de acordo com o DSM-5, essa patologia supõe um alto risco para o desenvolvimento do transtorno de personalidade antissocial, patologia que apresenta conotações claramente jurídicas e criminológicas. Esses diagnósticos são analisados em perspectiva crítica a partir do conceito foucaultiano de “dispositivo de segurança”.

Palavras-chave: Dispositivo de Segurança; Criminalidade; Foucault; DSM-5; TOD.

Introduction

Currently, we have witnessed the multiplication of psychiatric diagnoses related to early childhood, childhood or adolescence. This proliferation is sustained by the argument of the need to anticipate serious problems that can occur in adulthood if childhood psychiatric disorders are not correctly identified, diagnosed and treated at the right time. It is claimed that, in this case, the problems multiply in adult life. There will be not only medical and psychiatric problems, linked to the chronification and the irreversibility of serious mental illnesses, but also legal, related to social dramatic facts, such as crime and delinquency.

This speech stands in the idea of danger and of the growing seriousness of untreated mental illnesses, a thesis which contributes to legitimate the creation of risk anticipation strategies through the early identification of mental disorders in childhood. The *Diagnostic and statistical manual of mental disorders - DSM-5* (APA, 2013) is the technology, currently hegemonic, that will delimit the set of symptoms that, according to the American Psychiatric Association (APA), characterizes the various childhood diagnoses, like attention deficit hyperactivity disorder (TDAH), schizophrenia or oppositional defiant disorder (TOD), which we will study in this article.

Those childhood diagnoses, among many others listed in the DSM-5, delimit the landmark that is considered today a *psychiatrically abnormal child*, someone who presents some risk of violent or criminal behavior in adulthood, that is, someone who is likely to be regarded as a *dangerous child*, to itself or to others. Given this context, it may be useful to remember the course that Foucault held in 1981 in Louvain in Belgium, titled *Wrong-doing, truth-telling: the function of avowal in justice* (Foucault, 2014), which incorporates some ideas that had already been set out in the text “About the concept of the ‘dangerous individual’ in 19th century legal psychiatry”, published in the same year. Making a slight offset in relation to these texts, I propose to analyze here the place that another notion occupies today, no longer of a dangerous individual, but of a dangerous childhood

or child. To analyze this notion, we must use a historical look for that particular moment in which psychiatry and law established a lasting alliance to guarantee social security, as both speeches attribute the capacity to prevent and anticipate the occurrence of crimes.

One hundred years later we know that that promise was not fulfilled. However, it was at that moment that the medical and legal discourses, through the notion of dangerous individual, installed a new way of thematizing childhood. The child judged abnormal begins to be seen as a threat, both medically and legally. So, throughout the 19th century, childhood will be seen as a privileged moment to anticipate future serious or irreversible psychiatric problems and, at the same time, future violent acts and criminals.

As we will try to show here, everything seems to indicate that old strategies from the 19th century remain to this day. Psychiatry and law articulate around the so-called abnormal and considered dangerous childhood, giving way to what Foucault characterized as “Ubuesque discourses”, i.e., discourses of truth that may seem grotesque, make you laugh, but that in fact are tragic, as they have the power to determine, directly or indirectly, decisions of justice, referring to the type of sentence, freedom or punishment. These are speeches that have the institutional power to punish, exclude and, at the limit, kill.

For this reason, Foucault says “these speeches are, finally, in a society like ours, speeches that deserve some attention” (Foucault, 1999, p. 125). It is necessary to study the effects of power produced by these discourses that are, at the same time, statutory and disqualified, that reach certain truth value, status of scientificity, as they are set out by experts.

I propose, then, to analyze the construction of knowledge and intervention strategies by which childhood began to be thought, and still is to this day, as the axis of articulation of this security device centered on the risk problem that characterizes liberal and neoliberal societies. We can ask: what happens in that Ubu’s speech that is at the core of our criminal and psychiatric practice? How does that so little scientific speech, centered

on prejudices and moral qualifications, acquires scientificity?

As we will try to show here, the insistence on intervene psychiatrically on children’s behavior, the interest in defining and multiplying childhood psychiatric classifications, does not seem to be completely oblivious to the concern to anticipate violent behavior, suicidal people or criminals. In this article I propose to analyze one of the many diagnostics that the DSM-5 considers only for children and adolescents, the TOD (identified by code 313.81 in DSM-5 and F91.3 in ICD-9). As I also intend to show, this disorder is part of the field of what Foucault called “security device” (Foucault, 1978, 1997, 2004, 2005), as it is a diagnosis pervaded by the problem of risk, which the legitimacy and reason for being seems to be limited to the anticipation of psychiatric and legal problems.

Security devices

The existence of diffuse borders between normal and psychiatric pathology enabled not only the multiplication of diagnostics, but also the acceptance of the idea that it would be possible to identify small signs of a serious pathology. Thus, it was created the need for preventive interventions in the field of mental health that would make it possible to act before a possible psychiatric illness became chronic, before the pathological process began. There are mental disorders of development, i.e., pathologies that appear in childhood with “sub-clinical” symptoms, small indications that a behavior or learning disorder might happen in the future.

This logic of anticipation and prevention revolves around the concept of *risk*. Thus, it is claimed, even if there is no certainty, that children diagnosed with TDAH or TOD that are not treated in childhood will develop future irreversible diagnostics of schizophrenia, psychosis or the dreaded antisocial personality disorder, directly associated with crime and delinquency. Thus, although, in recent years, the critics related to the epistemological fragility of this diagnostic classification have multiplied, today hegemonic in Psychiatry, it continues to be used as a frame of reference for identifying symptoms, diagnoses and prescribing therapies, which are

limited, generally, by psychoactive drugs, sometimes combined with behavioral therapies.

The truth is that, regardless of the criticisms directed at this way of defining diagnoses, they are imposed worldwide by law. The existence of teachers trained to diagnose and identify mental disorders will certainly increase the number of diagnoses for behaviors that used to be considered common in childhood, regardless of the educational, social or family problems that may be involved. We have then a discourse of truth, based on the logic of fear and imposed by law, that is, a statutory speech, but disqualified.

To understand how this medical-juridical continuum that articulates around the idea of childhood dangerousness came about, we must place ourselves between 1890 and 1902. At that time, there was a transformation in the psychiatric and legal speech that allowed to articulate crime, abnormalities and risk categories, creating a powerful tool to exercise government over men, focusing attention on the conduct of childhood. Psychiatry abandoned the thesis, defended by classic alienism, that identified insanity or mental illness in a limited number of diagnoses. Insanity, through degeneration theorists, was no longer linked exclusively to existence of auditory or visual hallucinations to refer to behaviors considered diverted in relation to pre-established parameters of normality. At the same time, the capacity to anticipate serious and irreversible disorders that may occur in adult life, intervening in everyday behaviors and legitimizing the psychiatrization of childhood.

In the legal area, a parallel transformation was produced. The Escola Positiva de Antropologia Criminal proposes to replace a legal system centered on the opposition responsibility-irresponsibility for a legislation based on dangerousness. What matters is the social risk that an individual, adult or child, may represent for social security, so that the notion of risk as ability to anticipate a possible danger reappears as articulator notion both in the medical field and in law.

Foucault (2014) will summarize these changes stating that, in the early 20th century, the abandonment of the concept of responsibility

linked to the problem of free will is abandoned and is replaced by the degree of danger that individuals represent to the society. From there, the classic criminal law considered as irresponsible precisely those individuals, that is, the insane and the abnormal, who pose the most danger to society.

The inevitable question is: who can define whether an individual is or is not dangerous before they committed an act? In other words: who should decide whether an individual, adult or child, could trigger violence in the future? The answer is: psychiatry. Thus, the two proposed changes lead to a subordination of the right to psychiatry that produces a third transformation, which, in turn, will lead to the requirement of:

to redraw the social function of the penalty, which should no longer be seen as punishment for a crime actually committed, to be seen as a society defense strategy, made possible by the alleged ability of psychiatric knowledge to identify a dangerous individual. Increasingly in the nineteenth and twentieth century, penal practice and then penal theory will tend to make of the dangerous individual the principal target of punitive intervention. (Foucault, 2014, p. 235)

One might object that this penal reform project was not completed, that the criterion of responsibility-irresponsibility was kept in penal codes of different countries in the world. However, it was in this moment that Psychiatry earned the right of intervene in the medicalization of behaviors considered dangerous, targeting the childhood, as it is considered that Psychiatry can anticipate criminal offences that might be committed in adult life.

The psychiatric knowledge acquires a central role in the task of evaluating the degree of danger that individuals represent to society and to themselves, becoming a powerful ally of justice. Because only the psychiatrist can act not only before the chronification of a psychiatric illness, but also before a crime is committed.

I would like to stop here and analyze the way that the new version of *Diagnostic and statistical manual of mental disorders* is linked to this device of knowledge-power of liberal and neoliberal societies,

named by Foucault “security device” (Foucault, 1978, 1997, 2004, 2005): a device eminently centered in the logic of preventing and anticipating risks. As said before, that device precedes the classification, today hegemonic, of psychiatric pathologies, and certainly recedes the DSM-5, edited in 2013. However, in recent years, this device has gained strength by consolidating an increasingly solid line of research in Psychiatry, called “psychiatry for the development of children and adolescents.” According to this line of research and intervention, which pervades the DSM-5 completely, mental disorders should be understood as dysfunctional behaviors that worsen throughout an individual’s life, from childhood to adulthood (Caponi, 2014), requiring attention in the first years of life to be reinforced.

Although childhood disorders already existed in DSM III and IV, we can say that the boundaries dissolution between adults and children consolidated, finally, with the publication of DSM-5. In it, the controversial chapter named “Disorders usually first diagnosed in infancy, childhood, or adolescence” disappears, legitimating the indistinction between diagnoses of childhood and those reserved to adulthood. From that moment, we can speak without problems of TDAH in adults and major depression in childhood.

We can observe, for example, that the DSM-5 item dedicated to “Development and course”, before named “Course” in DSM-IV, each defined diagnostic has its reference in childhood or adolescence, or when the pathology would have started. There are also indications referring to the importance of identifying diseases at an early stage to ensure a good treatment. Thus, for the reactive attachment disorder (313.89), the item “Development and course” states: “The disorder was described from the second year of life to the adolescence” (APA, 2013, p. 270). In post-traumatic stress disorder, this same item states: “TEPT can occur at any age from the first year of life” (APA, 2013, p. 276), and the same logic is repeated in most diagnoses. It is worth remembering that the reactive attachment disorder did not exist in DSM-IV-TR, and that the post-traumatic stress disorder started in adulthood.

The examples also multiply in the so-called sexual pathologies. A new category appears:

“Gender dysphoria in children” (451). It states that transgender behaviors may already begin in pre-school age, with two or four years of age (APA, 2013, p. 455). Everything seems to indicate that the passage from the item “Course” to the item “Development and course” did not occur by chance, it is a position taken in relation to the validity given by DSM-5 to this ambiguous and dubious research line called, precisely, psychiatry for the development of children and adolescents.

Thus, the obsession to early detect childhood mental disorders seems to be the central axis around which the DSM-5 articulates. That strategy, which is present in nearly all mental disorders described in the manual, would enable psychiatry to identify and anticipate risks, both medical and legal.

This centrality of the Security device has two faces. On one hand, early detection presents, although unsuccessfully, as a response to avoid the chronification of pathologies that are allegedly irreversible in adulthood. On the other hand, and this is where the strategy finds its legitimacy, it fulfills a function of social protection. The task to detect disruptive disorders during infancy is presented as a solution to anticipate the most feared problems in liberal and neoliberal societies: delinquency, crime, homicide and suicide. The DSM-5 is, therefore, halfway between medical and legal.

We see, thus, that the strategy, necessary to ensure the indefinite expansion of diagnostics and psychiatric categories, is the obsession to identify small anomalies, daily sufferings, small misconducts, as indicators of a severe psychiatric pathology to come. The risk, as it appears to anticipate a possible danger (real or imagined) to life and health, is the strategy that allows to ensure legitimacy and acceptability of multiplication of diagnostics. One of the DSM-5 greatest critics, the Task-force chair of DSM-IV, Allen Frances, states:

Psychiatrists expect to identify patients early and create effective treatments to reduce the chronicity of pathologies. Unfortunately, the Task-force members usually make the mistake of forgetting that any effort to reduce rates of false negatives must inevitably increase the rate of

false positives (often dramatically and with fatal consequences). If ever possible to achieve the expected advantage of cases of early detection, we must have specific diagnostic tests and safe treatments. In contrast, the proposals of DSM-5 lead to the particularly dangerous combination of non-specific and inadequate diagnoses, and to not proved and damaging treatments. (Frances, 2010, p. 6)

The problem of risk is the strategy most used to legitimize the spread of mental illness. In this landmark, we can situate Frances' statement in which the risk syndrome of psychosis (later called *attenuated psychosis syndrome*) would lead to an alarming rate of false positives between 70 to 75%, leading to hundreds of thousands of adolescents and young adults to get, without need, the prescription of atypical antipsychotics that cause severe collateral effects, such as: weight gain, impotence and reduced life expectancy. So that,

The prevention of psychosis would be a great idea if we could really do it, but there is no reason to think we can. To go beyond our understanding will probably affect those we hoped to help. The Risk of psychosis should not be used as a clinic diagnostic, as it will almost always be wrong. The road to hell is paved with good intentions and bad unintended consequences. Firstly, do not cause damage. (Frances, 2013a, p. 1)

There is no point in the answer that the risk of psychosis was finally excluded from the DSM-5, because, besides the number of disorders considered a risk factor to severe and irreversible disorders such as psychosis having been expanded, the new restructuring of DSM-5 points out, already in the introduction, the importance of early detection of a wide range of psychiatric disorders that included psychosis. So, at the beginning of this manual, we can read:

To improve clinical utility, DSM-5 is organized on developmental and lifespan considerations. It begins with diagnosis thought to reflect developmental processes that manifest early in

life (e.g., neurodevelopmental and schizophrenia spectrum and other psychotic disorders), followed by diagnoses that manifest in adulthood. A similar approach has been taken within each chapter. This organizational structure facilitates the comprehensive use of lifespan information to assist in diagnostic decision making. (APA, 2013, p. 13)

As it was said before, the statement that mental pathologies would start in childhood and adolescence is not only limited to the first chapters of DSM-5. On the contrary, it reappears in each chapter of the manual, as they all start with a reference that this group of disorders may begin in childhood. This happens, for example, in the chapter named "Depressive disorders", starting with a disruptive mood dysregulation disorder, which begins before the age of ten. The same occurs with "Disruptive, impulse-control, and conduct disorders", chapter in which DSM-5 places TOD.

A ubuesque diagnosis: the oppositional defiant disorder

This chapter of disruptive conduct disorders groups the following pathologies, presented in ascending order of severity: oppositional defiant disorder, intermittent explosive disorder, conduct disorder, antisocial personality disorder, pyromania and kleptomania—besides the omnipresent category "unspecified". The manual also states that, due to its close association to this group, the antisocial personality disorder (301.7) has a double listing, in this chapter and in "Personality disorders". Concerning the TDAH, listed before with oppositional and conduct disorders, the DSM-5 states that it is frequently comorbid with disruptive disorders.

The trajectory that articulates those disorders presents as followed.

As it can be observed, the disappearance of the group "Disorders usually first diagnosed in infancy, childhood, or adolescence" is far from being good news to those who wish for the end of childhood psychiatric labels. The DSM-5 inaugurates, from the principles defended by Psychiatry of development, a process through which any mental disorder should be diagnosed in the first years of life.

Table 1 – Oppositional and Defiant Disorder, possible trajectory

Possible Trajectory	Oppositional Defiant Disorder	Conduct Disorder	Anti-Social Personality Disorder
Major Symptoms	Andry, argues, easily annoyed, disobedient, spiteful, loses temper, blames others	Violates other's rights, physical harm, property damage, deceitful, serious violations of rules	
Prognosis		Guarded with onset before age 10 or if more serious symptoms are present	Guarded
Risk Factors	As an infant was fussy, reactive excessive motor activity	Male, parental rejection, harsh parenting, peer rejection, trauma	Family Hystory
Protective Factos	Early identification, Effective treatment, Absence of ADHD, No family history of DBD	Mild symptoms, Early Assessment and Effective, Timely Treatment, No co-occurring Substance Use, No family history	

Source: Gathright e Tyler, 2012

It is a question of intervening in disruptive disorders before any alleged mental pathology chronifies, but also before the dreaded antisocial personality disorder consolidates. This is the psychiatric label most used to designate those who “fail to conform to social norms with respect to lawful behavior” (APA, 2013, p. 659). That is, people who have aggressive, violent or criminal behavior.

In this field between medical and law, we should situate the succession of diagnoses that make the group “Disruptive, impulse-control, and conduct disorders,” giving rise to what we can characterize as the process of configuring a dangerous childhood. As already mentioned, in *Abnormal*, Foucault analyzes legal discourses of truth as “ubuesques” (Foucault, 1999, p. 125). Because it is from those discourses, grotesque, but with pretension of truth and tragic consequences, that legitimate power strategies that can determine, directly or indirectly, decisions about normality and pathology, about therapeutic pharmacological, anyway, decisions about the life

and future of children classified in that category of disorders.

One of these ubuesque discourses is TOD. This disorder is defined as a pattern of “angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories and exhibited during interaction with at least one individual who is not a sibling.”¹

To diagnose this disorder, there must be at least four of eight symptoms the manual presents divided in three groups:

Angry/irritable mood

- Often loses temper;
- Is often touchy or easily annoyed;
- Is often angry and resentful;

Argumentative/defiant behavior

- Often argues with authority figures or, for children and adolescents, with adults;

¹ In DSM-IV: “Recurrent pattern of defiant, disobedient, and hostile behavior, started in childhood and adolescence and of sufficient intensity to impair the global functioning of children and adolescents” (APA, 1994).

- Often actively defies or refuses to comply with requests from authority figures or with rules;
- Often deliberately annoys others;
- Often blames others for his or her mistakes or misbehavior;

Vindictiveness

- Has been spiteful or vindictive at least twice within the past 6 months. (APA, 2013, p. 462).

Besides the fragility and ambiguity of those unobvious symptoms, DSM-5 adds a particularly significant note, in which it explains that, to perform the diagnosis, the behaviors do not have to be exclusively associated to the diagnosed individual's suffering. The note introduces a new element. It states that the diagnosis must consider the suffering those behaviors produce to "others in his or her immediate social context (e.g., family, peer group, work colleagues)", and those behaviors also "impacts negatively on social, educational, occupational functioning of the individual" (APA, 2013, p. 463). So that the child's suffering may no longer be the central reference, and the effects that this child has on the functioning of the school or the family will be relevant to the diagnosis. The door to the medicalization of behaviors common in childhood is, thus, open.

The DSM-5 presents other specifications to the diagnosis of TOD. In the item "Development and course", we can read that the first symptoms appear in pre-school years, before the age of five, and that this disorder appears as an indicator of a more serious one, conduct disorder (TC), which includes aggression to people and animals. It also states that "Children and adolescents with oppositional defiant disorder are at increased risk for a number of problems in adjustment as adults, including antisocial behavior, impulse-control problems, substance abuse, anxiety, and depression" (APA, 2013, p. 464).

An inevitable question, then, arises about this ambiguous diagnosis associated with a dramatic prognosis in adulthood. The question is whether there is any neurobiological marker, any cerebral change that allows to indicate that this set of

behaviors of childhood can be seen as an indicator of a psychiatric pathology. The DSM-5 answers when it states, in the item "Risk and Prognostic Features", that "a number of neurobiological markers (e.g., lower heart rate and skin conductance reactivity; reduced basal cortisol reactivity; abnormalities in the prefrontal cortex and amygdala) have been associated with oppositional defiant disorder." However, it immediately states that "it is unclear whether there are markers specific to oppositional defiant disorder" (APA, 2013, p. 465).

If, for a moment, we leave DSM-5 and analyze the Brazilian production dedicated to this question, we can take as reference a text published in the *Brazilian Journal of Psychiatry*, in 2004. The article "Oppositional defiant disorder: a review of neurobiological and environmental correlates" (Serra-Pinheiro et al., 2004) reviews the production dedicated to TOD. The study proposes to analyze existing evidences related to neurobiological correlates, of family and school functioning, comorbidities, prognosis and treatment, differentiating TOD from TDAH and TC.

Referring specifically to reviewed studies that try to establish markers or neurobiological correlates, the article states that none of them presents conclusive results. The analyzed studies tried to define the cause of TOD through different routes: identifying hormones and neurotransmitters, using electroencephalography, genetic markers, among others. However, the article observes that none of those studies is conclusive.

Regarding cognitive studies performed in children with TOD and normal controls, the authors state that there is evidence that children with TOD have greater learning difficulties, but that difference cannot be considered significant. However, none of those failures was considered by researchers as indication that the diagnosis is poorly defined or is a nonexistent pathology. It is stated, on the contrary, that such studies will give positive results in some remote and imaginary future.

Given the absence of genetic, physiological or neurobiological factors, that is, faced with the impossibility of counting with brain imaging studies, blood analysis or any kind of neurobiological marker, it will be necessary to

integrate other elements. It would be desirable to understand if those angry, defiant reactions are not more than a simple way the child found to express suffering, using ludic strategies so people can hear what he or she has to say. However, to define that ambiguous and inconsistent diagnosis that is TOD, the DSM-5 disregards explicitly children's reports when it states: "Individuals with this disorder typically do not regard themselves as angry, oppositional, or defiant. Instead, they often justify their behavior as a response to unreasonable demands or circumstances" (APA, 2013, p. 463). The manual believes that there are few contributions a child can give to define the diagnosis, so that, once again, we find the Kraepelinian maxim that leads to silence the patients' narrative.

Those alternatives are not considered when defining the diagnosis, according to DSM-5. The manual only presents one strategy, that is limited to measure the frequency and persistency of four of the previously mentioned symptoms during a period of six months. That is the only strategy to "to distinguish a behavior that is within normal limits from a behavior that is symptomatic." DSM-5 believes that "other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture." (APA, 2013, p. 463) You can only count the frequency of appearance of the symptoms, calculate the deviation the child presents compared with the average or standard of the same age.

Those ambiguous, quantitative pieces of information match with the reference to other "risk and prognosis features" the manual names "environmental". Among those, it points out: harsh, inconsistent, or neglectful child-rearing practices, because "these parenting practices play an important role in many causal theories of the disorder." (APA, 2013, p. 463). So that, to establish the psychiatric diagnosis to a pathology in which the biological cause will be assumed, without being identified, the DSM uses two strategies: counting symptoms and assess the child's parental history, that is, identify "environmental factors". Those would be the following (Goodman; Scott, 2012):

- Low socioeconomic level.
- Parental history of psychopathology.
- Parental criminality.
- Characteristics of parental care: hostility, lack of care, lack of supervision, rules and inconsistent discipline.

Observing these factors, it seems inevitable to highlight the place that poverty and parental criminality occupy. Psychiatry opens doors, thus, to evaluations with a strong and undesirable social determinism. This, repeating the logic of self-fulfilling prophecy, will diagnose more frequently behavior disorders in poor families or in children with families in conflict with the law.

This speech is repeated in several academic articles such as the one written by Serra-Pinheiro et al. (2004, p. 274), in which, in relation to familiar aspects, there is a more detailed explanation, that reproduces the same class prejudices and marks of social determinism. The authors state:

In a study comparing patients with ADHD with and without ODD, Kadesjo et al. found that having divorced parents and a mother with low socioeconomic level were more common in the comorbid group. Frick et al. demonstrated that children with ODD were distinguished from clinic controls in having higher prevalence of parental anti-social personality disorder and paternal substance abuse disorder.

Nothing new so far, just the repetition of the classic class prejudices presented in the form of scientific studies, because how can we scientifically determine the importance of the mother's education or the family's socioeconomic status, if we in fact do not have more than an ambiguous definition, a list of behaviors that cause nuisance in the child's places of conviviality, disregarding that this can be the only symbolic resource available for the child to express dissatisfaction, fear of suffering?

We must carefully analyze the role that poverty occupies in this speech. Certainly, this role is not analogous to that played by environmental factors in communicable diseases like cholera, leprosy and tuberculosis. We know the natural history of those diseases and we know the impact that poverty may

have on their proliferation. Certainly, this is not the model used by the DSM-5 when it states that poverty or parental criminality may be environmental, causative factors of defiant or oppositional behaviors. In this case, the incorporation of the poverty factor as a cause of an alleged pathology can only reinforce class stigmas and social exclusion of children whose behaviors, as Pierre Bourdieu showed well, do not adjust to the desired standards just because those children do not have the social or cultural capital that schools expect and want to find in their students.

TOD and the pharmacological therapy

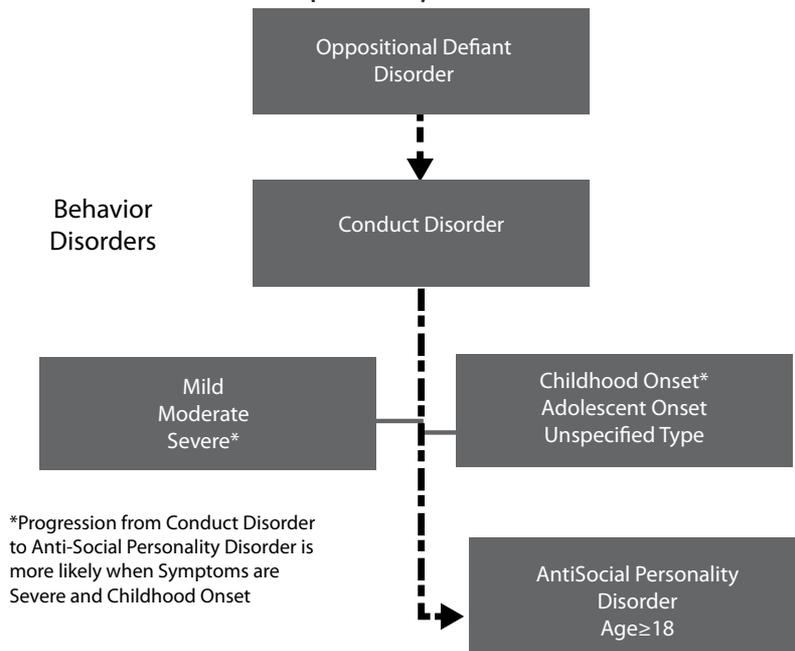
The therapy proposed to TOD still needs to be analyzed. To do so, we must remember that, according to DSM-5, it is not possible to identify a possible neurobiological mechanism; it is not possible to define determinant social or environmental causes; TOD does not refer exclusively to the child's suffering, but also to the problems they cause to the family, school, peers; its identification occurs by the strategy of measuring the frequency and intensity of symptoms appearance. We also know that there is no room for an attentive

listening that allows to understand the reasons that lead the child to: express discontent, oppose to external orders, lose temper or questioning authority figures; all are behaviors considered symptoms of TOD.

In front of so many unknowns, there is only one certainty defined in "Development and course": "TOD is one of the major precursors of psychopathology in adult life. Individuals with history of TOD and TC are more likely to present social prejudice in adulthood, have less professional qualification, less labor stability and more cases of divorce." (APA, 2013, p. 464). That is, according to DSM-5, there is a path to disruptive disorders that lead to antisocial personality. This trajectory is presented as an inexorable march.

As said before, disruptive behavior disorders are not explained by neurobiological, social-environmental or psychological causes, but by an alleged future trajectory that includes labor and personal failure, irreversible mental pathologies, as well as supposed acts of delinquency or criminality in adulthood. And it will be in function of this doubtful prognosis, presented under the form of a scientifically established truth, that defends a unified therapeutic intervention.

Figure 1 – From conduct disorder to antisocial personality



Source: Gathright e Tyler, 2014

There are two types of therapeutic proposals to disruptive behavior disorders, and those can be associated or not. On one hand, behavior intervention is proposed, that is, a familiar approach named “parental management”, associated to cognitive behavioral therapy (TCC). On the other hand, a pharmacological treatment is proposed, giving priority to atypical antipsychotics, such as risperidone. Depending on the pattern of comorbidities, the following medications will be included: with anxiety and depression, risperidone will be associated with SSRI antidepressants, and for TDAH comorbidities, it will be associated with Ritalin (Rigau-Ratera; García-Nonell; Artigas-Pallarés, 2006).

The side effects of antipsychotics are well-known. As stated by Pignarre (2006), all the effort that the pharmaceutical industry dedicated, in the last 50 years, to psychiatric drugs in general, and to antipsychotics in particular, seems reduced to find a drug with fewer side effects than the existing in the market.

Regarding the medication prescribed to a child with TOD, the therapy considered the most effective is a controversial, powerful psychiatric drug with several well-known side effects, such as risperidone (Moynihan; Cassels, 2006). We should remember that atypical antipsychotics may cause weight gain and alter the metabolism, increasing the risk of diabetes. They can also cause secondary effects related to motor function, such as stiffness, persistent muscle spasms, tremors and restlessness. Finally, it is worth remembering that the prolonged use of antipsychotic drugs can lead to a condition called tardive dyskinesia (DT), which prevents the individual to control muscular movements. leading commonly to stiffness in the mouth. In certain cases, it can also lead to neuroleptic syndrome, a serious side effect, associated with mental alterations, rigid muscles, hyperthermia, psychomotor alterations and signs of autonomic instability. Serious effects of a recommended therapy although there is no defined neurobiological cause.

To conclude

In his book *Saving normal*, Allen Frances (2013b) states that the increase in rates of mental disorders

in population occurs in two ways: (1) through the creation of new diagnoses that transforms behaviors common in society in pathological, which the pharmaceutical industry will popularize (in the case of TOD, lose temper, get angry, feel disturbed, resisting to adults and authority’s orders); and (2) establishing a lower diagnostic threshold to many existing pathologies, as occurs when common behaviors become a risk factor to an irreversible mental disorder (Frances, 2010, 2013b). In this context, we should note the apparently minor change that is established between DSM-IV and DSM-5 regarding oppositional defiant disorder. Until 1994, in DSM-IV-TR, TOD was part of “Disorders usually first diagnosed in infancy, childhood, or adolescence”, together with many other disorders.

In DSM-VI, TOD and conduct disorder excluded each other, that is, they could not exist at the same time. On the contrary, in DSM-5, TOD and TC can coexist, and TOD has a privileged place of risk marker to a set of behaviors considered socially threatening, behaviors that occupy an intermediate place between medical and juridical, associated to “conduct and antisocial disorders”, such as: violates others’ rights, physical harm and property damage, delinquency, deceitful and serious violations of social rules.

It is true that this supposedly performative dimension of TOD, that leads to believe that the child with TOD will be an adult in conflict with law or with a severe psychiatric behavior, was already present in studies on development psychiatry. But this ambiguous assumption was integrated explicitly to DSM-5 in 2013, as we tried to show here.

To conclude, we would like to resume to the study mentioned before (Serra-Pinheiro et al., 2004, p. 275). We see that, even though the article presents a succession of inconclusive studies, it finalizes with the definition of the recommended treatment. It repeats, once more, the importance of articulate pharmacological treatment with behavioral therapy and states that:

Therapeutic approach should probably vary according to the presence of comorbidity. Stimulants and clonidine seem effective for ODD symptoms

comorbid with ADHD, with methylphenidate being able to induce remission in ODD in a large proportion of patients with ADHD comorbid with ODD. Valproic acid, haloperidol, risperidone and lithium are probably more effective when there is notable mood instability.

It is worth mentioning that, in the end of the article, the conflicts of interest are shown, indicating that the main author “is on the advisory board of, is a speaker for, or has received funding from Pfizer, Janssen-Cilag, Eli Lilly, Wyeth, Novartis, and GlaxoSmithKline.” (Serra-Pinheiro et al., 2004, p. 275)

We have, then, another example of how the pharmaceutical industry operates in increasing rates of mental disorders in the population, in this case turning behaviors common in society in pathological, such as losing temper, feeling disturbed, resisting authorities’ or adults’ orders, which DSM transformed in psychiatric symptoms and which the pharmaceutical industry will spread and popularize through assisting researches, research funding, disclosure in medical congresses etc.

From what was stated here, it is worth mentioning that the pharmaceutical industry occupies only a part in this complex tangle of childhood psychiatrization, because, to make acceptable and legitimate the use of drugs with severe side effects—as occurs with atypical antipsychotics—, it was necessary that, initially, the categories proposed by DSM gained respectability, acceptance and recognition as a scientific discourse. A discourse that, however, as we tried to show, is permeated by a severe epistemological fragility. Its validation does not occur, as in general medicine (Foucault, 1987, 2003), through biological or neurobiological markers, but through references to doubtful risk studies, inconsistent statistics about an alleged pathological trajectory, in which children with TOD are destined to failure, delinquency or insanity in adulthood if the recommended therapy is not accepted.

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