CONSIDERATIONS ON THE PRESCRIPTION OF PSYCHODRUGS IN EARLY CHILDHOOD: THE CASE OF CHILDHOOD DEPRESSION

CONSIDERAÇÕES SOBRE A PRESCRIÇÃO DE PSICOFÁRMACOS NA PRIMEIRA INFÂNCIA: O CASO DA DEPRESSÃO INFANTIL

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ABSTRACT: Taking as a starting point the motors for modeling people proposed by Ian Hacking, I analyze the motors involved in the definition of childhood depression. I consider psychiatric classifications, psychometric scales, the neurochemical imbalance hypothesis, particularly serotonin deficits, as well as the supposed efficacy and adverse effects of antidepressants, such as selective serotonin reuptake inhibitors (SSRIs). I argue that these strategies induce a complete transformation in the way children think of themselves, causing a loop effect in the way they define their self, emotions, and behaviors, while silencing the social causes of suffering.

KEYWORDS: Depression. Childhood. Antidepressants. DSM. Social causes.

RESUMO: Tomando como ponto de partida os motores para modelar pessoas propostos por Ian Hacking, analiso os motores envolvidos na definição de depressão infantil. Considero as classificações psiquiátricas, as escalas psicométricas, a hipótese de desequilíbrio neuroquímico, em particular o déficit de serotonina, bem como a suposta eficácia e efeitos adversos de antidepressivos como os Inibidores Seletivos da Recaptação de Serotonina (ISRS) (Selective serotonin reuptake inhibitors SSRIs). Argumento que estas estratégias induzem uma transformação completa na forma como as crianças pensam sobre si mesmas, causando um efeito looping na forma como definem o seu self, suas emoções e seus comportamentos, ao mesmo tempo que silenciam as causas sociais dos sofrimentos.

PALAVRAS-CHAVE: Depressão. Infância. Antidepressivos. DSM. Causas sociais.

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RESUMEN: *Tomando como punto de partida los motores para modelar a las personas propuestos por Ian Hacking, analizo los motores que intervienen en la definición de la depresión infantil. Considero las clasificaciones psiquiátricas, las escalas psicométricas, la hipótesis del desequilibrio neuroquímico, en particular el déficit de serotonina, así como la supuesta eficacia y los efectos adversos de los antidepresivos, como los inhibidores selectivos de la recaptación de serotonina (ISRS). Sostengo que estas estrategias inducen una transformación completa en la forma en que los niños piensan sobre sí mismos, provocando un efecto de bucle en la forma en que definen su yo, sus emociones y sus comportamientos, al tiempo que silencian las causas sociales de los sufrimientos.*

PALABRAS CLAVE: *Depresión. Infancia. Antidepresivos. DSM. Causas sociales.*

Introducion

Daily, we observe in the media, in schools, in family relationships and in social networks, how this process was naturalized by which emotions and behaviors typical of childhood, which until recently were considered normal, came to be considered as psychiatric pathologies that can be diagnosed according to the parameters of normality and deviation established by Diagnostic Manuals such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Thus, any deviation from the supposed normality will be presented as a disease, stating that, in the same way as any organic disease whose biological cause is already known, it must be treated with medical-pharmacological interventions. Thus, the prescription of psychotropic drugs in early childhood was spread as a natural fact, arguing that in this way it would be possible to avoid the chronicity of an irreversible psychiatric pathology in adult life.

It is often said that this increase in the number of diagnoses is due to the appearance of more accurate identification mechanisms of diseases that would have made it possible to detect subclinical symptoms, which previously went unnoticed in early childhood, now detectable through increasingly accurate psychometric tests and scales. This perspective of analysis, today hegemonic, while depoliticizing psychic suffering, ignoring the social contexts that cause sadness and helplessness, affirms that there have always been children with mental disorders, but that only now we have the scientific advances that allow us to identify the symptoms of a psychiatric illness that may cause an abnormal development.

Authors from the field of critical psychiatry such as Sami Timimi (2021; 2018) or Allen Horwitz (2002) and social scientists such as Nicolas Rose (2019) and James Davis (2021), among others, have shown the weakness of this explanatory model based on medical categories.

They insist that there is little or no evidence on the supposed neurochemical causes that would explain the origin of these mental disorders.

Timimi (2018), for example, considers that there are two other possibilities to explain the dramatic increase in mental disorders in childhood. The first is that, in fact, it is possible to affirm that there is a real increase in psychological suffering and socially unwanted behaviors in childhood, but that this increase would be linked to social, economic and environmental changes resulting from the demands and the spirit of competition typical of neoliberal societies, whose direct impacts on the way of organizing family and individual life, have been well studied by authors such as Christian Laval and Pierre Dardot (2016). The second possibility refers to a social change in the way we manage our emotions and, consequently, in the way we connect with children's emotions and behaviors. This occurs when parents and teachers turn feelings of sadness or frustration, or their children's unwanted behaviors, into medical problems.

Timimi (2018) understands that these two possibilities, the increase in psychological distress in childhood, and the change in the way of naming feelings using medical and diagnostic categories, are not mutually exclusive, but interact as two phases of the same phenomenon. We can say that currently, certain cultural and environmental changes produce an increase in certain emotional and behavioral problems in childhood, changing our perception of the mental health of children and adolescents. Unfortunately, this new perception favors a medical approach to suffering, emotions and behaviors, changing our way of managing conflicts and our daily practices of education and care. These changes caused by the medicalization of everyday suffering, in turn, contribute to creating new health problems in the field of childhood (TIMIMI, 2018).

The iteration between the way we designate the subjects and the subjectivation process can be explored from what Ian Hacking (2007) calls the looping effect. He will say that in order to understand the true dimension of this interaction between the way we name emotions and behaviors and the process of construction of subjectivity, it is necessary to locate a key element between the name we give to classified people, in this case to children, and the processes of subjectivation linked to these names. Hacking (2007) considers that for a category, in our case a diagnosis, to produce effects on classified subjects, it is necessary to rely on the mediation of a third element, those who are considered "experts", in health, education or child development.

We know that when we classify people, when we assign them a diagnosis, there will inevitably be consequences for these subjects. This means that creating classifications, defining "types of people", necessarily implies creating an interactive relationship. But, for a name or a category to start its creative work (HACKING, 2006), it is necessary, first of all, that the one

who speaks, the one who enunciates a classification or a diagnosis, the one who places us inside this or that category, is imbued with a certain power or recognition. It will be necessary that there is a certain authority conferred on the subject of enunciation, an authority conferred by certain institutions, such as the school, medical knowledge or psi knowledge.

So, for a classification to have any effect on the classified subjects, there are at least five variables that are at play: (1) people situated within the category, in our case, children identified with the category of childhood depression ; (2) the category of infantile depression that will appear with force in the year 1990; (3) the experts (educators, psychologists, psychiatrists, pedagogues, neurologists or pediatricians) capable of classifying these children as being depressed; these experts must be located in (4) institutions such as schools, hospitals, health centers etc. These institutions must build their classifications from a certain type of (5) knowledge (HACKING, 2007), constructed from tests, measurement scales, normality and deviation curves, which allows differentiating a depressive child from a non-depressive child. For these experts, today this knowledge is objectively defined in the ICD-10 and the DSM-5 (APA, 2013).

In the last 20 years, the importance of expert knowledge in the field of childhood has grown. Increasingly, parents, family members and teachers turn to "experts" to guide them in the management of children's development and education processes. According to Timimi (2018, p. 2, our translation):

> It seems to me that we have professionalized the growing process to the point that many parents and other adults in caregiving positions (such as teachers) are afraid to actively intervene to guide the children in their care. They may feel that they need an "expert" to better understand what is the right thing to do with their children.

Through expert knowledge, children are measured, compared and classified using pre-defined norms and guidelines. Although it is not possible to say that there are two identical ways of constructing classes of subjects, it is possible to identify certain strategies that these expert knowledges use to create categories of people. Hacking (2006, 2007) called this set of strategies "engines to model people" (HACKING, 2006, p. 12; 2007, p. 14, our translation).

These engines are described as: (1) Count; (2) Quantify; (3) Create standards; (4) establish correlations; (5) medicalize; (6) biologize; (7) transform into genetic; (8) Normalize; (9) bureaucratize; (10) claim identity.

The first four are identification engines and the last four are intervention engines, the last being a subjectivation engine, the one that refers to (10) claiming identity. Although, when

assigning a diagnosis to a particular child, the identification engines precede the intervention engines, it is necessary to emphasize that the historical construction of the diagnosis of childhood depression emerged as a consequence of an explanatory inversion: it was from the appearance of a antidepressant that could be considered suitable for consumption in childhood, that is, from the preexistence of intervention engines, that the diagnostic category was consolidated and disseminated. When we refer particularly to the diagnosis of childhood depression and place this category in the network of experts linked to hegemonic biological psychiatry, we will see that the privileged strategy for normalizing behavior will be the prescription of an antidepressant. Since the appearance of a type of antidepressant, the Selective Serotonin Reuptake Inhibitors (SSRI), particularly with the appearance of Prozac, the diagnosis of childhood depression has become an increasingly widespread medical category in the childhood field. We see that the discovery engines presented by Hacking (2006) appear distributed in a very peculiar way when we refer to the category of childhood depression.

On the other hand, and considering the serious side effects of antidepressants in childhood, as well as the insistent affirmation that depression will accompany children throughout their lives, it seems inevitable to imagine that both the enunciation of the diagnosis and the use of drugs, constitute severe limitations for the creation of a subjectivation process capable of opposing or resisting this attribution of identity.

The identification engines in childhood depression

Depression as a mood disorder in adults is an old acquaintance that appears in the Diagnostic and Statistical Manuals of Mental Disorders referenced, in one way or another, since 1952 (APA, 1952). However, childhood depression in the field of psychiatry has a historical moment of birth, which is very recent.

In the 1980 DSM-3 (APA, 1980), there is no reference to childhood depression; however, in the DSM-IV (APA, 1994) the symptoms previously presented for adults are extended to children as well. It will only be in the year 2013, in the DSM-5 (APA, 2013), that the diagnosis appears with some characteristics that differentiate it from the diagnosis in adults under the name of Disruptive Mood Dysregulation Disorder.

> For the Diagnostic and Statistical Manual of Mental Disorders-5, disruptive mood dysregulation disorder is a new diagnosis referring to the presentation of children with persistent irritability and frequent episodes of uncontrolled behavior. These characteristics refer to depressive disorders in children aged

> 6 to 12 years (FERNANDEZ LIMA; SCHÜNKE; MOSMANN, 2020, p. 56, our translation).

From that moment on, it will be repeated over and over again that the high rates of childhood depression found by national and international studies justify the need for research that more accurately assesses depression in children. In the same sense, the website of the Institute of Developmental Psychiatry for Children and Adolescents (INPD, Portuguese initials) states that there are symptoms that differentiate depression in adults and children, they are: "exaggerated irritation, drop in school performance and social withdrawal" (INPD, 2021, [n.d.]). The same symptoms identified as central by experts in the field of psychiatry reappear in the field of pediatrics, advocating the attribution of this diagnosis also to very young children, of preschool age.

> In preschool children (under six years of age), the most common clinical manifestation is represented by physical symptoms, such as pain (especially in the head and abdomen), fatigue and dizziness. Goodyer cites that approximately 70% of cases of major depression in children have physical complaints. Complaints of physical symptoms are followed by anxiety (especially separation anxiety), phobias, psychomotor agitation or hyperactivity, irritability, decreased appetite, and sleep disturbances (BAHLS, 2002, p. 260, our translation).

We can imagine that the loss of the pleasure of playing, difficulties at school, changes in sleep and appetite, agitation, can be simple manifestations of the fact that these small children, with difficulty in verbalizing their emotions, may be going through adverse situations, such as sexual abuse, isolation, bullying, parental abandonment, being object of racism, feeling sadness for difficulties that the family is going through, or problems with relationships with family and friends.

The literature in the field of psychiatry, medicine and pedagogy, areas that directly participate in the process of building the diagnosis of depression in childhood, for a long time maintained that depression could only occur in adults. Later, people began to talk about depression in adolescents, then about depression in school-age children, and in recent years, the literature dedicated to talking about depression in children under 6 years old, that is, in preschool age, begins to appear timidly. There are still few studies dedicated to this age group, as Mariana Rangel Pande, Paulo Duarte de Carvalho Amarante and Tatiana Wargas de Faria Baptista (2020) point out. However, the attribution of diagnoses or the prescription of psychotropic drugs in early childhood seems to be a more frequent occurrence than the literature shows. For example, Joan Luby's work, published in 2010, *Preschool Depression: The Importance of Identification of Depression Early in Development*, points out what she considers

to be a serious error in psychiatry and psychology. The mistake is that they did not bother to identify the existence of depression in very young children, two and three year olds, beforehand. For Luby (2010, p. 91, our translation): "The longitudinal continuity of preschool depression to school age was established, suggesting that preschool depression is an early manifestation of later childhood disorder".

These arguments are tirelessly repeated to justify the identification of psychiatric pathologies in childhood, although there are multiple references to the fact that early psychiatrization of behavioral or emotional problems may be the gateway to a succession of new psychiatric diagnoses to be treated with new drugs. This is what is portrayed in the study analyzed by Pande, Amarante and Baptista (2020) in the text "*Este ilustre desconhecido*". The research by Silva *et al*., referenced there, seems to indicate that it is necessary to be very careful when we say that early identification is a protective strategy for children's lives. There we read that:

> A total of 348 medical records from a health service in Rio Grande do Sul were analyzed between 1998 and 2008. The study showed that children (of preschool age) who used medication stayed longer in the service, and had less discharge and improvement records than those in psychotherapy alone. It also identified that, over the years, the number of children who entered the service decreased, but the number of those medicated increased (PANDE; AMARANTE; BAPTISTA, 2020, p. 2307, our translation).

This study indicates that it does not seem to be as effective to anticipate and diagnose a child in early childhood, as they may remain longer with the diagnosis and, consequently, longer using antidepressants. On the other hand, it seems to be difficult to separate this new diagnosis from other psychiatric illnesses prevalent in childhood. There are overlaps, comorbidities, and multiple diagnoses, a fact that seems inevitable when we consider the similarity of symptoms that define childhood psychiatric conditions, such as Attention Deficit Hyperactivity Disorder (ADHD), anxiety, depression, and Oppositional Defiant Disorder (ODD) or childhood depression.

We are thus witnessing a true diagnostic inflation in the field of childhood. According to the World Health Organization (WHO) up to 20% of children and adolescents have disabling mental illnesses in the world. In Brazil, the data are similar, "a 2005 Ministry of Health document revealed that between 10 and 20% of children and adolescents would suffer from mental disorders and, among these, 3 to 4% would need intensive treatment" (PANDE; AMARANTE; BAPTISTA, 2020, p. 2306, our translation). A fact that has worsened severely as the end of the pandemic approaches.

There is talk of the need to identify depression in early childhood because it will be said that this is a disease that directly affects the brain and that can interfere with development. However, early psychiatrization of behavioral or emotional problems seems to be the gateway to a succession of new psychiatric diagnoses, which will be treated with new drugs.

Thus, we see that the starting point of the identification engines is the creation of the norms defined by the DSM. Based on these diagnoses, the cases will be counted, insisting on the importance of carrying out an early detection, even earlier, presenting alarming numbers of the impact that would be in adolescence and in their adult life, to stop intervening and treating children. For example, the website of the Brazilian Society of Pediatrics, reported in 2019, that: "Although the real prevalence of childhood depression is still unknown in Brazil, it is estimated that the disease is becoming a public health problem, as data from attempts to or consummation of suicides have increased in adolescence and at an increasingly early age" (SBP, 2019, [n.d.]).

Arguments like this lead to the creation of a real industry of identifying cases of childhood depression at an increasingly early age. Well, it can be said that in this way it is possible to avoid or anticipate the occurrence of suicide attempts in adolescence. In this context of alarm, efforts to enumerate (count) the number of children who supposedly suffer from psychiatric disorders in early childhood has multiplied in the literature over the last 10 years, presenting data and studies carried out with increasingly younger children. For example:

> In the birth cohort study carried out in Pelotas, Rio Grande do Sul, with the aim of investigating the early onset of psychiatric disorders in 2004, 4,231 babies were evaluated, along with their mothers, in the first 24 hours of life. (...) 3,585 children (84.7% of the original cohort children) were reassessed when they were 6 and 7 years old. The prevalence of mental disorders was 13.2%, and the most frequent conditions were anxiety disorders, attention deficit/hyperactivity disorder, oppositional defiant disorder or depressive disorder. 17% had some comorbidity (FERNANDES LIMA; SCHÜNKE; MOSMANN, 2020, p. 55, our translation).

If we analyze this data from the engines to model people, proposed by Hacking (2006), we will see that in order to count the cases (engine 1) and establish correlations (engine 4), from the definition of a set of norms (engine 3), it will be necessary to quantify (engine 2) these norms that were defined by the DSM, based on certain specific instruments. This second engine, quantification, has become a real battleground to build and validate instruments to assess childhood depression.

Thus, a set of psychometric assessment strategies was built, leaving peripheral countries, such as Brazil and other Latin American countries, limited to carrying out the validation process of tests and scales carried out in internationally recognized research centers.

It disregards the fact that these tests and these scales were created in social and cultural contexts that have little or nothing to do with the daily lives of Brazilian or Latin American children. At the same time, studies proliferate that have dedicated themselves to showing the subtle differences that exist between the rating scales for depression in adults and children.

There are inventories or assessment scales carried out by health or education professionals and self-assessment inventories. The most used self-assessment scale in educational and health contexts is the *Children's Depression Inventory* (CDI) I and II (CDI.II, 2022), considered the most common instrument for identifying depressive symptoms in childhood and whose application takes an established time set between 5 and 15 minutes. This is the first instrument designed to study the symptoms of depression in childhood, it was proposed by Maria Kovacs in 1979, and is still used today. This self-assessment scale has 27 items and is intended to identify symptoms of depression in school-age children, the objective of this standardization is not limited to carrying out epidemiological, population-based and comparative studies between different countries, they have a very clear clinical intention, coming to be considered as the best strategy to make a diagnosis of childhood depression. For many professionals in the field of education and the psi field, "objective assessments, such as questionnaires, self-assessment scales and inventories, are the most applied instruments and are preferred over clinical interviews" (CRUVINEL; BORUCHOVITCH; SANTOS, 2008, p. 472, our translation).

There are several works dedicated to validating international childhood depression assessment scales in Brazil, such as the Child Depression Inventory - CDI: adaptation study with students from João Pessoa (GOUVEIA *et al*., 1995) or the *Escala de Avaliação de Depressão para Crianças* (Depression Rating Scale for Children) (BARBOSA *et al*., 1997). However, these and similar works share exclusively technical concerns. The problems presented in choosing one or another rating scale are exclusively quantitative and statistical. Data such as risk factors, cut-off point, exploratory factor analysis and internal consistency, variables involved are indicated, but nothing is said about the world or the children's life context. The concern is to offer tests and instruments that are increasingly refined from a statistical point of view, which guarantee their suitability for the different stages of an individual's life, from childhood to adulthood. Referring to preschool age depression Joan Luby (2010) argues that:

> A major advance that led to this discovery (of depression in early childhood) was the development of age-appropriate psychiatric interviews, which can assess depressive symptoms as they would manifest in a young child, as

opposed to how they would manifest themselves in an adult. These so-called "age-adjusted symptom translations" are key to capturing depression and other mental disorders in young children (LUBY, 2010, p. 92, our translation).

The adaptation of the assessment instruments for childhood depression used internationally for different countries and for different age groups is considered by many to be the fundamental identification strategy to define the diagnosis.

In the specific case of validation of tests for childhood depression in preschool students, the literature points out some difficulties in applying self-assessment scales, considering that very young children may have difficulty understanding and answering some questions. The solution found by the researchers was to use external evaluation scales. A study by Andriola and Cavalcante (1999), which is widely referenced in the literature on childhood depression, proposes to transform the CDI instrument, so that it can be answered, not by preschool students, but by their teachers. The proposed instrument had 22 items and each of the teachers had to choose five or six students, according to a very ambiguous criterion as students close to the teacher (ANDRIOLA, CAVALCANTE, 1999), to guarantee more reliable answers. The sample consisted of 345 preschool children from the city of Fortaleza (CE), with an average age of 5, mostly girls. In order for the assessment to be considered reliable, the authors state that at least one assumption has to be made: "the measured variable (depression) can be dichotomized, that is, the subjects have depression or not" (ANDRIOLA; CAVALCANTE, 1999, our translation). After the application of this instrument, the researchers concluded that:

> The data that 3.9% of preschool-age children in the city of Fortaleza have a prevalence of depression is in the same percentage range found by studies by the *American Academy of Child and Adolescent Psychiatry* (1996), whose values fluctuated between three and six percent. [...] These data highlight the importance of the diagnosis of childhood depression, because according to the *American Academy of Child and Adolescent Psychiatry*, without the necessary help, serious damage can occur in the child's life, compromising their self-esteem, school performance and personal relationships (ANDRIOLA, CAVALCANTE, 1999, p. 6, our translation).

Finally, what do the authors propose as a necessary intervention, given the high number of cases of depression in preschool students that they seem to have identified? Well, the proposed solution to this complex statistical and mathematical problem proposed by the authors will be none other than pharmacological.

> It happens that, when the child is not treated in time, he may develop behavior patterns that become resistant to change. In specific cases, when the child presents a condition of certain severity. Drug and/or psychotherapeutic treatment is recommended, mainly due to the presence of behaviors and/or

thoughts related to suicide (AMARAL; BARBOSA, 1990 apud ANDRIOLA; CAVALCANTE, 1999, p. 3, our translation).

Thus, we move from the identification engines to the intervention engines, which are mostly focused on psychopharmacological therapeutic interventions.

The drivers of intervention in childhood depression

Marketing focused on the dissemination of the diagnosis of childhood depression, presents the same argument over and over again: "Contrary to what many think, children also suffer from depression". It is stated that depression, which has always seemed to be an illness exclusive to adults, today affects many children and adolescents in the world and that it is necessary to identify childhood depression early to prevent future problems, as it must be considered a precursor of adult depression.

As noted earlier, psychiatrists began prescribing fluoxetine initially to adults, then to adolescents under the age of 18, and finally "began experimenting with prescribing SSRIs in children, urging pharmaceutical companies to promote products aimed at children, such as a liquid version of Prozac to allow the prescription of doses lower than the standard 20 milligram capsule" (TIMIMI, 2021, p. 83, our translation). Thus, between 1992 and 2001, both in the United States and in England, prescriptions for children and adolescents increased tenfold, regardless of whether or not there was authorization from the U.S. Food and Drug Administration (FDA) for use of this drug in childhood. During the same period, the pharmaceutical industry sponsored research to verify the drug's effectiveness in treating children.

> Among SSRIs, fluoxetine is the only agent approved by the Food and Drug Administration (FDA) for use in depression in children 8 years of age and older. It is considered the first choice medication to treat children and adolescents with depression due to its proven efficacy and safety (CURATOLO; BRASIL, 2005, p. 173, our translation).

The argument for the rapid spread of SSRIs is given by the serotonin hypothesis of depression, the idea that there would be an imbalance in neurotransmitters, more specifically a serotonin deficit, which could be reestablished with the drug. The reference to the medical model, but particularly to a neurochemical imbalance, and the insistence that childhood depression is a disease that can be cured with a drug, constitutes the axis around which intervention models in childhood depression are built, even though this hypothesis of a biological (neurochemical) cause of depression has not been demonstrated.

Authors such as Robert Whitaker (2015), Peter Gotszche (2016) and Sami Timimi (2021), focused their work on the existing contradictions in scientific publications dedicated to evaluating the adverse effects of antidepressants, particularly in children, and the double-blind studies that showed the time effectiveness of antidepressants when compared to the use of placebo.

> When Prozac and other SSRIs, described as miraculous, came on the market, the prescription of antidepressants in children was soared. The percentage of children medicated with these drugs tripled between 1988 and 1999, in 2002 one in 40 children took antidepressants in the US (WHITAKER, 2015, p. 279, our translation).

According to Gotszche (2016) this increase was due to an immense marketing campaign, supported by scientific publications that had hidden the reality of the research data. Adverse effects were underestimated or omitted, extolling supposed unproven benefits. In view of the appearance of these studies, the FDA approved the use of Prozac in childhood, however, little later, more and more evidence began to appear of cases of children who committed suicide or had suicidal ideation.

Criticism and complaints about the adverse effects of antidepressants in the field of childhood rapidly multiplied. Some studies, such as "Study 329" published in 2001 and analyzed by Peter Gotszche (2016), in *Psicofármacos que matam y denegación organizada*, were funded by the *Glaxo Smith and Klein laboratory*. This study stated that paroxetine (Paxil), an SSRI, was well tolerated in adolescents, further studies carried out on these same data showed that in fact the result had been falsified and that there was no difference between the group that used the drug and the group that used the Placebo (GOTSZCHE, 2016). Other false claims were discovered in this period and were portrayed in a BBC documentary from London called *Panorana* which reached a huge diffusion. In the book *Insaine Medecine*, Timimi (2021) comments that after the documentary was shown, the BBC received thousands of calls from patients who claimed to experience the described side effects, anxiety, aggressive impulses and suicidal feelings, after taking antidepressants. In light of this information, in 2003 the United Kingdom issued new guidelines to doctors stating that antidepressants should not be prescribed to children under 18 years of age, a fact that managed to reduce the prescription for a period. Returning, shortly afterwards, to the previous parameters of prescription and consumption.

In the United States, a similar movement took place, criticism was piling up, until in 2004 the FDA issued a statement known as the "black box alert", a warning that should be presented on a black background, with the header in capital letters and text printed with bold

letters. This range should be present in the order of prescription of the medication, indicating that the medication has serious side effects, in this specific case it is about disclosing the risk that the medication presents for incitement to suicide, or suicidal ideation, when prescribed for children and adolescents under 18 years old. The "black box alert" statement came in response to a study by nine pharmaceutical companies that found that SSRI treatment doubled the risk of suicide in children when compared with the placebo group. Other evidence against the effectiveness of antidepressant use in childhood has accumulated in recent years. Recently, Peter Gotszche (2021) presented a meta-analysis showing that there was consistent evidence of serious side effects of antidepressants in children medicated with SSRIs, highlighting their addictive and disabling effects, and reiterating that SSRIs may be the cause of the increase in suicides in children.

Despite accumulating evidence, antidepressants continue to be prescribed to adolescents, school-aged children, and preschool-aged children worldwide.

In the specific case of Brazil, it is possible to observe a true covert publicity of antidepressants for childhood and early childhood, with permanent warnings aimed at parents about the risk that would entail not diagnosing and treating the disease early. Even though there are no scientific publications on prescribing antidepressants in early childhood, the recommended treatment is centered on the combination of behavioral therapy and psychiatric drugs, stating that SSRIs make it possible to reestablish the altered balance of neurotransmitters, particularly serotonin. One of the examples of this indication appears in the article "Depression in childhood: peculiarities in the diagnosis and pharmacological treatment":

> Selective serotonin reuptake inhibitors (SSRIs) antidepressants are currently considered the first-choice agents in the treatment of depression in children. These agents are prescribed more frequently because of their proven efficacy in this population, as well as their more favorable profile of adverse effects (CURATOLO; BRASIL, 2005, p. 172, our translation).

Final considerations

We thus observe the engines that participate in the discovery of childhood depression: normalization, through the definition of the diagnosis; biologization, through identification with the application of psychometric scales; cerebralization, through the construction of the hypothesis of neurochemical imbalance, in this case serotonin deficit; pharmacologization, due to the supposed efficacy of Selective Serotonin Reuptake Inhibitors (SSRIs). These strategies induce a complete transformation of the way the child thinks about himself, causing a looping

effect in the way he defines his self, his emotions and behaviors. This looping effect is never univocal, it can lead the child to identify with the label, translating his sadness into medical terms and considering himself sick, or it can cause this child to have a reaction of not recognizing himself as a depressive enunciating those situations that caused suffering, situations such as bullying, racism, sexism or moral or sexual abuse, facts that once stated will allow them to understand their emotions in a non-medical context and thus politicize suffering.

As already mentioned, classifications, once integrated into the lives of individuals, change the way in which they observe themselves. There are certainly multiple forms of interaction between the subject and the classification, however, when it comes to children, and even more so to preschool-age children, once the diagnosis of depression is defined, they will be forced to participate in an identification ritual, precisely because there are instances of bureaucratization (motor 9), which operate in areas such as school, family or social assistance networks, instances that will lead children to think of their suffering in biological terms, as a disease that must be treated with a drug. This identification process can create a label and a stigma of mental illness in children who are experiencing situations of deep sadness due to adverse life contexts, which will be silenced and will remain unchanged from the moment that suffering is individualized, biologized and medicalized.

Limiting yourself to counting symptoms from psychometric scales that define what is normal and what is pathological according to the criteria established by the APA, can lead to silencing real problems and naturalizing situations of violence, abuse, racism, extreme poverty, loneliness or bullying. For, as has already been said, at these scales there is no space to dwell on the accounts of children's lives.

The name we give to people, in this case the diagnosis of childhood depression, can have a decisive impact on the way each individual constitutes himself as a subject (motor 10). For this reason, it seems increasingly necessary to politicize psychic suffering and to think about the individual difficulties and social problems that are implicit in the use of this technology of attribution of identities that leads to disregarding the content of the patients' complaints and recording only what it was defined a priori as relevant by the assessment scales.

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How to reference this article

Processing and publishing: Editora Ibero-Americana de Educação.
Review, formatting, standardization and translation