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A FRAMEWORK FOR CRITICAL DISCOURSE STUDIES ON MENTAL HEALTH

Pedro Gustavo Rieger[1]
[1]Universidade Federal de Alagoas, Maceió, AL, Brasil

Abstract

In this article, I present a framework for critical discourse studies on mental health. By relying on principles belonging to Critical Discourse Studies (Flowerdew & Richardson, 2018; van Leeuwen, 2008; Fairclough, 2018; 2001), and the Sociology of Health (Caponi, 2014; Martínez-Hernáez, 2014; Mitjavila, 2015; Rose & Abi-Rached, 2014), at first I introduce a brief contextualization of Critical Discourse Studies as a field of research and establish connections between this field and mental health studies. In the sequence, I present a framework divided into 8 stages focused on the investigation of social practices involving mental health. These stages are then applied to the analysis of a judicial decision produced by the Superior Court of Justice in Brazil involving the diagnosis of Attention Deficit and Hyperactivity Disorder. The analysis reveals ADHD has a neuropolitical function and that authority related to the diagnosis is vested in medical expertise only, despite the lack of biological markers for it.

Key-words: critical discourse studies; mental health; attention deficit and hyperactivity disorder; neuropolitics; judicial discourse.

* Professor da licenciatura em Letras-Inglês na Universidade Federal de Alagoas (UFAL). Possui doutorado em Inglês: Estudos da Linguagem (PPGI/UFSC), mestrado em Inglês: Estudos Linguísticos e Literários (PPGI/UFSC) e graduação em Letras Inglês (DLLE/UFSC). É membro do Núcleo de Estudos de Gênero através da Linguagem (DLLE/PPGI/UFSC) e do grupo de pesquisa GEDEALL - Grupo de Estudos Discurso, Ensino e Aprendizagem de Línguas e Literaturas (UFAL). Atua nas seguintes áreas: estudos críticos do discurso; linguagem e saúde; linguagem e gênero; ensino-aprendizagem de língua inglesa. E-mail: pedro.rieger@fale.ufal.br. ORCID: https://orcid.org/0000-0002-3673-5565.

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First words

This article presents a framework for critical discourse studies on mental health. To do so, it relies on theoretical and methodological principles belonging to Critical Discourse Studies (Flowerdew & Richardson, 2018; Fairclough, 2018; 2001; van Leeuwen, 2008) and the Sociology of Health (Caponi, 2014; Caponi & Brzozowski, 2012; Mitjavila, 2015; Rose & Abi-Rached, 2014; Martínez-Hernáez, 2014). The framework is divided into 8 stages that seek, in general, to identify a social practice involving mental health in order to investigate discourses, social roles, and social functions implicated in it. To provide an example of the application of this framework, I analyze one judicial decision produced by the Superior Court of Justice in Brazil involving the diagnosis of Attention Deficit and Hyperactivity Disorder (ADHD). The analysis reveals that ADHD has a neuropolitical function in the judicial decision, working to keep an adolescent deprived of liberty. Moreover, it reveals that psychiatrists might be given more authority when compared to a multidisciplinary staff producing reports about social actors who have been diagnosed. At the end of the text, in the form of a meta-analysis, I briefly discuss aspects that can be considered and included in further analyses of similar texts.

Critical Discourse Studies and the Sociology of Health: an interdisciplinary dialogue

Critical Discourse Studies constitute a social, critical, and interdisciplinary field of research (Flowerdew & Richardson, 2018). If we understand discourse as ways of representing and constructing reality, we can comprehend CDS as an area inclined to identify social problems, explaining the relationship between such problems, discourse, and the social practices they are involved with, as well as pointing out solutions and courses of action so that these social problems are surpassed (Fairclough, 2018; 2001). According to Wodak (2001) and Fairclough (2001), the critical aspect of CDS relates to a sociologically and informed vision of society that results in political and social engagement with the aim of attending the interests of those who suffer and are oppressed the most in society - as it is the case of sociopolitical minorities of race, gender, class, among others. The critique is, within this context, related to "making visible the interconnectedness of things" (Fairclough, 1985:747 cited in Wodak, 2001).

Given the interdisciplinary status of CDS, in my analysis, I rely mainly on the Sociology and Anthropology of Health (Caponi, 2014; Caponi & Brzozowski, 2012; Martínez-Hernáez, 2014; Mitjavila, 2015; Rose & Abi-Rached, 2014) in order to interpret and discuss data involving mental health. Moreover, the analysis has been done by reference to categories proposed by van Leeuwen (2008) for critical discourse studies involving the representation of social actors and the construction of legitimation in discourse. Taking that into consideration, I shall

briefly present some of my main findings in these different areas of expertise that support and inform the discussion I develop.

The sociology and anthropology of health are fields of research concerned with the explanation of health conditions and practices from sociological and anthropological standpoints. Therefore, in the present case, this implies the adoption of a social framework for mental health - which, besides explaining mental health in sociological terms, also contests medical power and narratives produced about health conditions and practices centered on medical expertise and biological explanations only.

According to the World Health Organization (2001:1), mental health can be defined as:

> a state of well–being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Even though mental health is frequently associated merely to the absence of mental illness, or, in some cases, to the absence of brain dysfunction only, we may infer from the WHO (2005) that there are multiple factors affecting it, such as our gender, race, education, social class, physical, mental and social well-being. Moreover, from the definition presented above, we may also infer that mental health has qualitative aspects affecting it and should be as well evaluated in qualitative terms. Therefore, reducing mental health to narratives about the brain only and/or centered on medical terms and expertise implies reducing human subjectivity to brain function or dysfunction and medical conditions, denying all the previously cited aspects that influence our states of mind. This type of reduction produces medicalizing neuronarratives about mental health - since these narratives are, in part, the result of what Conrad (2007) addresses as the medicalization of society: when human capacities, capabilities, and subjectivities become subject to medical intervention and are treated and explained in medical terms.

Neuronarratives are a limited way of explaining social reality and, more specifically, mental health though. If human subjectivity, capabilities, and capacities are explained in terms of brain functions and medical expertise only (as, for instance, by reference to psychiatric expertise alone), the social structures that produce human ideologies, social norms, and behaviors are dismissed. If we take into consideration that deviant behaviors of social norms have been historically and continuously classified as mental disorders (Caponi, 2012; 2014), and that these are at times explained in medical terms, solutions to fit social norms will also be explained in terms of medical and/or brain knowledge to address mental health. This implies a concentration of power to explain social reality and social identities in the hands of those who are vested with the authority of knowledge about mental health and brain functioning - in general, psychiatrists and neurologists. Within this context:

> Caponi (2014) claims that neuronarratives gained prominence in a specific historical moment. According to the author, if on the one hand in the past patients' reports were central to the understanding of their clinical history, on the other hand, in contemporary societies such reports serve as a basis for the construction of neuronarratives, which associate the patient's' behavior to neurobiological dysfunctions. (Rieger, 2019:58)

Neuronarratives are key narratives to social control through brain knowledge, here referred to as a form of neuropolitics. In that sense, Rose and Abi-Rached (2014) define the neuropolitics of the population as the attempt to achieve social control through the brain. In short, neuropolitics implies that medical knowledge about the brain can explain, alone, why someone acts in a certain way. It is, therefore, a practice of social control through the brain, or in other words, through narratives produced about the brain by medical experts explaining social behavior and social identities. In turn, if neuronarratives explain human capabilities, capacities, and subjectivity in terms of brain functions or dysfunctions (Martínez-Hernáez, 2014) and they are centered on medical expertise, they can be, as a consequence, essential to the achievement of any social control by medical and - as it is the case of the judicial decision presented in this article - judicial institutions.

Since medicalizing neuronarratives are produced by language use, adopting discourse approaches to interpret them, combined with sociological frameworks, seems to be appropriate. Having that in mind, in this article I rely on Critical Discourse Studies in order to analyze and discuss data involving such narratives. To do so, I focus on two groups of analytical categories proposed by van Leeuwen (2008) for CDS and incorporate them into the framework I present: the discursive representation of social actors and the discursive construction of legitimation - since I attempt to focus on how social actors are represented in a narrative produced about ADHD, and since the narrative I am focusing on has been produced by a judicial court when judging a Habeas Corpus, a genre with a high concentration of legitimizing arguments. It is worth highlighting that I do not intend to conduct a linguistically oriented form of analysis at first if we consider this to be a predominantly grammar-oriented form of analysis, but rather discuss the sociological implications behind certain forms of representation and construction of reality in discourse, as for instance those of social actors who have been diagnosed with ADHD, and how legitimation is discursively constructed regarding a social practice involving mental health.

According to van Leeuwen (2008), social actors can be referred to in several ways, and the semiotic choices we make in representing social actors in relation to a given social practice reveal our position in relation to that practice as well as the position we place the social actors being represented in discourse. In the case of a judicial decision involving ADHD, the semiotic choices made by a single judge or judges "reveal different ways of understanding/referring to social phenomena and constructing social identities" (Rieger, 2019:73), and in this case, different

ways of understanding and referring to ADHD and constructing the identity of a social actor who has been diagnosed with it.

Legitimation, on the other hand, "is a framework proposed by Van Leeuwen (2008) for the analysis of how legitimacy is attributed in discourse" (Rieger, 2019:77). In sum, the aim of this framework is to interpret how social action is legitimized in discourse, or, in other words, how social actors and institutions justify why something has been done the way it has been done. According to the author, legitimation can be constructed by means of authorization (when voices of authority are used to legitimize social actions), moral evaluation (when things and/or people are represented by reference to a positive or negative value), rationalization (when legitimation is constructed in terms of the purposes and effects attributed to a certain action), mythopoesis (when legitimation is constructed by reference to a story, or by storytelling that makes reference to a positive or negative ending), and finally multimodal legitimation (when legitimation is produced by reference to multiple semiotic systems). In the framework I present, attention was given to legitimation through authorization and rationalization, considering that in judicial discourse it is common to find voices of authority as expert witnesses - and, in the judgment of the Habeas Corpus I analyze, these voices were included with the purpose of preventing an adolescent charged with rape and feminicide from returning to social life.

Finally, before I move to the presentation of the framework designed, it is important to explain why I focus on discourses produced by a judicial court involving ADHD. According to the Diagnostic and Statistical Manual of Mental Disorders (2013:61), ADHD is classified as a neurodevelopmental disorder with the following characteristics:

> The essential feature of attention-deficit/hyperactivity disorder (ADHD) is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. Inattention manifests behaviorally in ADHD as wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension. Hyperactivity refers to excessive motor activity (such as a child running about) when it is not appropriate, or excessive fidgeting, tapping, or talkativeness.

However, the same document affirms that "no biological marker is diagnostic for ADHD" (61). Therefore, if ADHD does not present a biological marker, we should ask ourselves: why is it commonly treated in terms of a psychiatric and neurobiological condition (for which medical experts even prescribe psychopharmaceuticals aiming at its control)? The answer to this question might come from what Caponi and Brzozowski (2012) address as a biological determinism in the case of ADHD - its inadequate classification as a neurobiological disorder despite the absence of biological markers attesting to it.

Besides that, the National Council of Health in Brazil claimed in a document published in 2015 that the country currently occupies the second position in the

world in relation to the consumption of methylphenidate, used to treat social actors who have been diagnosed with ADHD. In that sense, “there has been an increase of 775% in the consumption of methylphenidate between 2003 and 2012” (Rieger, 2019:34), in spite of the fact that ADHD can not be confirmed by any lab test (Brazil, 2015). The diagnosis is constructed on a discursive basis only, enough to legitimize the prescription of methylphenidate. In view of this scenario, if the consumption of methylphenidate has increased that much, we may take for granted that so has the number of social actors diagnosed with ADHD. However, there are inconsistencies related to the diagnosis and to the treatment itself. In that sense:

> the Agency for Health Care Research and Quality (USA, 2011), after evaluating the main publications concerning the use of methylphenidate to treat social actors who have been diagnosed with ADHD, discarded most of the studies conducted between 1980 and 2010 due to inadequate methodological procedures and their lack of consistency. Studies with consistency and adequate methodological procedures have shown that there is little evidence of good results from the use of methylphenidate, when compared to other therapeutic approaches, such as family orientation. (Rieger, 2019:35)

Taking that into consideration, we may infer that qualitative approaches (such as family orientation) to ADHD can be more effective than those involving psychiatric expertise only, and, consequently, pharmacological intervention. Keeping that in mind, it seems urgent that multiple fields of research engage in the investigation of discourses involving ADHD and mental health in general, especially those produced by institutions of social control and social regulation, such as medical and judicial ones - in an attempt to document which voices are given authority in these discourses, how ADHD is treated/represented within them, and by means of what arguments and terms legitimation is constructed in relation to mental health.

Discourse on mental health: 8 analytical stages

The framework designed for research on discourses about mental health is presented in this section. It has been divided into 8 stages that can be adapted by social scientists (anthropologists, discourse analysts, linguists, sociologists, among others) who aim at investigating social practices involving mental health. To a great extent, notably, it has been inspired by the framework proposed by Fairclough (2001) to Critical Discourse Analysis in social scientific research. From stage 2 forward, each will present a set of questions that can be answered through the analysis of texts, and these questions are simply an attempt to make each stage’s purpose clearer:

a. **focus on a social practice with a semiotic aspect involving mental health**

b. **identify if there are social actors being represented and, if so, how:** are they included, backgrounded, nominated, categorized, functionalized - and, if so, in what terms and social roles?

c. **identify which social actors and/or institutions are given authority in the social practice:** for instance, diagnosed patients, medical experts, a multidisciplinary staff, and non-experts? Is/Are any of these social actors and/or institutions given more or less authority?

d. **identify if mental disorders are mentioned and, if so, how they are treated and/or legitimized, and what their function is in the social practice:** are they treated in medical and/or neurological and/or biological terms only, or are they treated in terms of the social structures and social problems that result in idioms of distress and mental health harm? How are diagnoses legitimized? Do they have a function in the social practice being investigated?

e. **identify the existence of public policies and/or official guidelines addressing the mental health issue that is being focused on:** what policies and/or official documents address or are involved with it? In what terms are they constructed, and what types of solutions do they present to the mental health issue in question?

f. **identify how elements of the social order relate to the mental health issue being investigated through interdisciplinary research:** is the social order in a sense benefitting from the discourse produced, and/or is the discourse necessary to establish social orders and/or social and institutional roles?

g. **present alternatives for the discourse being analyzed:** what are alternative perspectives (discursive, linguistic, sociological) to approach the mental health issue and/or the social practice being investigated? Are changes in discourse somehow necessary?

h. **meta-analysis:** what aspects has the analysis not covered, and in what ways can it be used to support official and institutional guidelines involving the social practice under investigation?

Analysis and discussion

In this section, I present the analysis of one judicial decision produced by the Superior Court of Justice (STJ) in Brazil in 2017. The Habeas Corpus 388920 was filed to the STJ in favor of the accused after its denial by a State court. It

can be found through the combination of the words *hiperatividade* and *estupro* in the STJ jurisprudence website, among a total of six decisions resulting from this combination. A summary of the Habeas Corpus can be read in the following table:

Table 1 – Summary of the Habeas Corpus

Date	February, 22nd 2017 - HC 388920 retrieved from https://scon.stj.jus.br/SCON/
Summary	A Habeas Corpus had been filed by the São Paulo's Public Defender's Office to São Paulo's State Court claiming for an adolescent's release from the measure of internment. The HC was denied by the State court and the São Paulo's Public Defender's Office appealed to the STJ which, in turn, denied the appeal arguing for the necessity to wait for the 1st-degree judge's final decision, dependent on a psychiatric examination that did not occur. The appellate decision produced by the STJ thus maintained the adolescent, who was charged with rape and feminicide, as an intern at FUNDAÇÃO CASA.
Appellant	São Paulo's Public Defender's Office (Defensoria Pública do Estado de São Paulo).
Arguments supporting the appeal	São Paulo's Public Defender's Office claimed that a multidisciplinary staff had produced an official report arguing that the intern was fit to return to social life since he had accomplished all the objectives established by the Individual Plan of Assistance designed for him during his imprisonment. The Office also claimed that the psychiatric examination requested had been retarded for almost one year, preventing the 1st-degree judge from reaching a final decision.
Decision	The STJ denied the appeal and maintained the previous decision taken by the State court, claiming that it would be necessary to wait for a psychiatric examination so that the 1st-degree judge could determine if the adolescent was fit to return to social life.

Considering that a summary of the Habeas Corpus was presented, I will now move to the analysis following each one of the stages presented in the framework.

In relation to stage 1 - ***focus on a social practice with a semiotic aspect involving mental health*** - the social practice in which I focus is that of judgment, and the semiotic aspect I investigate is that of an Habeas Corpus that resulted in a judicial decision. Judicial decisions are produced by institutional agents with the prerogative of determining whether or not someone has dismissed the law system, and therefore they are vested with the authority of judging. Moreover, higher Courts are vested with the prerogative of changing lower courts' decisions. Judgment, in this case, is a social practice that includes multiple voices (as for instance claimants and appellants, appellees, judges, among others such as expert witnesses) and it necessarily includes a legitimizing narrative grounding the decision. In the present case, mental health is a determining element preceding the decision and its argumentative scheme since the accused has been diagnosed with Attention Deficit and Hyperactivity Disorder (ADHD) and the diagnosis was used to support the denial of the Habeas Corpus impetrated in his favor.

Moving to stage 2 - ***identify if there are social actors being represented and, if so, how:*** *are they included, backgrounded, nominated, categorized,*

functionalized - and, if so, in what terms and social roles? - I will focus on the representations of the only social actor represented within the judicial decision and who has been diagnosed with ADHD - the adolescent charged with rape and feminicide. The adolescent has been referred to as PRPG (1), adolescent (8), juvenile (11), intern (2), patient (9), he/him (5), young patient (1), Paulo Roberto (1), individual (1), Paulo Roberto Pereira Goulart (1). From these examples, we can see that the social actor who has been diagnosed with ADHD was represented through name obscuration, when only the initials of his name were mentioned (as in *This is a Habeas Corpus impetrated in benefit of P R P G)*; by categorization through identification and classification in relation to his age, when he was addressed as 'adolescent' (such as in "*The adolescent is interned", "determining the adolescent's submission to a psychiatric examination*"); by categorization through relational identification, when he was referred to as 'intern' (such as in *"did not point out the socio educational aims that have not yet been achieved by the intern*") and 'patient' (such as in "*the patient social reinsertion*", "*aiming the patient's return to social life")*; by categorization through identification and relational identification, when he was referred to as '*young patient'* (such as in "*illegal embarrassment to the young patient's liberty*"*);* and finally by nomination through unique identification, when referred to as 'Paulo Roberto Pereira Goulart', therefore in reference to his unique identity.

The social actor has been predominantly referred to in terms of his age (adolescent, juvenile) and in relation to his condition as an intern in Fundação CASA. Given the context of the judicial decision, these choices are expected and they are not uncommon. It is worth noticing, however, that when referred to as 'patient', that form of representation is not related to the diagnosis of ADHD attributed to him. Instead, it relates to his momentaneous condition as an intern at Fundação CASA - thus creating a prominent relationship between the institution and himself, even though this relation is dismissed when it comes to the institution's prerogative of producing a report attesting him to be fit to return to social life. Moreover, since Fundação CASA attends adolescents accused of law infringements, it is comprehensible why the social actor is referred to as 'juvenile' and 'adolescent' often.

In relation to stage 3 - ***identify which social actors and/or institutions are given authority in the social practice:*** *for instance, diagnosed patients, medical experts, a multidisciplinary staff, non-experts? Is/Are any of these social actors and/or institutions given more or less authority?* - HC 388920 and its resulting judicial decision present multiple social actors and institutions vested with authority (the 1st-degree judge, the multidisciplinary staff from Fundação CASA, and Psychiatry). However, the degree of authority attributed to each of them differs. The denial of the HC was grounded on the lack of existence of a psychiatric examination witnessing that the accused was fit to return to social life in considering his diagnosis of ADHD. Therefore, the report produced by the multidisciplinary staff from Fundação CASA attesting the accused was fit to return to social life since he had achieved the goals previously established in

his Individual Plan of Resocialization was given less authority and, in fact, it was dismissed by the 1st-degree judge, by the State Court, and finally by the magistrate in STJ judging the HC. This can be seen when, for instance, the São Paulo's Public Defender's Office argues that "*the report produced by FUNDAÇÃO CASA was treated as juridically nule*" and "*without mentioning the conclusive report produced by FUNDAÇÃO CASA, [the judge] overlaps the multidisciplinary report with a psychiatric report*". As a result, the accused remained interned waiting for a psychiatric examination that, alone, could witness he was fit to return to social life - revealing the much higher degree of authority attributed by three different courts to a single medical report.

On what concerns stage 4 - ***identify if mental disorders are mentioned and, if so, how they are treated and/or legitimized, and what their function is in the social practice:*** *are they treated in medical and/or neurological and/or biological terms only, or are they treated in terms of the social structures and social problems that result in idioms of distress and mental health harm? How are diagnoses legitimized? Do they have a function in the social practice being investigated?* - the only mental health diagnosis mentioned within HC 388920 and the resulting judicial decision is ADHD. It has a neuropolitical function and legitimation concerning it is vested on psychiatric authority. ADHD has been used to delegitimize the report produced by the multidisciplinary staff from Fundação CASA and to dismiss its claim that the adolescent was fit to return to social life. In the original decision, the 1st-degree judge claimed for the "*necessity of a medical evaluation considering the gravity of the infringement (rape and physical injury resulting in death), [considering] his inclination to reinfringement, not deconsidering that he was diagnosed with ADHD (Attention Deficit and Hyperactivity Disorder), what reinforces the justification of internment without the expert medical report*". In dismissing the report produced by the multidisciplinary staff from Fundação CASA, STJ confirms the original decision that classifies ADHD as an element that could represent potential risks to society in this case - and does so by reference to two different types of legitimation: by authorization, when the STJ grounds its decision on the need of a psychiatric examination; and by rationalization, since such need has the purpose of maintaining the adolescent deprived of liberty until examined.

In relation to stage 5, ***identify the existence of public policies and/or official guidelines addressing the mental health issue that is being focused on:*** *what policies and/or official documents address or are involved with it? In what terms are they constructed, and what types of solutions do they present to the mental health issue in question?* - it is worth-mentioning the *Fórum sobre medicalização da educação e sociedade: Recomendações de práticas não medicalizantes para profissionais e serviços de educação e saúde*, in Brazil, a forum concerned with the medicalization of education and society that provides recommendations of non-medicalizing practices to education and health professionals; the *Recomendação 19/2015 do Conselho Nacional de Saúde*, an official document produced by the National Council of Health in Brazil that recommends the adoption of

non-medicalizing practices by health services and professionals, as well as the publication of clinical protocols and guidelines by the Ministry of Health and by State and Municipal secretaries involving the use of methylphenidate, with the aim to reduce the medicalization of children and adolescents; and the *Recomendações do Ministério da Saúde para adoção de práticas não medicalizantes e para a publicação de protocolos municipais e estaduais de dispensação de metilfenidato para prevenir a excessiva medicalização de crianças e adolescentes*, a document published by the Ministry of Health in Brazil in 2015 with recommendations for the adoption of non-medicalizing practices and for the publication of Municipal and State protocols regarding the providence of methylphenidate, aiming to prevent the excessive medicalization of children and adolescents.

What these documents have in common is that they all provide recommendations focused on the reduction of practices of medicalization involving children and adolescents' mental health in the contexts of health services and education. Therefore, we may infer that there is a concern of health institutions in relation to these practices, especially on what concerns their growth, attested by official documents and studies that place Brazil as the second consumer of methylphenidate in the world and, consequently, as one of the countries with the higher number of diagnoses attributed to social actors. However, if on the one hand these documents and institutions recommend the reduction of medicalizing practices in mental health and the adoption of alternative approaches in education and health services, on the other hand, they lack in addressing the judiciary system as well. As a result, and given the lack of recommendation, the judicial decision produced resulting from the Habeas Corpus 388920 has been grounded on the presence (or the absence) of one medical report only, in this case, one provided by a psychiatrist. Therefore, we may also infer that the judicial decision is not in compass with the recommendations produced by other State institutions, such as the Ministry of Health itself, since it has dismissed the authority of a multidisciplinary staff in order to give authority to a psychiatrist alone, thus adopting a medicalized perspective to mental health. With that in mind, similar documents could be produced and addressed specifically to the judiciary system in Brazil.

In what concerns stage 6 - ***identify how elements of the social order relate to the mental health issue being investigated, through interdisciplinary research:*** *is the social order in a sense benefitting from the discourse produced, and/or is the discourse necessary to establish social orders and/or social and institutional roles?* - we should keep in mind that the HC 388920 involves an accusation of rape and feminicide against an adolescent who had his request to return to social life denied. Considering this scenario, and considering that his return to social life was denied on the basis of the absence of a psychiatric examination regarding the diagnosis of ADHD attributed to him, there is an explicit relationship between the social order and the function the diagnosis plays in this decision. In denying the return of the adolescent to social life, the STJ does so (and so did 1st and 2nd-degree courts) based on the notion that such return represents a risk to

society and to the social order itself since the adolescent has been diagnosed with ADHD. Taking that into consideration, we may consider judicial institutions as instruments of social control and regulation that, as is the case, may rely on (the lack of) medical expertise to claim that someone is not fit to return to social life for representing a risk to the social order.

In that sense, Mitjavila (2015:120) argues that the notion of risk works as a biopolitical device centered on the premise of defending society. Taking that into consideration, the author points out that:

> what Feeley and Simon (1992) defined as a "new penology" would express the emergence of a rationality on the biopolitical management of crimes based on the production of discourses organized around the idea of risk (Kemshall, 2006), (...) and on the use of standardized instruments of classification of the population according to criteria determining risks of criminal behavior.

The diagnosis of ADHD, we may infer from the decision produced by the STJ, could fit these criteria when combined with the degree of gravity attributed by a judge to any infringement committed by a social actor. However, as I mentioned before, a multidisciplinary staff from Fundação CASA had produced a report claiming that the adolescent was fit to return to social life. Even so, the diagnosis of ADHD worked as an instrument for every court to claim that the adolescent could still represent a risk to society if not examined by a psychiatrist - and should, therefore, remain as an intern until the examination. As the author suggests, "one of the main strategic functions of risk as a device is to provide an instrument to the administration of uncertainty and fear, mainly in relation to the occurrence of undesirable future events" (Mitjavila, 2015:120). In the case of the judicial decision resulting from HC 388920, ADHD has a neuropolitical function based on the notion of risk that the adolescent could represent for society.

On what concerns stage 7 - ***present alternatives for the discourse being analyzed:*** *what are alternative perspectives (discursive, linguistic, sociological) to approach the mental health issue and/or the social practice being investigated? Are changes in discourse somehow necessary?* - the recommendations I present are in compass with those presented by the Ministry of Health in Brazil, the National Council of Health, and the Forum of Medicalization. ADHD could be approached, in this case, by a multidisciplinary staff instead of a psychiatrist only, and this multidisciplinary staff should be given as much authority as any other health professional - since evidence suggests that qualitative approaches can produce better results in the treatment of ADHD. Moreover, if a psychiatric examination remains indispensable, the courts involved should have intimated the State to provide a professional capable of proceeding with such examination. It would be also necessary to have objective protocols defining in what cases ADHD would constitute a risk for society - given the number of people diagnosed with ADHD in Brazil, is their social life and liberty also at risk, or is their every social conduct going to be associated with their diagnosis? By simply assuming that the lack of a

psychiatric examination combined with the diagnosis of ADHD can represent a potential risk of reiterated rape and feminicide, we risk dismissing macro social structures that produce such crimes: misonigy, sexism, gender roles, lack of gender and sexual education, among others. Therefore, instead of approaching cases like this from a medical and psychiatric perspective to mental health only, judicial institutions could, in fact, adopt a multidisciplinary approach and recognize that ADHD can not, alone, in a sense legitimize gender-based crimes.

Finally, stage 8 of the framework presented consists of a ***meta-analysis:*** *what aspects has the analysis not covered, and in what ways can it be used to support official and institutional guidelines involving the social practice under investigation?*

In this article, I incorporated two instruments from CDS in the framework I developed to approach discourses about mental health. Other instruments could have been used, such as those belonging to socio-semiotic theories such as Systemic Functional Linguistics to construct a more linguistically/grammarly oriented form of analysis. One of the reasons behind my choice to not focus on a grammarly oriented form of analysis is that tying myself too closely to grammatical aspects was dispensable to discuss discursive productions and their sociological implications in the Habeas Corpus and its resulting judicial decision. Moreover, I hope this framework can be used by social scientists in general, not only linguists - who are free and encouraged to include additional layers of analysis to this and similar texts.

It is worth mentioning that I did not have access to the entire content of the lawsuit, since the Habeas Corpus publicly available is just a small part of the entire process. By having access to its entire content since its beginning, other dimensions of the text could have been explored in the analysis. It is also important to take into consideration that I presented just a brief overview of Critical Discourse Studies and the Sociology of Health - and for a more detailed discussion on these areas I recommend the reading of the dissertation that is the basis for this text - where the concepts of medicalization, mental health, neuropolitics, neuronarratives and (although not explored here) pharmaceuticalisation are explored in depth.

Finally, I strongly recommend that, first, specific guidelines regarding mental health are produced and addressed to the judiciary system in Brazil. Moreover, further research on discourse studies about mental health could focus on how diagnoses in mental health are discursively and/or linguistically being addressed in different contexts (if as a risk device, for instance), in order to provide a more accurate systematization of studies combining linguistic and discourse perspectives to discuss the implications behind these diagnoses, their neuropolitical function and forms of representation and/or organization - with the aim of presenting alternatives from a variety of fields of expertise to cases as the one discussed in this article.

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Notes

1. I would like to thank professor Débora de Carvalho Figueiredo, who advised the doctoral dissertation that originated this article.
2. I adopt the term Critical Discourse Studies rather than Critical Discourse Analysis considering that, as pointed out by John Flowerdew and John E. Richardson in the Routledge Handbook of Critical Discourse Studies, "CDA was increasingly not restricted to applied analysis, but also included philosophical, theoretical, methodological and practical developments". Since this article presents a methodological framework for critical discourse studies on mental health, I am inclined to assert that it goes beyond applied analysis - although an analysis is also presented in the text.
3. The Ministry of Health in Brazil estimates that 7,6% of children and adolescents aged between 6 and 17 years old carry the diagnosis. Data has been published in 2022 by the institution within the Protocolo Clínico e Diretrizes Terapêuticas para o Transtorno do Déficit de Atenção com Hiperatividade (TDAH). Retrieved July 7, 2022, from: http://conitec.gov.br/images/Consultas/Relatorios/2022/20220311_Relatorio_CP_03_PCDT_TDAH.pdf.
4. https://scon.stj.jus.br/SCON/
5. My translation to: "O adolescente encontra-se internado".
6. My translation to: "determinando a submissão do adolescente a perícia psiquiátrica".
7. My translation to: "Deixou de apontar as metas socioeducativas que ainda não foram alcançadas pelo interno".
8. My translation to: "a reinserção do paciente ao convívio social".
9. My translation to: "a fim de que o paciente retorne ao convívio social".
10. My translation to: "verdadeiro constrangimento ilegal à liberdade do jovem paciente".
11. My translation to: "Tratou-se o relatório conclusivo da Fundação como um nada jurídico".
12. My translation to: "Sem fazer qualquer menção ao conteúdo do relatório conclusivo da Fundação CASA, sobrepõe infundadamente àquele relatório multidisciplinar um laudo médico-psiquiátrico, cujo resultado se espera há quase um ano".
13. My translation to: "a magistrada da execução apontou a necessidade da avaliação médica ante a gravidade do delito cometido (estupro de vulnerável e lesão corporal com resultado morte), sua inclinação para a reiteração infracional, não se podendo olvidar que ele já foi diagnosticado com TDAH (Transtorno do déficit de atenção com hiperatividade), o que reforça a justificativa da manutenção da medida extrema sem que aporte o laudo médico pericia".
14. My translation to the original: "o que Feeley e Simon (1992) definiram como "nova penologia" exprimiria o surgimento de uma racionalidade na gestão

biopolítica do crime baseada na produção de discursos organizados em torno da ideia de risco (Kemshall, 2006), (...) e na utilização de instrumentos padronizados de classificação da população em função de critérios de risco de comportamento criminal".

15. My translation to the original: "Uma das principais funções estratégicas do risco como dispositivo é proporcionar um instrumento para a administração da incerteza e do medo, principalmente com relação à ocorrência de eventos futuros de caráter indesejável".

16. The Brazilian Protocolo Clínico e Diretrizes Terapêuticas para o Transtorno do Déficit de Atenção com Hiperatividade (TDAH) published by the Ministry of Health in 2022 claims that conduct issues may be presented by social actors diagnosed with ADHD towards the end of preadolescence. However, this implies the reduction of social problems (and their consequences) to a pathological instance while these problems remain untouched.

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