A Case Against the Categorisation of Children and Youth

Part 2: Professional perspectives

Peter Stanley
Senior Lecturer, Department of Human Development and Counselling, The University of Waikato at Tauranga

We don't need no categorisation
We don't need no thought control
No dark sarcasm in the classroom
Teacher, leave them kids alone

(Pink Floyd, Another brick in the wall, modified)

ABSTRACT

This is the second of two papers providing a critique of categorisation and of the biomedical interpretation of personal adjustment issues experienced by children and youth. Whereas the first paper (Stanley, 2006; published in *Kairaranga* earlier this year) appraised this approach from an array of theoretical vantage points, this paper extends the critique by the author reporting on his professional practice experiences. The reporting on the work experiences is aligned with findings and theorising from the current literature.

Position Paper
Keywords
Adjustment disorders, behaviour problems, clinical diagnosis, mental disorders, professional problems, school counselling.

LESSONS FROM EXPERIENCE

Our professional perspectives and frames of reference are the products of pivotal events and experiences and as I look back over my work as a counsellor and a psychologist I can discern involvements which have shaped my viewpoint and which may resonate with others. As a guidance counsellor in a secondary school I was alerted to the extent of adjustment issues in adolescent lives, the importance of context and connections to young people, and the continuities and discontinuities of teenage development that are represented in pathways and trajectories. Work as a psychologist with Specialist Education Services showed the significance of gender and socioeconomic status to referrals and the etiological patterns amongst referrals. As well, psychological work emphasised the importance of maximising the adaptive capacities of students with special education needs. These varied experiences called into question biomedical interpretations of human conduct and the relevance of categorisation.

As I drove around the zone of the decile 9 secondary school where I worked as a counsellor I would occasionally count the homes that I had visited in a professional capacity. As time passed the number rose spectacularly and the exercise became cause for reflection.

Wicks-Nelson and Israel (2000) say that it is generally accepted that there is a 15-20% prevalence of clinic-level problems among children and youth while Dryfoos (1998) contends that 35-60% of 14 year-olds are at moderate to high risk. These North American figures have some parallels with the findings of our first national survey of teenage wellbeing, *Youth2000* (Adolescent Health Research Group, 2003), which showed, amongst other things, that 33.9% of 15 year old female students think about killing themselves and 13.9% actually attempt to do so, and almost 40% of Year 9 students report recent incidences of bullying. When we read the various indicators of personal difficulties and distress in *Youth2000* we need to remember that a quarter of the students who were asked to participate in the survey declined to do so and that the investigation did not extend to those young children who had already left school (Stanley, 2005).

The number and the nature of the various problems in young lives represent a series of challenges to medical interpretations of adjustment. Firstly, there are just too many of them to be readily accommodated by allegations of defective genes, faulty neurology, and aberrant biochemistry. Secondly, there is considerable overlap amongst the types of problems that teenagers experience. For instance, suicidal young people frequently abuse substances as well as often being depressed (Forman & Kalafat, 1998). The co-occurrence of psychosocial problems is typically referred to as comorbibity in the medical/psychiatric framework and it is equivalent in the physical realm to the one person having diabetes, cancer, and muscular dystrophy at the same time. In my opinion, the extension of the disease concept of premorbibity, or being prodromal for a condition, is even more suspect and untenable. A third point is that adolescents have assets and protective factors in their circumstances as well as risk factors. However, as Glantz and Sloboda (1999) say, the medical model ignores or minimises positive influences. It is a binary system, in which health is an assumed standard, illness is a deviation, and mixed profiles are not really possible.

When I was first appointed as a guidance counsellor I encountered various myths about the role. For instance, there was a belief amongst some of the teaching staff that counsellors sat in offices and waited for students to come and see them about their problems. However, teenagers do not readily refer themselves for professional help and there are various reasons for this, such as not being bothered and not wanting to make a fuss (Adolescent Health Research Group, 2003).

Another major issue with psychosocial problems, in particular, is that there is usually more than one person involved and the student who voluntarily comes to the counsellor's door is effectively dragging a matrix of relationships behind them. The self-referral approach is an adult conception of the medical model and of individual dysfunction and distress. By contrast, contemporary developmental perspectives tend to emphasise the importance of context, and specifically, the impact of the young person's relationships with significant others. For instance, Sameroff says 'If a parent or teacher is unresponsive or unadaptive to the unique needs of the child, this should result in a diagnosis of deviancy aimed at the parent or teacher as well as the child' (2000, p. 309). A contextual viewpoint has all sorts of implications and occasionally this approach attracts allegations of family or teacher blaming. This is mistaken because the significant adults are also seen as enmeshed in situational influences (for example, impoverished neighbourhood), and in the case of parents the influences often cross generations.

The location of guidance counsellors on school sites, like resource teachers: learning and behaviour (RTLB) and some social workers, may reinforce an appreciation that children develop and change from year to year. Human service workers respond to crises and in the press of demands it can be easy to lose sight of the fact that 'behavioral effects are cumulative, even though their products appear episodically', as Gordon and Song put it (1994, p. 34). The young client represents a life in progress and the presenting problem will have been preceded by events and it will condition subsequent occurrences. This developmental perspective conflicts with psychiatric categorisations, which are static determinations. The reliance on an illness analogy, with its insistence that personal problems are no different from other diseases, means that they are essentially part of the lottery of life and, while they may be activated or aggravated by stressors, they represent an internal malfunction that acts in some way which is fundamentally disconnected from circumstance. However, as novice caseworkers soon discover, life goes on for a young person and his or her family after the attainment of a medical label (Stanley, 2003a). The client who is referred on for some specialist assistance (for example, drug counselling) often comes back, and the critical social and educational issues continue to need to be addressed.

Social service agencies receive large numbers of referrals for boys, and especially for boys with behavioural challenges (Wicks-Nelson & Israel, 2000). In the psychiatric lexicon difficult behaviour constitutes conduct disorder, oppositional defiant disorder and attention deficit/hyperactivity disorder and the preponderance of males in these categories is a challenge for the medical approach. It may be that these problems are really gender-specific, like undescended testicles, but the more obvious explanation is that CD, ODD, and AD/HD are social constructions or inventions, as postmodern theorists suggest, and these relate much more to the expectations of parenting and of the classroom than they do to something inherent in boys. Similarly, children from economically disadvantaged homes are much more likely to be given a psychiatric classification.

For instance, Read (2004) reports research showing that young people from deprived backgrounds are seven or eight times more likely to receive a diagnosis of schizophrenia. As a psychologist, I worked with a high decile school that had a rented house in its catchment area. The children from this home came from contrasting and less affluent families and I typically received a new referral from the school with each change of tenants. Luthar and Burak (2000) demonstrate what many people already know, and it is that having different goals and values is not the same as being dysfunctional.

I found that the longer I worked with children and youth with behavioural challenges the clearer it became about the cause and course of these difficulties. My experience increasingly aligned with the Oregon Model (Reid, Patterson & Synder, 2002; http://www.oslc.org) which describes a pattern and sequence of negative exchanges between parent and child, that transfers to school, and that progressively results in social rejection, academic failure and antisocial conduct, and that can lead ultimately to adult criminality. This is a powerful conceptualisation, which suggests that stressors such as poverty and divorce have indirect effects by disrupting caregiving practices. It also indicates that sadness and poor self-esteem amongst these young people is a consequence, or by-product, of their plight rather than a cause. Informed and research-based perspectives inevitably conflict with the array of popular viewpoints that are available to account for behavioural issues in children. I developed something akin to a phobic response to the repetitive invocation of AD/HD but other simplistic interpretations and misattributions abound including claims that the challenging student is gifted, has a food allergy, or must have been abused.

Medicalising and categorising behavioural problems mean important opportunities can be lost. For instance, it is possible that the act of diagnosis, with its accompanying appearances of authority and expertise, actually distances and disempowers caregivers at a time that parent-child relations need to be strengthened rather than diminished. A second point is that the psychiatric labels do not easily distinguish between shorter-term behaviour problems and more serious, persistent situations, and this distinction has important implications for the kinds of interventions that are provided. Based on research with New Zealand males, Terrie Moffitt (Moffitt, 1993; Moffitt, Caspi, Harrington & Milne, 2002) differentiates between antisocial individuals whose conduct is life-course-persistent and those whose delinquency is confined to adolescence, although adolescence is admittedly now a fairly extensive period of time. The short-termers are more amenable to turning point experiences and brief professional involvements whereas the children who appear destined to a career characterised by multiple problem behaviours can require intensive, individualised programmes (Stanley, 2003b). The third related matter is that the developmental perspective, which traces the antecedents and pathways associated with personal difficulties, emphasises the need for preventive actions and services. The biomedical approach, by contrast, endeavours to treat one case at a time (Albee, 1999). Hence there are long waiting lists and calls for more of the same services without any serious consideration of the inherent limitations of a reactive approach (Cowen, Hightower, Pedro-Carroll, Work, Wyman & Haffey, 1996).

Down syndrome, low vision, and brain damage caused by anoxia contrast with AD/HD and other constructions because they are statements of fact. There are important reasons for retaining the organic syndromes. A proportion of those that result from prenatal, perinatal and postnatal insults can be prevented and the conditions often have particular problems associated with them (e.g. Down syndrome and health issues). However, in terms of a young person's education, the presence of a syndrome is not especially significant, and it can function as a distraction. There is a danger that students with a specific syndrome are seen as similar when they may differ as much or more from each other as they do from other children (Foreman, 2005). As well, this stereotypic thinking can extend to popular postulates about the principal difficulty associated with all special needs. For instance, when intellectual difficulties were the favoured explanation in special education this was the consuming emphasis in any assessment (Zigler & Hodapp, 1986). Fashions change, and with the rise in the popularity of autism and autism spectrum disorders, deficits in social cognition and communication are a current preoccupation. For all children it is presumably the quality of adaptive functioning that is critical, and this includes both cognitive and socioemotional competencies.

Syndromes, organic or otherwise, tell us very little about a student's learning and teaching requirements. Effective instruction is dependent on appropriate assessment, useful adaptations, and the will to make it happen. As Ysseldyke, Algozzine & Thurlow (2000) say, there is no magic here; good teaching is good teaching. Sometimes, in another appropriation of the medical model, special educators may mistakenly see placement (whether a special or regular class) as an intervention of itself. Doctors see people in clinics and they send them to hospitals but it is what actually happens in these settings that makes the difference. In a review of special classes, Kavale and Forness (2000) found that the type of class was less important than the instructional and social dynamics that transpired. Deschenes, Cuban, and Tyack (2001) trace the history of students who have failed in American education and they show that while the names for these children have changed, the continuing expectation has been that the student adjusts to the school system in preference to any significant modifications being made to educational provisions. Deschenes et al. (2001) consider the ceaseless categorisations to have functioned as alibis and pretexts for professional failure. It is, of course, a fundamental change from seeing the problem within the child to regarding it as requiring a matching of student to environmental characteristics. A colloquium of New Zealand commentators have identified this change as a paradigm shift and, more familiarly, as representing markedly contrasting "stories" in special education (Moore, et al., 1999).

The primary function of categorisation may be to provide an admission ticket, or passport, to additional assistance as some suggest (for example, Moore et al., 1999). Human service workers can know that there will be costs to the young person and their family but they may believe that these are outweighed by the advantages. This is the administrative or system justification for categorisation and a number of countermanding comments can be made in regard to it.

Firstly, the process of identifying and classifying young people with special needs is expensive and it uses time and money that could be used to work with them directly. Secondly, diagnosis or verification procedures can be highly negative experiences for children and caregivers because workers can emphasise the worst features to ensure a successful application. A third point is that systems encourage categorisation with incentives. There can be direct pay-offs in terms of extra staff and resources and there can be the less obvious reinforcement of having a difficult case allocated elsewhere. The fourth concern is that categorisation, of itself, does not ensure better instruction or treatment. As has been suggested above, labels can be used as excuses for not providing useful services. A fifth matter is that practitioners are increasingly being caught between imperatives to categorise *and* to deliver outcomes, and typically there is little connection between diagnoses and interventions with psychosocial issues. Finally, a system's favoured categories become the focus of professional attention and other problems and issues are ignored. It is possible that this has happened in New Zealand and there could be several client groups (for example, primary school students with emotional difficulties) who do not have ready access to appropriately skilled services.

There are some intriguing, but rarely considered, questions associated with categorisation and these include how unidentified and unlabelled "mentally ill" young people cope in the community and by what combination of circumstance do a percentage of problem children and youth come to official notice. The *Mental Defectives Act* of 1911 contained an interesting provision and it was that if an escaped mental patient could remain at large for three months they were deemed to be discharged, presumably because they had proven that they could manage. As discussed above, problem behaviours are common in the child population but only some children are categorised. RTLB and other special educators may be called upon by some schools far more than by others and some teachers can provide inordinate numbers of referrals. Clearly, a range of considerations apply to categorisation events and such 'clinical' components as response frequency, intensity, and chronicity probably take second place to adult tolerance levels, knowledge of child development, and interpersonal skills. Nevertheless, the presence of large numbers of troubled and troublesome young people in the community without labels, and the selective nature of referrals and categorisations, represent important conceptual challenges to those who favour medical interpretations of human conduct.

PROFESSIONAL AUTHORITY AND CHILDREN'S REALITY
It can be instructive to reflect on how professional authority actually functions in the life of a child. Consider the average student who is evidencing behavioural difficulties and who is at risk for an antisocial career. When he is about 6-7 years of age, according to research, this child is probably experiencing rejection at home and it is likely that there is ostracism by age mates (Reid et al., 2002). Studies that are available of this student's classroom experience also suggest that his teacher will treat him markedly differently.

For instance, Lago-Delello (1998) found that an ethnically diverse group of teachers evidenced negative attitudes, perceptions, and behaviours toward students at risk for serious emotional problems, and this included making limited accommodations for them. In effect, the child is participating in a comprehensive punitive experience and, until adolescence ushers in the antisocial peer group, there is unlikely to be any source of solace for him. Nonetheless, it is during early childhood that an adult expert may provide a psychiatric diagnosis and it is formally established that the problem resides within the youngster's brain and biochemistry. The preceding, and surrounding, psychosocial events can be largely ignored and this includes the possibility that the "system" in the form of teachers, therapists with their labels, and other adults could be contributing (if inadvertently) to the young person's adjustment difficulties and unhappiness.

There is a risk associated with critiquing categorisation and it is that some people may see this as confirmation that children and youth do not have serious personal issues. Viewed in this way, my analysis would be in keeping with several other positions that have the capacity to trivialise the circumstances of young people with special needs and that could ultimately deny them services. Kauffman (2002) would include postmodernism and radical deconstructivist philosophy here, which he describes as 'a bad cognitive tumble' (p. 17), and which he says has nothing practical or positive to contribute to special education. Worse perhaps is the fact that postmodernism, in its denial of scientific methods of proof, leaves children and parents particularly vulnerable to charlatanism. Another position with adverse potential has the ingenuous notion that *all* children have special needs. The pupil who is anxious when doing mathematics or who is lonely warrants attention but these problems are not on the same plain as the youngster with spina bifida or who is threatening suicide, and we currently distinguish the latter students by their needs for extra support and specialist assistance. It is important to remember that whether we classify, deconstruct, or even "democratise" human problems, events remain the same and young people with significant personal difficulties and distress are part of reality.

CONCLUSION

The central points of this paper and of my preceding paper are that categorisation and the illness ideology are, in my belief, neither an accurate nor a helpful way of interpreting human problems and the issues encountered by young people in particular. When we lift our vision above provincial professional viewpoints we can see a much fuller vista of the forces that shape human development. In effect, what has transpired is both an elaboration and a demystification of important influences and this expanded purview makes clear that we can do more for children and youth, and our efforts need to be addressed at multiple social settings and they need to come early in the life course. Significantly, with respect to professional practice, there are much more beneficial appropriations that might be made from physical medicine other than some unsubstantiated system of categorisation.

Included here would be the strengthening of assessment strategies (Meyer, 2002; Stanley, Rodeka & Laurence, 2000), the wider utilisation of empirically-supported interventions (Chambless & Holon, 1998; Evans, 1997), and enhanced awareness of the ethical dimensions of work with children and youth (Bentall, 2004; Corey, Corey & Callanan, 2003). Specifically, with respect to ethics, Bentall (2004) says that any medical system has obligations to improve quality of life, to avoid causing harm, to respect autonomy, and to allocate resources justly. These moral imperatives, like the theoretical viewpoints that were previously discussed, combined with the lessons of casework, severely challenge the categorisation of problems of living and the practices that are referenced to it.

REFERENCES

Adolescent Health Research Group. (2003). *New Zealand youth: A profile of their health and wellbeing.* Auckland, New Zealand: University of Auckland.

Albee, G. W. (1999). Prevention, not treatment, is the only hope. *Counselling Psychology Quarterly, 12,* 133-146.

Bentall, R. (2004). Sideshow? Schizophrenia as construed by Szasz and the neo-Kraepelinians. In J. A. Schaler (Ed.), *Szasz under fire: The psychiatric abolitionist faces his critics* (pp. 301-320). Chicago: Open Court.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66,* 7-18.

Corey, G., Corey, M., & Callanan, P. (2003). *Issues and ethics in the helping professions* (6th ed.). Pacific Grove, CA: Brooks/Cole.

Cowen, E. L., Hightower, A. D., Pedro-Carroll, J. L., Work, W. C., Wyman, P. A., & Haffey, W. G. (1996). *School-based prevention for children at risk: The Primary Mental Health Project.* Washington, DC: APA Books.

Deschenes, S., Cuban, L., & Tyack, D. (2001). Mismatch: Historical perspectives on schools and students who don't fit them. *Teachers College Record, 103,* 525-547.

Dryfoos, J. G. (1998). *Safe passage: Making it through adolescence in a risky society.* New York: Oxford University Press.

Evans, I. M. (1997). The role of research in psychological practice: Implications of the scientist-practitioner model. In H. Love & W. Whittaker (Eds.), *Practice issues for clinical and applied psychologists in New Zealand* (pp. 323-339). Wellington, New Zealand: New Zealand Psychological Society.

Foreman, P. (2005). Disability and inclusion: Concepts and principles. In P. Foreman (Ed.), *Inclusion in action* (pp. 2-34). Victoria, Australia: Thomson.

Forman, S. G., & Kalafat, J. (1998). Substance abuse and suicide: Promoting resilience against self-destructive behavior in youth. *School Psychology Review, 27,* 398-406.

Glantz, M. D., & Sloboda, Z. (1999). Analysis and reconceptualization of resilience. In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development. Positive life adaptations* (pp. 109-126). New York: Kluwer.

Gordon, E. W., & Song, L. D. (1994). Variations in the experience of resilience. In M. C. Wang & E. W. Gordon (Eds.), *Educational resilience in inner-city America: Challenges and prospects* (pp. 27-43). Hillsdale, NJ: Erlbaum.

Kauffman, J. (2002). Commentary: Today's special education and its messages for tomorrow. In M. Byrnes (Ed.), *Taking sides: Clashing views on controversial issues in special education* (pp. 14-23). Guilford, CT: McGraw-Hill/Dushkin. (Reprinted from *The Journal of Special Education, 32,* 1999).

Kavale, K. A., & Forness, S. R. (2000). History, rhetoric, and reality – analysis of the inclusion debate. *Remedial and Special Education, 21,* 279-296.

Lago-Delello, E. (1998). Classroom dynamics and the development of serious emotional disturbance. *Exceptional Children, 64,* 479-492.

Luthar, S. S., & Burack, J. A. (2000). Adolescent wellness: In the eye of the beholder? In D. Cicchetti, J. Rappaport, I. Sandler & R. P. Weissberg (Eds.), *The promotion of wellness in children and adolescents* (pp. 29-57). Washington, DC: CWLA Press.

Mental Defectives Act, 1911. Public Act 1911, No. 6.

Meyer, G. J. (2002). Implications of information-gathering methods for a refined taxonomy of psychopathology. In L. E. Beutler & M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective* (pp. 69-105). Washington, DC: APA Books.

Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. *Psychological Review, 100,* 674-701.

Moffitt, T. E., Caspi, A., Harrington, H., & Milne, B. J. (2002). Males on the life-course-persistent and adolescence-limited antisocial pathways: Follow-up at age 26 years. *Development and Psychopathology, 14,* 197-207.

Moore, D., Anderson, A., Timperley, H., Glynn, T., Macfarlane, A., Brown, D., & Thomson, C. (1999). *Caught between stories: Special education in New Zealand.* Wellington: New Zealand Council for Educational Research.

Read, J. (2004). Poverty, ethnicity and gender. In J. Read, L. R. Mosher, & R. P. Bentall (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia* (pp. 161-194). East Sussex, UK: Brunner.

Reid, J. B., Patterson, G. R., & Synder, J. (Eds.). (2002). *Antisocial behavior in children and adolescents. A developmental analysis and model for intervention.* Washington, DC: APA Books.

Sameroff, A. J. (2000). Developmental systems and psychopathology. *Development and Psychopathology, 12,* 297-312.

Stanley, P. (2003a). Risk and resilience: Part 1, Theory. *Kairaranga, 4*(1), 4-7.

Stanley, P. (2003b). Risk and resilience: Part 2, Applications. *Kairaranga, 4*(2), 25-32.

Stanley, P. (2005). The best of times and the worst of times for young people: A tale of two surveys. *Teachers and Curriculum, 8,* 25-30.
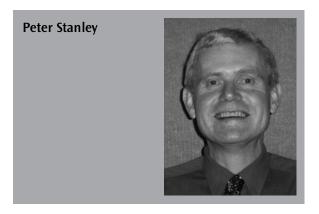
Stanley, P. (2006). A case against the categorisation of children and youth: Part 1, Theoretical perspectives. *Kairaranga, 7* (1), 36-41.

Stanley, P., Rodeka, P., & Laurence, K. (2000). *Guidelines for teachers for the identification of year 7 students at risk for substance abuse and other problem behaviours.* Porirua, New Zealand: Specialist Education Services.

Wicks-Nelson, R., & Israel, A. C. (2000). *Behavior disorders of childhood* (4th ed.). Upper Saddle River, NJ: Prentice.

Ysseldyke, J. E., Algozzine, B., & Thurlow, M. L. (2000). *Critical issues in special education* (3rd ed.). Boston, MA: Houghton.

Zigler, E., & Hodapp, R. M. (1986). *Understanding mental retardation.* Cambridge, UK: Cambridge University Press.

Peter Stanley

AUTHOR PROFILE

Peter Stanley is a Senior Lecturer in the Department of Human Development and Counselling within The University of Waikato at Tauranga. He has previously worked as a psychologist, counsellor, primary and secondary school teacher, probation officer, and police constable.

Email

peter@waikato.ac.nz