The labelling and categorisation of children with EBD

A cautionary consideration

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The argument

There is a story that tells of a man who happens across another man who is on his hands and knees at the footing of a bright street lamp staring into the gutter. The man who is standing motions towards the other person and asks quietly so as to avoid startling him:

‘What are you doing? May I be of assistance?’

The man looks up towards the other, looks back into the gutter and resumes pushing his hand through a dark mass of sodden fallen leaves. He says:

‘Yes, I am looking for my watch. I lost it.’

As many of us do in this circumstance, the would-be helper asks a silly question:

‘Where did you lose it my friend?’

Surprisingly, the man who remains on his hands and knees thrusts his right arm back over his left side towards the dark end of the street and replies:

‘Over there.’
‘Then why are you looking here?’
‘Because the light is much brighter here.’

Many readers who are attracted to this text will be inclined to dismiss this chapter as unhelpful to the cause of educating children who fall into the ever-widening spectrum of emotional and behavioural disorders (EBD). Indeed, critiques of developments in the field of diagnoses and responses to EBD (Rose 2005; Slee 1995) have not been well received or incorporated into the
development of the science of this field of research and educational practice (Kauffman and Hallahan 1995; Cooper 2008). Cooper (2008: 457), likening critical researchers David Skidmore, John Visser and the present writer to a Gary Larson Far Side cartoon where alligators pluck poodles from a water bowl, suggests that the critique is a danger to children with EBD through our refusal to recognise the legitimacy of behavioural disorders such as ADHD (attention deficit/hyperactivity disorder). The charge is, of course, incorrect and misleading.

The purpose of this chapter is neither to deny nor to affirm the existence of behavioural disorders such as ADHD. The author is neither qualified to, nor interested in doing so. The growing concern is, however, with apparent problems in diagnosis and responses to troubling and/or disengaged children, especially those who are attributed with ADHD (Slee 1995, 2010; Harwood 2006; Graham 2010; Laurence and McCallum 2009; Tait 2010). The assignation of children to special educational needs (SEN) classifications has a long-standing record of controversy. Indeed, Daniels (2006) alleges corruption in the deployment of special education labels.

Tomlinson (1979) directed attention to the disproportionate attachment of SEN classifications and subsequent referral of Caribbean boys to special education services in England. The disproportionate assignation of minority racial groups continues to trouble researchers around the world (e.g. Gillborn 2008; Parsons 1996, 2009 in the UK; Parrish 2002 in the USA; Graham and Sweller 2011; and Slee 2010 in Australia).

Dyson and Kozleski (2008) recently considered the disproportional representation of specific groups of children in special education on either side of the Atlantic Ocean. Both the USA and the UK are, they argue: ‘… economically rich, but socially poor’ (Dyson and Kozleski 2008: 170). Both have well-resourced school systems that ‘… are capable of making high levels of provision for children who are deemed to be in some way needy’ (Dyson and Kozleski 2008: 170). They go on to register their concerns about the impact of SEN classifications:

On the face of it, special education systems of this kind are both benign and rational. The targeting of need is one mark of a just society, and the use of scrupulous and scientifically based assessments is, arguably, a mark of a technologically advanced and equity-minded one. Yet in both countries, there is a puzzling phenomenon. Although students from any social group can be and are identified as in need of special education, members of some groups are more likely than others to be identified. Groups whose members tend to do badly in the general education system supply more students to the special education system. (Dyson and Kozleski 2008: 170–1)

Consistent with Wilkinson and Pickett’s (2009) influential analysis of growing levels of inequality in affluent countries and its deleterious impacts on a range of social and economic outcomes, Dyson and Kozleski’s (2008: 171) investigation of disproportional referrals to special education show that they are not random, but represent ‘precisely the groups that do least well in terms of a whole range of social indicators: health, employment, income, encounters with the penal system and so on’. James Kauffman (see Chapter 2 in this volume) makes little of the fact of the racialisation of behaviour disorders through disproportionate classification in the USA. Instead he turns to a distracting discussion of political correctness, the excesses of which are used to deflect from the value of any critique of the science of special education.

Echoing Bronfenbrenner (1979), those whom Brantlinger (1997, 2006) might now call the new breed of traditional special educators characterise their work as embodying a biopsychosocial perspective (e.g. Cooper 2008: 465). This is progress. A more trans-disciplinary and nuanced analysis is required. However, at this stage it seems that physiological explanation dominates an incomplete socio-political analysis.
At the heart of any analysis of the deployment and impact of systems for classifying children and calculating educational entitlements there must be a strong political and economic analysis. The absence of this analysis and the reliance on special educators and psychologists to design and administer models of student classification and resource allocation will have perverse effects. These effects may include:

- **Net-widening**: is where children who show a range of behaviours consistent with the symptoms of official disorders are swept up and referred in large numbers to alternative education settings or programmes that seriously attenuate their educational achievements and social opportunities.

- **Accelerated disablement**: is where the gravity of the model presses diagnosticians, administrators, teachers and parents to emphasise or overstate impairments in order to secure additional or basic resource entitlements. This is made all the more possible where psychiatrists and psychologists allow for the assignation of patients to ‘shadow syndromes’ when the symptoms do not conform precisely to the DSM (Diagnostic and Statistical Manual of American Psychiatric Association) schedule (Greenberg 2010; Kutchins and Kirk 1997).

- **System segmentation and atomisation**: is where more students are drawn to the therapeutic margins of education and resources are diverted from the requirement for system reform that will benefit all children.

- **School-to-prison pipeline** refers to a growing body of evidence from the USA and Australia (Slee 1995; Wald and Losen 2003; Graham and Sweller 2011) that suggests that increasing numbers of young people are being identified with behaviour disorders earlier and that the transition from school-based categories of behaviour disorders to adult incarceration is established. This is not to suggest causation; it simply reflects that classification and special educational services are not a guarantee of better educational and social outcomes.

This leads to Norwich’s (2008) question about what kind of classification system would prove useful to pedagogical and school reform. Norwich’s question helps us widen our gaze from the bright streetlamp of individual pathology to build the social analysis into lopsided extant biopsychosocial offerings. He offers a *dilemmatic approach* to understanding the complex relationships between disability, difference and education based on the work of Minow, Robert Dahl and Isaiah Berlin amongst others. Terzi (2008) draws on Amartya Sen’s *capability approach* to conceptualising and responding to injustice. It has been suggested elsewhere that although there is an acknowledgement of its importance, an authentic biopsychosocial analysis has not yet been provided by those working in the field of childhood behavioural disorders (Slee 2010).

The argument is that our analyses remain incomplete. Pursuant to this broader analysis, this chapter represents research that strengthens the analysis of the biopolitics of emotional and behavioural disorders. This will not in or of itself build a will for better analyses and diminish the ongoing drift to over-diagnosis and under-diagnosis. This requires a willingness to engage in a trans-disciplinary critical research programme rather than a determination to prove a case. Winning the argument may be a pyrrhic victory that sells troubling children (Youdell 2010) and school reform short.

**Towards a broader and deeper reconnaissance**

In his book *The Politics of Life Itself*, Nikolas Rose (2007) commences his analysis of biopolitics with a lesson he draws from Foucault’s genealogy of the assemblage of medical knowledge in *The Birth of the Clinic*.
the epistemological, ontological, and technical reshaping of modern medical perception at the start of the nineteenth century came about through the interconnections of changes along a series of dimensions, some of which seem, at first sight, rather distant from medicine.

(Foucault 1973, cited in Rose 2007: 9)

Straddling traditional knowledge disciplines to understand complex phenomena, Rose uses five lines of inquiry into biopolitics and contemporary knowledge of ‘vitality’ (life). A summary of these five interrogative elements follows. The summary illustrates how to strengthen the ‘social’ understandings of how we know and approach what has come to be described as EBD. Rose reminds us, by example, of the necessity for interrogating how we come to know phenomena, and the impacts that ways of knowing have on what counts and what is to be dismissed.

The first investigation considers the progress and the shaping of knowledge through molecularisation. Molecularisation refers to the way in which we have moved from the dissection table where we visualized the body as an intricate interconnection of tissues, limbs, joints, organs, bones, cartilages, blood flows and other fluids. This we came to know from the surgeon’s table. Technological transformations spanning early x-ray machines to informatics and computational modelling developed across the disciplines of biology, engineering, physics, mathematics, renders life as a series of DNA sequences. New ways of visualising the body at the molecular level reshape our understanding of the body and allow for radical interventions.

Political fracture around the nature and effects of such interventions is inevitable. What human characteristics will we successively eradicate from the species as the knowledge and technology enables us to make these determinations? ‘Contemporary medical technology’, says Rose (2007: 16), ‘do not seek merely to cure diseases once they have manifested themselves, but to control the vital processes of the body and the mind’. Under these conditions of knowing life, we can target elements, at molecular level, therein to alter humans to better fit the changing requirements of their world. Hence so-called smart drugs become feasible for the flagging worker or student.

The second element of investigation he calls technologies of optimisation. New technologies for visualising the body at the molecular level both reflect and propagate new ways of thinking about life and, inevitably, about intervening in what once was seen as its natural course. New knowledge of the molecular structure of the brain has given rise to very persuasive, but contestable brain sciences (Rose 2005). Perfection, from body shape, function and longevity, becomes an overriding quest. Difference is reconceptualised and our narrowing tolerance is represented through the increasing range of tools to change ourselves. Nature is redundant as women contemplate post-menopausal childbearing and men are offered the eternal erection: trite, but real examples of how the effect of new knowledge reorders social thinking and organisation. Thinking about changing conditions and expectations from schooling and the optimisation of children is no longer the realm of fantasy. Not only can we attain the long-coveted normalisation, but the new normal is based on what dominates as the optimal human form.

Third, is subjectification. Here Rose examines the formation of a new politics of health and medicine. Rabinow (1996) deployed the term biosociality to describe the social relations of medicine. Individual and group identities are formed around genetic profiles. They then mobilise around health identity and genetic research projects to negotiate their world and to shape or reshape their future. An apparent example of this is seen in the way that groups form around syndromes or diseases, and in the way that parents seek confirmation of diagnoses for their children in order to secure educational, health and leisure entitlements. In this respect there is a possibility for the application of particular diagnoses and SEN labels in order to renegotiate the status of the child and the terms of schooling.
Rose then turns to an analysis of the experts of life itself:

As the quest for health has become central to the telos of living for so many human beings in advanced liberal democracies, people have come to experience themselves and their lives in fundamentally biomedical terms, and with the best of intentions on all sides have become bound to the ministrations and adjudications of medical expertise, and/or those paramedical alternative and complementary forms of expertise that have partaken of much the same logic. *(Rose 2007: 28)*

Hitherto, doctors enjoyed a privileged position as the custodians of medical knowledge. This has profoundly changed, as have the social relations of medicine. People invest in themselves and their kin as an ongoing medical project. Experts exert pastoral power over a population seeking speech therapy, occupational therapy, art therapy, music therapy, physiotherapy, aromatherapy, and psychotherapy. We enlist dieticians, nutritionists, personal trainers, marriage counsellors, mental health counsellors, educational counsellors, genetic counsellors, and fertility and reproduction counsellors to augment the services of traditional medicine.

Fleck identifies thought collectives that form around soma identities:

From the stem cell experts to the molecular gerontologists, from the neuroscientists to the technologists of cloning, new specialists of the soma have emerged, each with their own apparatus of associations, meetings, journals, esoteric languages, star performers and myths. Each of these is surrounded by, augmented by a flock of popularizers, science writers and journalists. While often disowned by the researchers themselves, they play a key translational and meditational role in forming the associations. *(Rose 2007: 29–30)*

The final analytic strand is bioeconomics. Biocapital shapes relationships, sets political priorities, traverses national borders, builds a discourse of urgency, need and benevolence, and defines the parameters of important knowledge and the next big question *(Slee 2010: 132)*. Governments, corporations and university laboratories fall into step with each other in defining new medical research partnerships and priorities. Rose is not lapsing into a conspiracy theory that suggests that pharmaceutical companies create new medical disorders for their own profit. Rather, the relationships between capital, government and medical research and practice are complex and do establish agendas and particular forms of ethics. At times, interests blur and merge and science reflects such interests *(Kutchins and Kirk 1997; Rose 2005; Greenberg 2010)*.

While we have complicated administration of ethical research practices (with good reason), the ethical agenda is proscribed. The ethics of practices in research into human fertility are carefully managed. The ethical consideration has not been extended to question why human fertility commands the expenditure it does while we allow children to die in Malawi for ‘the want of a dollar’ for simple vaccinations *(Sachs 2005)*. Ethics itself is a malleable project.

**So what?**

For the social element of the biopsychosocial analysis of EBD to acquire authenticity there needs to be a more searching probe into the context and conditions of schooling that establish the field of social relations that shape and respond to troubling behaviour. In the last part of this discussion three frames are used to illustrate the attractiveness, power and consequences of EBD labels. They also frame alternative analyses and responses to that which is lodged as EBD scientific practice.
Before embarkation it is important to restate that this is not an atheist’s treatise seeking to deny childhood disorders. Family circumstances remind one of the reality and trauma of mental illness. It is simply an invitation to become more discerning in our relationship with medical and special educational authority.

The frames may shape an introduction to the social as a forerunner to re-examining the bio and the psycho domains. Of course, the domains or perspectives are contingent and may reshape each other through respectful dialogue.

Tables are inevitably reductive. Table 3.1 is a point of embarkation rather than foreclosure. Along the top of the table are three frames (of course there are more) for thinking about the socio–political production of children and schooling. These are: policy and culture (framing policy and culture), children’s identities (framing children) and school practices (framing practice). The four domains of policy and culture and accompanying bullet points are prompts. Following is an elaboration of the four policy and culture domains—globalisation and neo-liberal ethics, education markets, neo-special education, and inclusive schooling—and their interactions relationship to thinking about EBD labels.

**Globalisation and neo-liberal ethics**

Rizvi and Lingard (2009) contend that policy is in effect the allocation of values. Profound changes in flows of capital, information and people have generated a pervasive neo-liberal ethic of competitive individualism. This is the hallmark of the culture of new capitalism (Sennett 2006). Fuelled by a fear of the spectre of uselessness (Sennett 2006: 86), families atomise and community breaks down. Bauman (1997: 22) observes that notwithstanding an official discourse

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Labelling of children with EBD
that promotes difference, diversity and multiculturalism, we live in a condition of ambient fear, the hallmark of which is mixaphobia. The drive for cheap labour produces redundant or waste populations (Bauman 2004). This collateral damage is always described in technical terms to deflect from the human cost. Phrases like ‘the terms of trade’, ‘currency crisis’, ‘efficiency measures’, and ‘right-sizing’ deflect from the fact that these are decisions that devastate real people with names, families and postcodes (Bauman 2004). The technical timbre and pitch of SEN classifications may play a similarly deflective role of objectifying suffering and marginalisation.

Transnational organisations such as the World Bank and the Organisation for Economic Co-operation and Development (OECD) now determine education policy and cultures at global and local levels. The establishment of international benchmarks such as the Programme for International Student Assessment (PISA) and the Trends in International Maths and Science Study (TIMMS) reach across and into national education systems. High-stakes standardised testing is used to establish standards and schools are ranked on the basis of children’s test results (Stobart 2008). Schools aim to demonstrate success and teachers suspend education in preference to test coaching. Under these conditions mistakes have little place in learning and represent a risk to reputation and funding. Risk-averse schools need to protect against the deleterious effects of dysfunctional individual children on their overall results and standing on league tables (Slee 1998). Under these conditions it is important to establish the child’s academic identity. Should they represent risk, it becomes important to establish a special identity: SEN, EBD, ADHD, OCD, ODD and so the acronyms flow. In this way the school can enlist necessary support and/or exemptions. If the assignment of the labels reflects a will to improve pedagogy and educational opportunities for children, this is indeed a sound development. If other imperatives are at play that lead to greater separation of EBD children, the lowering of teacher expectations and narrowing curriculum and restricted pedagogy, our practices are in need of critique and change.

**Education markets**

Education is a commodity of varying quality and utility. Parents become choosers and or purchasers on behalf of their children as they invest in their future ascension to labour market entry points. As we have observed, schools are ranked and education consumers make choices. This choosing also works the other way as schools seek to improve rankings through the selection of students. The calibration and classification of the school population becomes important in this context. Troubling students are problematic. The application of a formal diagnosis is procedurally important. It may be the lever for unlocking additional educational support to support their continuing participation at their neighbourhood school. Conversely, it may be the trap-door lever that drops them into the growing offering of residual schools that remove them from the education mainframe (Parsons 2009).

It is correct to argue that many children’s behaviour excludes them from participation within the regular school. They are disengaged and their learning has been suspended. Moreover, they do interrupt the learning of others and the teaching of the school curriculum. Under these circumstances a formal diagnosis of their aberrant behaviour becomes attractive and useful. The improvement of the machinery of classification is important and can be justified on behalf of the troubled and troubling child. The problem stands—is this an essentially conservative mechanism for underwriting institutional equilibrium? Are we eschewing much-needed school reform?

**Neo-special education**

Does the assignation of labels lead to an improvement of educational services, educational outcomes and life-chances for children who are diagnosed with behaviour problems? Norwich
suggests the need for a revision of extant SEN classification systems. He intimates that a biopsychosocial assessment may be achieved through the application of the World Health Organization’s (WHO) 2002 International Classification of Functioning Disability and Health (Norwich 2008: 147). This may well help to return the social, and knowledge and pedagogy, to the school-planning table.

The diagnostic instruments for behaviour disorders remain troubling. The substantive questions that have been levelled at the DSM (APA 2000) by researchers such as Kutchins and Kirk (1997) and Steven Rose (2005) have not been sufficiently addressed by the biopsychosocial analysis of behaviour disorders (Cooper 2008). Taking up Fleck’s observations about thought collectives, ADHD provides an interesting test case for improving biopsychosocial investigation. The scientific basis for diagnosis is changeable and disputed (Rose 2005; Rose 2007; Graham 2010). This is not remarkable as the same applies to conditions such as multiple sclerosis and many other maladies. The manner and administration of diagnosis is often inconsistent, derived from decontextualised checklists and geographically disproportionate. The growth of organisations such as CHADD (children and adults with ADHD) in the USA to secure substantial Federal government and pharmaceutical company funding is significant to questions about the growing pervasiveness and respectability of the syndrome and the acquisition of its label. Financial and professional interest is sufficiently at play to push us towards greater scrutiny of developments in this area.

Inclusive schooling

Inclusive education is used here as a proxy for school reform. It allows us to issue a broader set of questions about education cultures, policies and practices (Booth and Ainscow 2010). This frame returns us to the dark street, the solitary streetlight, the man on his knees searching the gutter, and the bemused interloper. It is not offered as an educational endpoint, but as a means for testing taken-for-granted educational practices. In this instance it is an invitation to step up the interrogation of the development, assignation and effects of EBD labels through a more expansive interrogation of our knowledge and practices in special and regular education. Special education is not to be demonised and regular education sanctified. They are co-dependent institutional inventions in need of the reformer’s inquisition.

This chapter has called for a more robust consideration of the nature of scientific knowledge and the actions that proceed from that knowledge. It has also argued that labels are not neutral medical descriptors; they are political artefacts. This being the case, we need to test the claims of the biopsychosocial analyses with an urgent intensity.

Note

1 ‘Science’ has been italicized to suggest that it is not a neutral term. It is often used to suggest that those who gather to create and apply it are free from ideology, untainted by prior assumptions or other intrusions from the world outside the laboratory. This is, of course, not the case.

References


