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Between badness and sickness: Reconsidering medicalization for high risk children and youth

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ABSTRACT

Most of the sociological literature about "troubling" children and youth focuses on how the scientific authority of medical experts, with a discourse of sickness, has come to displace the moral authority of justice enforcement officials and their rhetoric of badness as arbiters of childhood pathology. Yet my experience working with high-risk children and youth during a post-MSW fellowship strongly suggests that discourses of badness have not supplanted discourses of sickness. Indeed, these discourses remain deeply intertwined with implications for the way we conceptualize troubling children and youth, for the treatment we prescribe, and for how children and youth understand themselves. Discussing two composite cases to illustrate how negotiations of badness and sickness unfold, I argue that shifts in attributions of badness and sickness follow predictable patterns generally occurring in response to: (1) changes in the context (whether the child is at home, school, or in a treatment setting); (2) changes in an actor's interests or role (parents may attribute troubling behaviors as badness at home but frame them as sickness with people outside the family); and/or (3) changes in external structures of time (e.g. the end of the school year or the end of a Medicaid authorization). In conclusion, I consider the implications of partial medicalization and these patterns of narrative negotiations for future research and practice.

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1. Introduction

An eleven-year-old boy with a history of disruptive behavior in the classroom gets upset, throws his chair, tears up his work, and runs down the school halls, unable to calm down. The principal calls his parents, who take him to the psychiatric emergency room where he is admitted and treated for a disruptive behavioral disorder. A couple of months later the same thing happens: the child gets upset and is unable to calm down. Fed up, the principal calls the police, who arrest him and issue a citation to appear in juvenile court where he receives probation for disorderly conduct.

These very different responses to an identical set of actions raise questions about how we make sense of children and youth with troubling behaviors: Are they mentally ill, in need of medication and supportive therapy? Or are their troubling behaviors really just a sign of defiance, best dealt with through punishment and good sense? Most of the sociological literature about "troubling"[1] children and youth focuses on how the scientific authority of medical experts, with a discourse of sickness, has come to displace the moral authority of justice enforcement officials and their rhetoric of badness as arbiters of childhood pathology. Yet my experience working with high-risk children and youth during a post-MSW fellowship strongly suggests that discourses of badness have not supplanted discourses of sickness. Indeed, as the above example demonstrates, attributions of badness and sickness remain deeply intertwined with implications for the way we conceptualize troubling children and youth, for the treatments we prescribe, and for how children and youth understand themselves. What does it mean when discourses of badness and sickness overlap? How do children and youth, their families, and professionals make sense of, and contend with, these competing designations?

My intent in this article is to develop new thinking concerning what I term the *partial medicalization* of children and youth diagnosed with behavioral disorders. Specifically, I argue that troubling children and youth constantly negotiate designations of themselves and their behaviors as both bad and sick. Reflecting a deeper cultural ambivalence about the meaning of mental illness and deviance, the resolution of these narrative negotiations often has negative consequences for children and youth who are geographically, economically, and racially marginalized. In making this argument, I do not mean to suggest that mental illness or bad behaviors are not real. Rather, organizational actors (therapists, parents, teachers, police) often interpret the *same* behaviors differently (as sickness or badness)—a phenomenon with far-reaching implications for children and youth. It is not the child himself or herself, but who is in charge of defining and responding to the problem that shifts a behavior's meaning.

This paper draws on my experience as a new clinician treating children and youth with severe emotional disturbances (SED) that put them at risk for psychiatric hospitalization, incarceration, or removal

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[1] I use troubling to refer to children and youth that challenge or trouble the legal, medical, educational, and/or familial systems and who themselves are also considered to have troubles in the form of socially disruptive or aggressive behaviors.

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from their home by Child Protective Services. I begin by briefly reviewing, and then critiquing, the theory of medicalization. Following this, I explain the philosophy of the program in which I trained in order to provide a context for my observations. Discussing two composite cases to illustrate how negotiations of badness and sickness unfold, I argue that shifts in attributions of badness and sickness may follow predictable patterns generally occurring in response to: (1) changes in the context (whether the child is at home, school, or in a treatment setting); (2) changes in an actor's interests or role (parents may attribute troubling behaviors as badness at home but frame them as sickness with people outside the family); and/or (3) changes in external structures of time (e.g. the end of the school year or the end of a Medicaid authorization). In conclusion, I consider the implications of partial medicalization and these patterns of narrative negotiations for future research and practice.

2. From badness to sickness: medicalization in context

Over the past five decades, there has been widespread scholarly attention to how behavior comes to be classified as deviant or troubled. The sociology of knowledge posits that our understanding of the world develops from a specific set of social circumstances rather than from an objective truth. Within this framework deviance becomes defined by the institutional, political, and religious values of a particular time and place. Conrad and Schneider (1992) assert:

> What is considered deviant in a society is a part of a political process of decision making. The behaviors or activities that are deviant in a given society are not self-evident; they are defined by groups with the ability to legitimate and enforce their definitions. (p. 22).

There is no such thing as an inherently deviant act; what is labeled "deviant" reflects the violation of societal norms. Behaviors held up for collective condemnation change as deviance in one time and place often becomes normative behavior in another (Spector & Kitsuse, 1977).

In the past three decades, one of the most significant changes to how deviant or troubling behaviors are addressed in children and youth has been the transfer of authority and action from the legal to the medical system; non-medical issues are redefined as requiring the treatment or supervision of health professionals. For example, a disruptive student who would have been punished by a trip to the principal's office is now understood to suffer from a medically diagnosed condition best treated by psychotropic drugs and/or behavior modification (Attention Deficit Hyperactivity Disorder; ADHD), or a defiant adolescent who was previously dealt with by parental or legal action is now perceived to have a condition recognized by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and attended to by a range of medical, educational, and psychological specialists (Oppositional Defiance Disorder; ODD). Psychiatric diagnoses have moved disruptive and troubling behaviors from constructions of badness to constructions of sickness (Conrad, 1992; Schneider, 1978; Scull, 1975).

This reconstruction frames deviant behaviors as symptoms of abnormal functioning caused by a mental disorder. By locating the source of trouble within the person, medicalization removes individual intent and blame from a person's actions (Conrad & Schneider, 1992). Instead of punitive responses and punishments, the treatment of sickness requires medication or other ameliorative therapeutic interventions such as cognitive behavioral therapy or psychodynamic therapy which can offer relief from discomfort and pain as well as hope for improvement and change (Conrad & Schneider, 1992). In doing so, medical social control (in the form of definition, diagnosis, and treatment) is often framed as both a more flexible and humane approach for addressing troubling behaviors than legal social control (in the form of punitive institutional responses) (Conrad & Schneider, 1992).

While medical control may be more flexible than legal social control, it is hardly ever neutral in the values that it embeds. Scholarship on medicalization raises important questions about the implications of understanding behavior through a medical lens. By continually narrowing the field of what is normal or acceptable, medicalization allows little room for individual variation in behavior (Finn, 2009). Recoding socially deviant behavior as a medical condition does not necessarily make the display or experience of these behaviors less disruptive or disturbing, and medicalization often fails to fulfill its promise to recast the negative implications of specific behaviors (Link & Phelan, 2001). Perhaps most importantly, repeated behavioral disruptions that could be understood as a reasonable response to a lack of economic resources or unjust treatment are instead interpreted through a medical framework that locates the cause of the problem (and its solution) within the individual (Carrier, 1983; Tierney, 1982). Any attempts to challenge these medical interpretations of behavior pose real challenges for lay people who possess few resources to challenge expert authority (Conrad & Schneider, 1992; Link & Phelan, 2001; Zola, 1972).

Medicalization as a macro-phenomenon is part of a cultural shift that Philip Rieff has identified as the "triumph of the therapeutic" and that Mark Jacobs claims has given rise to "tragic narratives in the no-fault society" (Jacobs, 1990; Rieff, 1987). Constructions of childhood more generally map onto this cultural shift. Nybell (2001, p. 4) notes that "the study of child development as a 'natural process' has been primarily a project of developmental psychology," which envisions childhood as a series of normative stages organized around the mastery of sequential physical, cognitive, social, and emotional tasks within specific time frames. As ideas about childhood as a natural process converge, deviations from this course come to be considered disturbances that originate inside the child and require professional remediation and attention. Medicalized notions of childhood allow for the expansion of medicalized accounts of children's troubling behavior; indeed diagnostic categories such as attention deficit disorder (ADD) and oppositional defiance disorder (ODD) could not have been discovered without it (Pawluch, 1983).

Treated as a macro-level phenomenon, the process of medicalization is often assumed to be both established and stable (Pastor, 1978). Once a behavior or process has been medicalized, then the idea, broadly speaking, is that professional, public, and private understandings of it will be filtered through a medical lens. Ironically, even scholarship that critiques practices of medicalization may have the unintended effect of reinforcing its totalizing nature; obscuring alternative narratives of deviance that still operate powerfully in everyday organizational actors' sense and decision making about children and youth. New work in medical sociology has begun to wrestle with the multiple forms that medicalization may take. Anspach (2011) proposes that the diagnostic process is best conceptualized not as a rigid binary but in terms of "hybrid diagnostic repertoires" or sets of cultural schemas that play out in complex ways during micro-level interactions between the medical system and patients. In practice, the varied nature of these cultural repertoires makes the process of medicalization far from uniform. For example, Hoppe contends that laws criminalizing the spread of HIV have reframed the disease as a form of badness rather than a form of sickness (Hoppe, 2012). Yet, we still know relatively little about how processes of partial medicalization play out at the micro-level. What happens when medical interpretations of social problems intersect with other powerful and competing narratives about their origins? That is, how does medicalization operate not just as a socio- historical process, but also in everyday life? My intent here is to begin to fill a gap in our understanding of partial medicalization and to start to theorize about the conditions under which children and youth diagnosed with behavioral disorders are viewed as both bad and sick. My observations strongly suggest that the medicalization of troubling behavior, particularly for children and youth who are economically and racially marginalized, may best be understood in relation to other explanations of behavior rather than solely within a medicalized framework. Both the mental disturbance and the socially disruptive behavior may be considered real; how they are categorized is contingent on a wide range of contextual factors.

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