Medicalization in schools

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Abstract
Medicalization can be characterized as the product of processes that seek to put social problems into a medical framework. This process of placing phenomena into a medical framework has become more commonplace (Conrad, 2007, p. 88; Conrad & Schneider, 1992; Zola, 1972) with the concept being examined in relation to a number of areas, including: sex (Hansen, 1992); ADHD (Conrad, 1975); racialization (Kew, 2009); sleep (Kroker, 2007; Seale, Boden, Williams, Lowe, & Steinberg, 2007); pregnancy and birth (Arney, 1982; Walzer Leavitt, 1986); shyness (Lane, 2007); menopause (Bell, 1987); and psychiatry (Lunbeck, 1994). There are a number of disciplines and perspectives on medicalization, including sociology of health, critical psychology, critical psychiatry, history and philosophy of medicine, medical anthropology, and the sociology of medicine. In education, the issue of medicalization has been examined in terms of a number of considerations, such as inclusion (Isaksson, Lindqvist, & Bergstrom, 2010) and refugee students (Taylor & Kaur Sidhu, 2012).

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INTRODUCTION

Medicalization can be characterized as the product of processes that seek to put social problems into a medical framework. This process of placing phenomena into a medical framework has become more commonplace (Conrad, 2007, p. 88; Conrad & Schneider, 1992; Zola, 1972) with the concept being examined in relation to a number of areas, including: sex (Hansen, 1992); ADHD (Conrad, 1975); racialization (Kew, 2009); sleep (Kroeker, 2007; Scale, Boden, Williams, Lowe, & Steinberg, 2007); pregnancy and birth (Arney, 1982; Walder Leavitt, 1986); shyness (Lane, 2007); menopause (Bell, 1987); and psychiatry (Lunbeck, 1994). There are a number of disciplines and perspectives on medicalization, including sociology of health, critical psychology, critical psychiatry, history and philosophy of medicine, medical anthropology, and the sociology of medicine. In education, the issue of medicalization has been examined in terms of a number of considerations, such as inclusion (Isaksson, Lindqvist, & Bergström, 2010) and refugee students (Taylor & Kaur Sidhu, 2012).

Given the scope of medicalization to be applied in varying sites, it is not surprising that medicalization occurs in schools. Schooling and education are on the receiving end of medicalization as well as contributing to medicalization (Harwood, 2006, 2010a, 2010b, 2011). In terms of experiencing the effects of medicalization, schools are clearly influenced by medicalization. Examples include the medicalization of bodies, such as what is occurring with new
healthisms and obesity (Wright & Harwood, 2009), where medical concepts are used to position size, weight and shape as medical problems and concerns to be administered to medically.

The extent of the influence of medicalization in schooling and school practice can slip under the radar, and this can occur despite the tendency to rely on medicalization at the expense of other forms of explanation. Medicalizing discourses are especially influential in special education, but at the same time are not always acknowledged and questioned. For instance, while commentary on medicalization is often included or alluded to in work in disability studies (Barnes, Oliver, & Barton, 2002; Barton, 2001; Hickey-Moody, 2009) with its central tenet of critique of normalizing practices, within special education such critique is not necessarily a standard expectation (Slee, 2001). Special education has been significantly influenced by medicalization and the jurisdiction of medical power and legitimation (Potts, 1983). Although there are examples of critiques and discussion of medicalization in special education literature, it is less subject to ongoing analysis, with the exception being areas of topical debate such as ADHD, which attract numerous critiques that include analysis of medicalization (see for example Watson, 2010). As we will outline, medicalization can lay unnoticed and at the same time, very much a part of the texts that form the substance of pre-service teacher education. In this chapter, we will use the example of challenging behaviour to illustrate how medicalization infiltrates the conceptualization of challenging behaviour – from the more obvious biomedical explanations to accounts such as the ‘ecosocio’ and biopsychosocial.

Medicalization is not a problem in and of itself, since understanding phenomena medically can be extremely helpful, if not life-saving. The issue is what it means to understand phenomena (especially phenomena that aren’t previously considered of medical interest) from a medical perspective. There are problems associated with medicalization, chief of which is the tendency for an overemphasis of a medical way of thinking about phenomena such as behaviour. Medicalization in school settings can mean that medical authority takes precedence over other viewpoints or interpretations, one of which, as we go on to discuss, is the perceived need to be reflective about teaching practices.

MEDICALIZATION

There are differing definitions of medicalization, with Williams and Calnan (1996) providing a summary that commences with Illich’s critique that makes claims regarding to the way medical knowledge controls the public and in so doing, deprives them of skills; to Foucault’s (1979, 1994, 2006) well-known arguments about the clinical gaze, the effects of discourses and how these produce ‘docile bodies’. One of the observations about medicalization that makes it profoundly important to wrestle with (and especially for special education) is the way that what was once not medical, becomes so. For example, with reference to mental disorder:

Before the problems are medicalized, construed as a mental disorder or as mental health problems, they may appear as problems of bringing up children, being of many kinds, boy/girlfriend/parent generated troubles in adolescence, poverty-related or overwork-related worries, problems of laziness, lack of motivation, shyness, male aggression, problems associated with social exclusion of many kinds, antisocial or criminal behaviour. None of these kinds of problems areas has to be construed as a medical or to do with mental health . . . The medicalization of these types of problems is one particular kind of social representation and set of practices among others. (Bolton, 2008, p. 256, emphasis added)

How then do problems such as shyness or troubles in adolescence become medicalized? Reflecting on the interest of the State in matters of health, Foucault made the observation that ‘the present situation has actually been developing since the eighteenth century not as a theorization, but a “somatization”’ (2004, p. 7). This ‘somatization’ ‘sees the care of the body, corporal health, the relation between illness and health, etc. as appropriate areas of State intervention’ (Foucault, 2004, p. 7). Does for instance, shyness in school settings need to be referred to and placed under the care of a medical gaze? When actions such as this occur, it becomes readily apparent how schools, via their referral to and engagement with medical expertise function as an edo-somatocracy.

Add to this concentration on health is what Foucault identified as the ‘scientificty’ of medicine and what he termed ‘undefined medicalization’. The former draws attention to the power wielded via scientific knowledge – how, for example, via its scientificty, medicine has a much greater reach than between one clinician and his or her patient. It reaches, for instance, to a range of biotechnologies that affect us at the population, and as some now argue, the global scale (Rabinow & Rose, 2006; Rose, 2006). ‘Undefined medicalization’ refers to medicine moving beyond its traditional field, to areas such as law, employment and to our area of interest, education (Foucault, 2004). Just as someone wishing to be employed or who has committed a crime might be medically examined, so too are children in schools. They might be examined because they are doing very well (are they gifted?) or because they are not moving at the same rate as others (are they slow?). Children might be referred for medical examination because they misbehave (do they have a behaviour disorder?).

It is perhaps the issue of ‘undefined medicalization’ that is of particular concern in education and in special education in particular. This is where the extension of medicine and medical knowledge is palpable, with the clinical gaze reaching much further than the four walls of a physician’s surgery (Harwood, 2010a). Recent work has proposed the importance of conceiving the clinic – and its gaze more broadly. In much the same way, institutionalization can be understood as occurring without walls (Priebe, 2004). In this sense, the influence of all things medical needs to be understood in more complex ways, and certainly, medicalization is not always a progression of ‘an increasing hold of medicine over things and people’ (Fassin, 2011, p. 88).
Nye (2003) offers a useful explanation of medicalization, maintaining it is a ‘process whereby medical and health precepts have been embodied in individuals who assume this responsibility for themselves’ (p. 117). This way of viewing medicalization is likely to be debatable, since for one, it makes medicalization something that is possible from myriad practices. By contrast, Williams and Calnan’s definition echoes a more widely assumed definition, that the ‘concept of medicalization refers to the ways in which medical jurisdiction has expanded in recent years and now encompasses many problems which hitherto were not defined as medical issues’ (1996, p. 1609). In this sense, there is much more to medicalization than the actions of those who have the official power to diagnose. There is an important function that discourses have, whether via the direct route from physician to patient, or via more circuitous processes that involve a number of aspects, including the influence of media representations (Coveney, Nerlich, & Martin, 2009).

THE CASE OF TEXTS THAT MEDICALIZE CHALLENGING BEHAVIOUR

Challenging behaviour provides a useful case study for analysing how medicalization occurs in educational contexts and specifically, how it becomes integrated into special education. While often assumed to be the domain of special education, challenging behaviour intersects with many areas of schooling with discourses of behaviour weaving into teacher conversations, textbooks and into children’s playgrounds. Such processes connect special education to education more broadly, as well as explicitly connecting education and special education. In our analysis we particularly focus on discourses, for these enable medicalization to be ‘undefined’ (Foucault, 2004), traversing other fields to extend the influence of medicine. Foucault (1972) described discourse as the ‘practices that systematically form the object of which they speak’ (p. 72). From this perspective, medicalizing discourses systematically form their medicalized objects. In contemporary educational contexts, teachers and schools play an integral role in the diagnostic apparatus for behaviour disorders (Harwood, 2006), including those disorders characterized by attentional deficits, impulsivity (such as blurtting out answers) and fidgeting (APA, 2005). In having this function, teachers and schools become involved in processes that medicalize. This is not to say that this is a necessarily deliberate practice; rather, medicalization can extend in a range of practices beyond the clinic. One of these domains is teacher knowledge, and it is here that the scientificity of medicine as well as undefined medicalization (Foucault, 2004) can influence the daily interactions in the classrooms of teachers.

In Australia, accredited teachers must have specific knowledge of and strategies for teaching children with ‘challenging behaviour’ (Education Services Australia, 2011). Such requirements are not confined to countries such as Australia, England and the United States have similar teacher accreditation requirements. One of the ready routes by which medicalization can occur, can be studied and, arguably, might be countered, is in the textbooks and reading materials given to pre-service teachers (students studying education). The extent of medicalization became readily apparent to us when we closely reviewed readings for university courses on knowledge and pedagogy for children with challenging behaviour that were given to student teachers in an undergraduate program at an Australian university.

In our survey, 73 unique texts were reviewed (including textbooks, book-chapters, journal articles and policy documents). As might be expected in any teacher education course, discerning what documents were included in, or excluded from the review was a complex process. University subject outlines (as well as their respective required and recommended readings) were selected based on whether they addressed the local professional teaching standards. From this process, 20 subjects in the undergraduate program schedule were identified. Following informal interviews with subject coordinators of the 20 identified subjects, 11 subjects were discarded from the review for one of two reasons: either the subject was an elective that did not run due to low enrolments; or, the standard was included in the subject outline for one of the other criteria in standards 2.1.5 and 2.1.6 (i.e., the coursework related to teaching Aboriginal and Torres Strait Islander students, students with Special Education Needs [SEN] or Non-English Speaking Background students, but not ‘students with challenging behaviours’). Required and recommended readings of the remaining nine subjects (comprising six compulsory and three elective subjects) that addressed New South Wales (NSW) Institute of Teachers’ teaching standards about challenging behaviour were included in the document review. Of the 73 texts, 49 addressed the topic of behaviour, and it is these texts that inform our analysis of education texts and medicalization.

In these texts we found that three different ‘types’ of children were described as challenging, with types differing in terms of the assumptions about causal attributions: (i) the in-actively challenging child; (ii) the pro-actively challenging child; and (iii) the re-actively challenging child. This generated a triple taxonomy (see Table 53.1). As we will outline, it is possible to identify the influence of medicalization in each of these ‘types’ – even though one of these appears at first glance to be the antithesis of medicalization.

The first ‘type’ that we identified in the education texts, the in-actively challenging child, occurred when challenging behaviour was construed as beyond the willpower of the child. This was construed as innately part of the child’s biology and so the child was not responsible for behaving in challenging ways. The pro-actively challenging child is by contrast, not understood as dominated by its biology. Rather, in the education texts this was when the child was viewed as willfully serving his or her own purposes. These purposes can be to fulfill a psychological function or to gain or resist power. The third type that was described in the education texts that we canvassed we termed the re-actively challenging child. In this type, the challenge was seen as
mostly reactive to environmental and structural supports (or lack thereof) surrounding the child.

When a ‘type’ of child was referred to in education texts that discussed challenging behaviour, there were clear delineations between disciplines. Sociology, for instance, did not speak of the in-actively challenging child, nor did psychiatry speak of the re-actively challenging child. In this sense the types of child were very closely related to the discipline of the text.

With the exception of a few, the curriculum and pedagogy and behaviour management and SEN education texts that we surveyed tended to focus less on the teacher and the structures surrounding the child and more on the child, and did so in ways that medicalized. While behaviour management and SEN texts variously spoke of both the in-actively and pro-actively challenging child, it was the latter that dominated. These texts deployed notions of faculty, self-control and choice to assert that the challenging behaviour was a pro-active attempt for the child to fulfill a psychological need — that is, the behaviour functionally served the child. Behaviour management texts tended to describe that behaviour was learnable and thus used behaviourist and functional behaviour theories to posit the best ways to manage the pro-actively challenging child (and explicitly teach them more appropriate behaviours). Occasionally, these texts spoke of the in-actively challenging child. Firstly, the in-actively challenging child was spoken of insofar as certain behaviour was attributed to gender, and so biological differences. In these cases boys, in particular, were framed as innately (and in-actively) presenting with more challenging behaviour than girls (e.g., Brent, Gough, & Robinson 2001; Konza, Grainger, & Braddock, 2001; Marsh, 2004). Also, these texts occasionally spoke of the in-actively challenging child as the child with undiagnosed and unremedied biological dysfunction; for example, the child with undiagnosed ADHD ‘can’t help’ his/her poor classroom behaviour.

By contrast, education texts that focussed on inclusive education and reflective practice, Aboriginal education and sociology of education tended to consistently speak of the re-actively challenging child (e.g., Connell et al., 2010). This was evident because these education texts primarily responsibilized the teacher to create, critique and facilitate an environment and curriculum that was structured to support children; that is, to devoice the schooling structures and experience of that which may trigger a re-active challenge from the child.

In demarcating the different ‘types’ in these education texts we are making differentiations between biomedical and biopsychosocial discourses — discourses that are arguably difficult to disentangle. Engel’s (1977) biopsychosocial theory provides a construct for demarcating biomedical and biopsychosocial discourses of challenging behaviour. Engel’s theorization of these perspectives rests in variations of their causal attribution of behaviour. In explaining the biomedical perspective, he argues, ‘The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline...’ (Engel, 1977, p. 130). This provides a way to name and describe the biomedical view of challenging behaviour, where the cause is attributed as entirely ‘within’ the child. The naming of these discourses is reflective of the causal attribution ascribed to challenging behaviour (see Table 53.2).

We have represented causal attribution as a continuum, with the biomedical on the left, biopsychosocial in the centre and ecosocio on the right. As we argue, it is not the case that medicalization only occurs when a biomedical attribution is used; rather, whilst the biomedical is the most obvious, medicalisation of challenging behaviour can occur in biopsychosocial or ecosocio accounts. This is important to consider as it underscores the extent to which processes of medicalization can be bound in schooling and education. Importantly, each set of these pedagogical discourses (Behaviour Management, SEN, Inclusive Education, Aboriginal Education and Reflective Practice) make possible certain teacher subject positions, and as we will outline, these subject positions can become bound up with practices of medicalization.

Although there are a number of ways that these discourses can be of influence, a key one is the influence on the teacher, especially the pre-service teachers that read and learn from these texts in university settings in many countries worldwide. As might be anticipated, education texts that draw on biomedical discourses are the most likely to have medicalizing overtones while ecosocio discourses have the least. The ecosocio discourse is characterized by the understanding that behaviour is socially located and it is the social structures, physical environment, artefacts and relationships surrounding an individual that most significantly shape and prompt their behaviour. That is not to say that the individual is seen as non-agentive. Rather, there is a subtle move away from emphasizing the individual as the ‘causal’ site of behaviour; biology is de-centred as a concern and psychology’s theorization of the individual’s agency, self-control and responsibility to ‘learn’ desirable behaviours is tempered. At least partly, this discursive move is supported by particular conceptions of the adult/child relationship. That is, the causes of behaviour are located primarily ‘around’ rather than ‘within’ the child.
Education texts that draw on biopsychosocial discourses while numerous and varied are especially represented in SEN. This, we contend, poses a significant influence on medicalization in education. One of the reasons that this is influential in SEN and beyond is due to the capacity for ‘undefined medicalization’ and the impacts of scientifi cacy (Foucault, 2004), which can occur in more subtle ways. For example, because these education texts use discourses that aren’t biomedical or advance at the outset a biological cause, they appear to be not medicalizing. However, this is often far from the case. Furthermore, there are the snowballing influences of other discourses that can serve to reinforce or even build upon medicalizing viewpoints (Harwood, 2010b).

As the name suggests, biopsychosocial discourses sit in the middle of the continuum of causal attribution for behaviour that spans from ‘within child’ to ‘socially located’. In this way the biopsychosocial discourse provides a theoretic middle ground for understanding challenging behaviour. Importantly though, the biological premise of the biomedical discourse (that the problem is within the child) is accepted in the biopsychosocial discourse. It is the psychological factors contributing to the biopsychosocial understandings of behaviour that distinctly differentiate this discourse from the biomedical and ecossocio discourses.

Arguably, biopsychosocial discourses for understanding behaviour function as an ideal combination of medicine and psychology. The point of conceptual overlap in the combining of these disciplines is essentially a biological one. However, this biological point of agreement is also a point of schism. For example, the biomedical discourse holds that behaviour is symptomatic of biological dysfunction and it follows that a person, or their environment, is not to be blamed or held entirely responsible for their behaviour. Unlike the biomedical perspective, the biopsychosocial perspective holds that learning from teachers, peers, home-life and psychotherapy can positively impact on dysfunctional behaviours. So then, the central defining tenant of the biopsychosocial discourse of challenging behaviour rests on the distinctly psychological tenant that, although biology is a factor, ultimately, behaviour can be learned. Yet, while appearing non-biological and in many ways, as countering a medical view, the biopsychosocial discourse does in many instances, support medicalizing perspective. This discourse can and does, medicalize.

**TAKING STOCK OF THE IMPACTS OF ‘UNDEFINED MEDICALIZATION’**

Discourses of behaviour could be simply named according to the disciplines that offer statements on the topic. What is problematic in this approach is this can elide the ways that medicalization occurs in education texts. The disciplines of medicine, psychology, sociology and education did not offer the unique ‘discursive regularities’ on ‘challenging behaviour’ that traditional conceptions of ‘discourse as discipline’ seemed to warrant.

By re-casting of discourses of challenging behaviour according to causal attribution rather than discipline it is possible to see how an undefined medicalization progresses – and how, as Foucault (2004) suggests, this forms part of an apparatus that, to put it in strong terms, socially controls children in schools. This can be demonstrated in a vertical assessment of Table 53.2. Reading down the columns, each discourse of challenging behaviour can be seen to generate and delimit certain conditions of possibility for pedagogy and teacher subjectivities and gives rise to different possibilities for talking about children with challenging behaviour in educational contexts. Each discourse also maps against specific pedagogic discourses and gives rise to unique possible subject positions for the teacher.

For instance, particular clusters of pedagogical discourses can generate subject positions for teachers in relation to the challenging child. Teachers who speak of the in-actively challenging child may position themselves as ‘non-expert’ in relation to children with challenging behaviour. This teacher might
only see him/herself as a non-expert because the challenge is biologically innate and so irreparable by means of teaching. In this scenario there is very little ‘teaching’ as it were, to do. One very problematic interpretation is that the teacher is no more than the enforcer of treatment modalities; ensuring medication regimens are adhered to. In effect the teacher becomes a part of the assemblage ensuring compliance (Allan & Harwood, 2013).

Ecosocio discourses, by contrast, would describe a re-actively challenging child, and position teachers along a continuum of possible subject positions where the teacher is a supporter. The teacher may question if the physical environment, classroom routine, relationships, lesson design, timing, pacing, content and resources are supportive. They may be encouraged to query if lessons are engaging, or whether the teachers are culturally sensitive to their students’ lives. Education texts using these discourses reminded teachers to constantly reflect on curriculum and pedagogy. From our assessments, understanding behaviour in this way has a significant impact on possibilities for talking about and responding to individuals with challenging behaviour. In this sense, education texts that drew the most on ecosocio discourses tended to medicalize the least.

In our view, it is the biopsychosocial discourse that has the most potential to medicalize. The teacher who draws on the biopsychosocial discourse manages a pro-actively challenging child. This positions the teacher along a continuum of expertise that has a focus on ‘managing’ the child. When the teacher manages using these biopsychosocial discourses they do so with the knowledge and experience to successfully carry out a raft of potentially-medicalizing activities. These include: conducting functional behaviour assessments; identifying reinforcers; designing and employing token economies; promoting positive feedback; discriminating appropriate use of extinction strategies; and explicitly teaching target behaviours. While we readily acknowledge an interlocutor who might raise the objection ‘these are psychological strategies and not medical’ we stress the effects of undefined medicalization. Because of their conceptual relation (or overlap) with biomedicine, these actions are implicitly linked to medicalizing knowledge, and documentation processes such as functional behaviour assessments may become documentary springboards to diagnoses or medication reviews or to referrals to school counsellors.

Positing three discourses of challenging behaviour is not tantamount to offering three definitions. The categories offered are far too broad and overarching for that. The breadth of the discourses works to encompass ‘the mess’ of definitions found in education texts and policy documents. This provides a framework via which it is possible to grasp how medicalization is present in the education texts used in pre-service teacher programs. By offering these three discourses of challenging behaviour, it is possible to unravel some conditions of possibility as to how these are talked about, who may do the talking and to what effect. It would be wise, we suggest, to dig deeper into the education texts that are used, and at the very least, incorporate education about medicalization and critique of these discourses in pre-service teacher education courses.

CONCLUSION

How then, do we work with these tendencies to medicalize in a medicalization-rich culture? Is it possible for knowledge (and the special education texts that draw on this knowledge) that has the capacity to medicalize to be used to inform, as opposed to medicalize? We can identify the tripping wires that spark the medicalized route. Carter, Clayman and Stephenson (2006) found that the most frequent of the challenging behaviours identified by primary school teachers were: being off task (lacking attention to the task at hand); talking out of turn (not observing conventions of silence in educational contexts); and, being out of their seats (unwanted physical mobility during seatwork). Seatwork, as Adams (2006) and Graham (2006a, 2006b) point out, is highly valued in contemporary educational contexts. What if we taught pre-service teachers about these tripping wires and asked them to consider how social activities such as seatwork can become objects for a medicalizing gaze? Might it be possible to encourage teachers to reflexively engage with their own practices that might medicalize the social and in so doing to make the move to medicalization more transparent? At the very least such analysis would put teachers in an informed position where they might weigh up the knowledge that is applied to understanding the children in their care.

Perhaps what is most at stake is the lack of awareness (and debate) of medicalization and medicalizing processes as opposed to medicalization in and of itself. Medicalization is not something confined to and the responsibility of those employed in the discipline of medicine. To depict medicalization in this manner would be foolhardy, and risks missing the extent to which education is involved. We would be wise then, as Fassin (2011) sought, to ‘complicate somewhat the paradigm of the medicalization of drug abuse’ (p. 92) to strive to complicate the medicalization of children and young people in special education. Toward this Fassin (2011) suggests considering medicalization from the viewpoint of ‘problematization’, arguing:

Problematization avoids considering a particular configuration of reality either as an ‘anthropological constant’ or as a ‘chronological variation’ and allows analysing ‘questions of general import in their historically unique form’ (Fassin, 2011, p. 87 citing Foucault, 1984, p. 56).

The point is not to find a solution by invoking a structured analysis of medicalization and applying this to special education. Rather, it is to encourage problematizing medicalization, which could include problematizing how special education might be simply depicted as medicalizing. It is more important, we suggest, to consider how medicalizing practices may or may not be present and to what effect. For this reason, biopsychosocial discourses demand more careful attention. It is easier to identify, and consequently, problematize biomedical discourses. For instance, take the teacher who believes the cause of behaviour to be biological and consequently sees himself/herself as a non-expert on challenging behaviour. If this teacher is talking of the in-actively challenging child, we might readily assume a biomedical understanding is being implemented. But
what of the biological overlap in the biopsychosocial? Might the teacher who describes responding to a pro-actively challenging child also be influenced in particular ways by biological beliefs?

These are valuable considerations because one of the problems with a medicalizing thesis of behaviour is the impact on the teacher, whether it convinces them of a biomedical standpoint or prompts confusion when drawing on biopsychosocial discourses. Such confusion can occur when a teacher using a biopsychosocial discourse draws on biological interpretation of behaviour and consequently oscillates between biological and psychological explanations. This leads to switching understandings and responses between for example the child can’t change or the child can. Moreover, one of the seductive properties of the theoretic middle ground (the biopsychosocial discourse) is that it positions the teacher as expert in educational interventions to teach and modify behaviour. Yet this very positioning as expert can be the prompt for undefined medicalization to occur.

Being aware of medicalization, and especially the teacher’s role in this process, is important for reflective practice in special education. Indeed, it is perhaps the issue of reflective practice that stands out to us as the fundamental reason for rigorously engaging with the concept of medicalization in special education. We must, we contend, be aware of the lines that are drawn by ourselves as much as by others:

In practice we must draw a line between what counts as medical care and what does not. The question is where to draw that line. What is a disease and what is not? What should be treated medically, by physicians or medical personnel, and what should not? (Szesz, 2007, p. xiv)

We might do well to take an active stance in where we want to draw the line, and we would do well to educate our future teachers that part of their practice (whether they like it or not) is not just deciding where they sit on that line. By virtue of working in education and in special education in particular, they are making decisions and drawing a line on a very regular basis.

NOTES
1 The name ‘ecosocio’ is used to refer to a blend of the names of several disciplines that deploy this unique knowledge of challenging behaviour: ‘ecological’ (from ‘ecological psychology’) and ‘sociology’, and we use it to portray the cross-disciplinary utility of this discourse.
2 These texts included coursework textbooks and readings used in pre-service teacher education.
3 In our analysis, we examined the New South Wales Professional Teaching Standards. New South Wales is the largest Australian State, and provides a good contemporary case study on the education texts that influence teacher education degree programs. We specifically used 2.1.5, 2.1.6 and 3.1.5 of the standards as 2.1.5 and 2.1.6, which were the teaching standards that explicitly mention ‘challenging behaviour’ (New South Wales Institute of Teachers [NSWIT], 2006, p. 6). Standard 3.1.5, whilst not explicitly mentioning challenging behaviour, is the first in a progression to standard 3.4.5, which does explicitly mention ‘challenging behaviour’ (NSWIT, 2006, p. 8).
4 Examples of texts that were exceptions include Groundwater-Smith, Ewing, & Le Cornu (2007). Curriculum and Pedagogy and Behaviour Management texts included Brady (2003); Koen, G.

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INTRODUCTION

Contemporary writers on special education face a particular challenge. They have to take account of quite distinct frames of reference, each with its own history and discourse, which are not always well aligned with each other. The first frame of reference is the situation of the individual child and young person whose learning may be compromised by a mixture of innate, environmental and interactive factors. A second frame of reference derives from the school and its associated systems dedicated to promoting learning — the curriculum, assessment, support services, policy and resourcing. A further frame of reference centres round the future of schooling and issues to do with quality of life and reasonable expectations.

This serves to highlight the overarching challenge posed by the present enterprise. Producing a handbook in any domain of education is an ambitious task, doing so in special education all the more so because of the dynamic nature of the field and the multiple frames of reference that bear on it. What this handbook provides is a mapping of a changing — and contested — domain, a distillation of thinking about particular parts of it and a review of what is known about specific areas of practice. Contributions range over the vastly different situations of individuals and give rich, nuanced accounts of their learning environments. To the extent that many of them are cutting-edge in their knowledge of the field, they point suggestively to the future in terms both of roadblocks to circumvent and pathways to follow.