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Society, Schooling, and Childhood Misbehavior

What seems self-evident in daily classroom experience—the disruptiveness of certain student behaviors and the sense that these behaviors somehow must change—has deep, tangled roots within schools and society itself. Beyond the initial, frustration-ridden impulse to call some students "bad" or "disordered" runs a host of complex issues about how our society raises and schools children. Examining these issues leads us to explore how we have come to view and treat challenging children, a journey that brings us inevitably to interrogate ourselves—to question who we are and what we think we are doing.

Deviant and disruptive student behavior is anything but a recent issue. The most difficult task a teacher has faced from colonial days through modern times is dealing with the disrespectful and rowdy behavior of students (Cremin, 1970, 1980, 1988). One-room schoolhouse teachers on the prairies of the early 1800s often complained of the overwhelming burden of managing 40 to 60 students of all ages and abilities in one large room. Central to this challenge was effectively withstanding the tradition of "turning out" the teacher, an age-old ritual in which the children attempted to cruelly persuade a new teacher to quit by placing numerous roadblocks and humiliations in his or her way (Cremin, 1980). It was common practice in many 19th-century schools for teachers or principals to settle conflicts with students with bare fists. Tyack

(1974) tells the story of one frontier principal who was reprimanded by local authorities not for fighting with a student but for losing that fight.

Occasionally, one hears nostalgic voices calling for a return to the "good old days" when children were as saccharine and obedient as Wally Cleaver; however, there is no historical evidence of any such times (Coontz, 1992). Teachers have always had to deal with troubling students. What has changed dramatically over time are the kinds of trouble; the social problems facing children, families, and schools; and the ways that schools and professionals have viewed those problems.

An exploration of the history of behavior problems in the American public schools allows us to take a broader view of the issues we are facing today, making our current perspectives seem less absolute and our current steps less sure-footed. We can understand how behavioral difficulties have changed over time, how the problems of misbehavior in the schools have been linked to the difficult social issues of various time periods, and how changes in educational and mental health professions altered the way such problems were perceived and handled. In this chapter, we focus on student behavioral and social problems during the 20th century in order to understand how we have arrived at our current array of challenges.

AMERICAN SCHOOLS BEFORE 1900

Here [the public school] children should be taught the usual branches of learning, submission to superiors and to laws, the moral or social duties, the history and transactions of their own country, the principles of liberty and government. Here the rough manners of the wilderness should be softened and the principles of virtue and good behavior inculcated. (Noah Webster, as quoted in Cremin, 1980, p. 265)

By 1900, public schools supported by tax dollars and serving white students were operating in virtually all regions of the country. Early public schools were founded by political leaders who envisioned an institution in which to pass on the values and beliefs of democracy to the young. This included preparation in the traditional European academic disciplines deemed necessary for proper citizenship. Additionally, this early idea of schooling embraced a distinctly Anglo-Saxon, Protestant brand of morality—a combination of work ethic and a fairly submissive orientation to religious tradition and civil authority (Cremin, 1970, 1980, 1988). To the 19th-century founders of public education and the educators of 1900, a vast portion of the mission of the public schools was the education of children as virtuous citizens.

Business and municipal leaders often encouraged the schools to bring virtue to families viewed as incapable of correctly raising their children. The schools could rein in the wayward and unclean children of the lower classes. The child in dire need of moral correction—according to the public schools of

1900—was poor, male, and either an immigrant or a rural transplant to the city. His parents worked as low-wage laborers for a factory, mill, or forge. They probably spoke a foreign language such as German or French. It is likely they were Catholic or Jewish. This "problem boy" either worked side by side with his parents or spent his days unsupervised on the city streets. Professional attention was devoted to softening the rough manners of this uncivilized child (Cremin, 1980; Katz, 1971; Nasaw, 1979).

TURN-OF-THE-CENTURY CULTURAL CHANGES

The American public schools at the dawn of the 20th century faced a host of serious problems arising out of dramatic, 19th-century changes in the social fabric of the country. By 1900, American society had become increasingly industrial. Between 1860 and 1890, the United States grew from a primarily agricultural nation into a world industrial power. Nasaw (1979) notes that although the United States trailed England, France, and Germany in industrial production in 1860, by the mid-1890s, the New England states alone outproduced all three of those nations combined.

Simultaneously, a great proportion of the American population shifted to the industrial ghettoes of the major cities. An agrarian, rural nation was changing into a modern form that combined industrial production and urban living. The booming factories of the large cities employed vast numbers of new arrivals, eastern and southern European immigrants as well as rural Americans fresh off the farm. The urban ghettoes quickly became the steaming holding tank of the industrial workforce, an overworked and underpaid labor resource with slim hope for economic advancement and individual achievement. These overcrowded neighborhoods often had no functioning sewer systems, no electrical service, no running water, and infrequent garbage collection. Most families lacked basic dental and health care. Disease, malnutrition, crime, and discontent brewed in the overpopulated, impoverished neighborhoods of the factory worker class (Addams, 1972, 1981; Katz, 1996).

The public schools in large cities such as New York and Chicago faced enormous challenges educating the children of poor immigrants. More than half of all students in major urban public schools were immigrants or the children of immigrants. Whereas English was the language of schools, most students spoke a foreign language at home (Richardson, 1989).

THEORIZING JUVENILE DELINQUENCY

Government officials and the public worried about the "youth problem" during the first three decades of the 20th century. Within the industrialized urban ghetto, juvenile delinquency was born. How juvenile delinquency was viewed and dealt with was very different prior to 1915 and after 1915. Before 1915, those

attempting to solve the urban youth problem were radical childsavers—groups of primarily well-to-do, college-educated women who were the forerunners of the social work profession. The radical childsavers viewed juvenile delinquency as a complex social and political problem requiring intervention at many levels. Certainly, the energies of adolescent boys and girls required redirection toward more productive and healthy pursuits. But they were well aware that the delinquent youth they encountered were primarily immigrants who struggled to cope with the social prejudices, unjust laws, and economic inequalities of their new land. The problem was not merely an individual failure of an immoral child or the child-rearing failure of incompetent parents. The delinquent was just one aspect of a complex social puzzle (Jones, 1999; Richardson, 1989).

The radical childsavers worked on a number of political fronts to improve the lives of the urban poor: They worked to increase public welfare programs to support the poor; initiate mothers' pensions so that mothers could stay home and raise children instead of working; pass child labor laws outlawing or limiting the number of children working in dangerous factories; decrease the industrial laborers' standard work hours to permit parents time and energy to spend with their children; and increase the strength of unions to bargain for workers' rights and fair compensation. The childsavers knew that social and economic changes were necessary to alleviate the underlying stresses and obstacles facing poor families and neighborhoods. Their practical politics attempted to improve home, work, and community conditions for the immigrant poor, emphasizing education, nutrition, health care, recreation, and the interdependence of the community (Addams, 1972, 1981).

After 1915, efforts to solve the problem of juvenile delinquency took a dramatic turn, changing the focus from social and political problems surrounding youth to the defective character of the individual delinquent. With this change in theory came a shift in strategies. Many efforts turned away from political activism addressing the living and working conditions of poor, immigrant families and toward professional interventions to diagnose and change the maladjusted individual. The turning point was the publication of an enormous 800-page volume called *The Individual Delinquent* by a physician named William Healy (1915), an early leader in the development of child guidance clinics that offered mental health services to troublesome youth and their families. In his studies of delinquents in Chicago, Healy searched for the root factors that caused delinquency. He combined environmental factors and individual biology, what we would call nurture and nature, to explain that delinquency was a complex phenomenon with many causes but only one location: the defective character of the individual. To Healy, with his medical training emphasizing physical and mental disease, the proper way to address the problem of delinquency was the medical treatment of the individual child. Social change and political activism were irrelevant (Horn, 1989; Jones, 1999).

By 1921, Healy's focus on the individual had swept the imaginations of early mental health professionals. In that year, the influential Commonwealth Fund brought together leaders in the new field of juvenile delinquency for a conference

in Lakewood, New Jersey. Conference participants did not even consider the social and economic conditions faced by immigrant families. The conference report deemed topics related to "poverty, variations in employment, migration to cities with consequent exposure to bad housing and other similar conditions" (quoted in Jones, 1999, p. 59) as irrelevant and therefore beyond the scope of discussion. Edith Abbott, a prominent social worker, was a lone critical voice, claiming that the Illinois Child Labor Law of 1917 had done more to decrease juvenile delinquency than all the mental health treatment offered by a well-known Chicago child guidance clinic. But her voice was ignored. Physicians, psychologists, and powerful funding groups like the Commonwealth Fund (a charitable arm of Standard Oil Company) followed Healy's lead. Juvenile delinquency was not a social and political problem. It was a medical and psychological problem of poor adjustment. What was needed were mental health professionals to help children become more adjusted to the conditions of their lives. The social change approach of the radical childsavers had been replaced by a professional mental health approach that denied the salience of social inequality in the lives of poor immigrant families (Horn, 1989; Jones, 1999; Richardson, 1989).

The juvenile delinquent was, virtually by definition, the disrespectful and dangerous child (typically a boy) of urban factory worker parents (Slawson, 1926). The helping professionals generally viewed this son as wild and menacing, a threat to the social order. Charles Loring Brace, the founder and long-time executive of the Children's Aid Society in New York City, "referred to the neglected children of the 'outcast poor' as the most threatening members of the 'dangerous classes' and conveyed the impression that unless immediate action was undertaken the more respectable classes would soon be overwhelmed" (Cremin, 1988, p. 276).

At the turn of the century, many viewed the public schools as the primary means of compensating for perceived weaknesses in the child-rearing practices of working-class families, approaches that reformers viewed as failing to instill the values of cleanliness, obedience to authority, and hard work. As Cremin (1988) describes, educators and helping professionals "never really trusted the mother" (p. 294). Mothers were frequently seen as ignorant or neglectful. The helping professions and the public schools focused their attention on cleaning up the troubling behavior of this new class of urban youth—lower-class adolescents who roamed the streets late at night, drank, spit, used foul language, gambled, performed sexual acts, frequented dance halls, and engaged in petty thievery.

Richardson (1989) explains why boys became the primary focus for professionals concerned with juvenile delinquency. The primary offense of the delinquent was truancy, or failing to attend school. Massachusetts enacted the first compulsory school attendance law in 1852. The last state to enact a compulsory attendance law was Mississippi in 1918. In the late 1800s and early 1900s, a girl who missed school was typically assumed to be at home helping with gender-appropriate domestic chores such as cleaning and child-rearing. In a sense, her very absence from school was preparing her for what most viewed as her

future. On the other hand, boys who missed school were viewed as dangerous elements within their community, street criminals in the making. Therefore, truancy was viewed as a problem primarily involving boys and not girls. The professionals' preoccupation with the activities and offenses of boys was to continue throughout the 20th century.

THE NEW HELPING PROFESSIONS: SAVED BY SCIENCE

> Science would produce the experts who would serve the common good.
> (Cremin, 1988, p. 243)

The shift from viewing juvenile delinquency as a social and political problem requiring a wide range of social actions to an individual problem requiring treatment was one indication of the power of the new helping professions. The development of helping professions of a scientific nature occurred as a prominent response to the 20th-century social problems of immigration, urbanization, and industrialization. By 1900, scientific ways of viewing social issues and possible solutions had become increasingly popular in the media and the public. Educators who called themselves "progressives" espoused the need for educators to develop an expertise based in the new social sciences. Given the success of the physical or natural sciences, as evidenced in the development of the engines that powered factories and railroads, it was common to hope that the application of scientific methods to the social world would produce similarly fantastic improvements in society.

The human service professions such as psychiatry, psychology, social work, and education claimed scientific expertise in raising children of a moral and virtuous character. They believed that the problems of poverty and social deviance could be solved through the action of professionals whose practical expertise was based in this enlightened understanding. Universities would provide the research to unlock the social puzzles of modern life. Professionals would put this research into practice. By the early 1900s, the new social science-based professionals were applying their newly minted expertise within the public schools (Baritz, 1960; Cremin, 1988; Danforth, 1997).

Perhaps foremost among the turn-of-the-century educational reformers who claimed a scientific quality to their methods were the "administrative progressives" (Tyack & Hansot, 1982, p. 105)—turn-of-the-century schoolmen (early administrators) who claimed that schools should be run not by local politicians but by professional leaders who could make decisions through scientific means. Prior to the development of the professional administrator (and the science of management), schools answered directly to local political leaders—mayors, city councils, ward bosses, and so on. The new professional administrators said that they would pull the schools out of politics by managing them in an objective and unbiased way.

These early school administrators remained closely linked with the wealthy corporate leaders who served as their advisors and financed the political operations necessary to bring about the switch to the management of schools by professional administrators. The common value that both the business leaders and the educational administrators gravitated toward was industriousness, the old Protestant work ethic refashioned to meet the personnel needs of factory owners (Cremin, 1988; Tyack & Hansot, 1982). Business leaders influenced schools to prepare factory workers by altering the traditional academic curriculum with industrial education tracks, including special classes for poor, immigrant, and "backward" children. These early forms of "ability tracks" were designed to instill in working-class and poor students the limited aspirations and efficient habits needed for a life of manual, industrial labor with low pay and little opportunity for advancement (Katz, 1971; Tyack & Hansot, 1982). This was the beginning of the differentiated curricula that culminates today in both ability tracking and special education programs.

SOCIAL ILLS AND NEW MENTAL HEALTH PROFESSIONS (1890–1945)

As the new mental health professions of psychiatry, psychology, and social work sought legitimacy for their fields, they often worked in conjunction with the public schools. The most prominent and powerful mental health field of both the early 1900s and today is psychiatry.

Before 1890, the field of psychiatry had been devoted to the development and management of institutions for lunatics (the mentally ill) and the feeble-minded (the developmentally disabled). Yet it had been viewed within the medical profession as unscientific and greatly ineffective. To many physicians, it wasn't even a branch of medicine.

By the end of the 19th century, psychiatry embraced the notion that a more scientific approach to the diagnosis and treatment of mental illnesses would allow psychiatrists to make a dramatic impact on social problems of the community. Although the psychiatric profession had demonstrated little or no success treating mental illness in decades of institution work, a new horizon for professional authority dawned. They would practice the "new psychiatry" (Grob, 1994, p. 129), a yet undeveloped but supposedly more scientific mode filled with great promise. They would apply this new curative power to the common social afflictions of the time: juvenile delinquency, prostitution, alcoholism, economic dependency, widespread syphilis infections, vagrancy, and the problematic adjustment of European immigrant groups.

Jettisoning their history as institution managers, these physicians used the promise of a new medicine of mental disease as a means to expand their professional authority beyond institutional walls. They would seek a medical approach to common social problems and suffering. In the early 20th-century

rush of professionals to harness science to gain authority and expertise over social problems, psychiatry led the way (Grob, 1983, 1994).

The new mental health fields of child psychology and psychiatric social work derived much of their legitimacy from their close affiliation with the developing field of child psychiatry. Medicine was viewed by government officials, research funding foundations, and the American public as the most trustworthy and authoritative human service profession.

Ironically, as the less prestigious mental health professions (especially social work) hitched their stars to psychiatry in hopes of looking medical, the field of psychiatry itself struggled to be viewed by other physicians as a real branch of medicine. The 20th century brought a unique opportunity for psychiatry to step out of the institutions and into the limelight. Modern social problems were described by the media and the professions as dire. Horn (1989) captures the common sentiment in a 1926 editorial from a prominent mental health profession publication:

> It seems to be an accepted axiom nowadays that our young people are going to the devil. Press, pulpit, and publicist are agreed that youth is wild and getting wilder. The college boy and his flapper friend, it is charged, drink, pet, and are disrespectful to their elders; while the neighborhood gangster, aided by his youthful sweetie and stimulated by false course of heroin or cocain, robs and murders with casual calmness long before he is out of his teens. (p. 10)

If the times were supposedly troubled and dark, the professions spoke of optimism and light. The progressive mentality of the times put forth a new belief that social problems could be solved by forward-thinking, scientific workers. This combination of widespread social problems (or at least the public perception of such problems) and the promise of the new sciences of human psychology and behavior offered psychiatrists and other mental health professionals an opportunity to gain prominence as leaders in the business of solving social ills. Undoubtedly, these professionals gained tremendous prominence. How well they have been able to live up to their early ambitions of solving social ills is open to question (Grob, 1983, 1994; Horn, 1989; Jones, 1999; Richardson, 1989).

THE EARLY MENTAL HYGIENE MOVEMENT (1890–1930)

The creation of the mental health professions as a way of alleviating suffering and regulating deviance and nonconformity in communities—often called the mental hygiene movement—was launched by a book that spoke not of social change and society but of the cruelty of psychiatric institutions. Clifford Beers spent 3 years in a series of psychiatric facilities after attempting suicide. His

groundbreaking book, *A Mind That Found Itself* (1907), was both a harsh critique of terrible conditions within mental hospitals and an eloquent personal testimony to the curability of mental illness. His criticism of institutions was raw and striking, but his story about the curability of mental illness was far more influential. If mental illness could be cured, then the work of psychiatrists and other therapeutic professionals could have a profound impact upon American society. Beers teamed up with prominent physician Adolph Meyer to found the National Committee for Mental Hygiene (NCMH), the driving force behind the mental hygiene movement in the pre–World War II years (Grob, 1983, 1994).

Mental hygiene was a vague concept that meant different things to different people. The movement concentrated on the idea that social problems in the community were manifestations of mental disease that could be prevented and/or treated by qualified mental health professionals. Psychiatry—and, to a lesser extent, social work, education, and psychology—could wipe out social ills at the root cause, the mental disease (Horn, 1989; Jones, 1999; Richardson, 1989).

In 1922, the NCMH set up the Division on the Prevention of Delinquency, an organization that quickly founded a number of "child guidance clinics" in major urban areas. The child guidance clinics were multidisciplinary field teams uniting psychiatrists, psychologists, social workers, and teachers to work with poor families in urban neighborhoods. They were often affiliated with the new juvenile courts that had been set up to deal with youth crime in a compassionate way. The courts frequently sent the young lawbreakers to the clinics for treatment rather than sending them to adult prisons. The child guidance clinics were the first attempt of the fledgling field of mental health to provide treatment to children and families in an effort to prevent or cure juvenile delinquency. Their motto, a familiar stanza to current-day professionals, was to "reach them earlier" (Ridenour, 1961, p. 35), treating would-be juvenile delinquents before delinquent tendencies had a chance to fully develop.

The child guidance clinics were the modern birthplace of child psychiatry and child psychology, spawning the development of a variety of treatment program options: residential treatment centers, juvenile court psychiatric clinics, school-based mental health interventions, and outpatient psychotherapy. Most important, the clinic placed medical doctors at the steering wheel of child mental health in the 20th century. Physicians successfully moved their authority and newfound expertise beyond the very limited confines of the 19th-century institutions to enter communities and schools (Horn, 1989; Jones, 1999; Richardson, 1989).

As the various mental health specialties developed into full-fledged professions, they built up their own knowledge bases about the problems of living, their own ways of describing and thinking about the troubles that their patients faced. This vocabulary and host of concepts drew greatly from Freud's psychodynamic psychology as well as other branches of psychology such as mental measurement (e.g., IQ testing). Just as architects had their own way of talking about and conceptualizing the physical arrangement of buildings, or engineers had a way of framing problems of design and utility, so, too, did the mental

health fields create their own lingo and their own theories about the suffering, failures, and possible improvement of their patients. Beneath the increasingly complex jargon and theory ran a rather simple, everyday notion: The relationship between the therapist and the patient was both the place and the path of improvement.

THE LATE MENTAL HYGIENE MOVEMENT (1930–1945)

In the 1930s and early 1940s, the focus of the child guidance clinics shifted dramatically from the illegal behavior of the urban lower/working class toward the milder, typically legal misbehavior of the middle class. Treating immigrants who stole or vandalized gave way to treating the sons of businessmen who stayed out too late in the family car. The child mental health professions that had been launched as a means of taming the delinquent teenagers of the immigrant working class suddenly extended their expertise to include what was called "the problem child." The media, the mental health professionals, and the many new parent education groups defined the problem child as a normal, everyday child—not at all insane, feebleminded, or delinquent—who had taken a few wrong turns and needed guidance and correction. This middle-class child was predelinquent, displaying rather mundane behavior problems that required address before they bloomed into more serious concerns (Horn, 1989; Jones, 1999).

The change in child guidance clinic clientele occurred for a number of reasons. First, the child guidance clinics could not boast much success in curing juvenile delinquency. Although their diagnostic and treatment programs undoubtedly helped some youth and families, the problems of poverty and cultural dislocation facing new immigrants ran too deep for psychotherapy. Second, the mental health professionals and the media made great efforts to popularize the child guidance clinic approach to child rearing. Rearing children was not a matter of following maternal instincts and traditions, they claimed. It was a psychological matter requiring professional training. Magazine and newspaper articles by these new experts encouraged mothers to view themselves as inadequate and to view the mental health professionals as child-rearing authorities.

Finally, the radical modernization of American society put new stresses on middle-class families in the 1930s. The rapid pace of social and technological change that is very familiar to current-day readers had begun. The small, relatively private world of parents and children had been split open by the development of automobiles, the cinema, and the telephone, and also by liberalized sexual attitudes among the young. Middle-class parents felt that they were losing authority over their defiant adolescents. Mental health professionals served as mediators between adolescents seeking freedom and fearful parents baffled by their child's need to rebel (Horn, 1989; Jones, 1999).

PSYCHOLOGY, MEASUREMENT, AND DISORDERS

It was the school, the courts, the police, and the army which provided the psychology of the individual with those whom it would have to be able to construe as abnormal. (Gross, 1987, p. 229)

At this point, our story turns to the emergence of the field of psychology as a social force to define the moral problems (behavior problems) of children and adolescents in the 20th century. As the modern world became increasingly scientific, civil authorities who dealt daily with the deviant behavior of children—the schools, the police, the courts, and the early juvenile prisons and reform schools—looked to this new social science for authoritative knowledge about the children who crossed them. The moral themes of 18th-century rural Protestantism—the need for hard work and submission to authority and tradition—were assumed to be upheld by the institutions of civil authority. The new social sciences and the mental health professions refurbished this old religious morality in a new scientific form, stripping away the Christian references to Jesus and the New Testament while primarily upholding the same middle-class norms of behavior and attitude.

In the first four decades of the 20th century, psychology became a budding field of expertise concerning those who failed to comply with the rules and norms defined and enforced by the schools, police, and courts. Psychologists attempted to define the reasons why some children went morally bad while others remained normal and good. During that time, the emphasis of scientific study focused on the general question, "What is wrong with this individual?" Although a variety of factors may have contributed to the life and life conditions of the child, psychology assumed that the moral failing itself was within the individual who ran afoul of authority. If a child opposed or deviated from the social order as defined and defended by the school, the police, or the courts, that child was in some way lacking, deficient, or ultimately disordered (Gross, 1987).

PRE–WORLD WAR II SCHOOL PROGRAMS FOR SOCIALLY MALADJUSTED YOUTH

Ignore children who are physically sick and they will probably die; ignore the mentally sick and they may starve to death; ignore the socially sick and they will spread the contamination of unrest and vice to vast numbers of their associates. (Heck, 1940, p. 19)

Conformity to the dominant social order is health: failure to conform is illness. (Carrier, 1983, p. 957)

Growth in special education programs in the public schools was very gradual during the early decades of the 20th century (Heck, 1940; Stullken,

1950; Winzer, 1993). For example, in 1929, special classes for disruptive students, often called "disciplinary classes," existed in only one out of every three states. Only 16 cities had special schools for delinquent children (Heck, 1940). Additional programs were called "industrial schools," which were early vocational training schools designed for working-class and delinquent youth (Winzer, 1993).

The public schools in the late 1800s and early 1900s were faced with the challenge of teaching and managing a student population of tremendous cultural, socioeconomic, and linguistic variety. Waves of immigration and the growth of the urban, industrialized poor brought many students to public schools that were unaccustomed to dealing with such heterogeneity. Ten million immigrants entered the country between the Civil War and 1900, mostly from England, Wales, Ireland, Germany, and Scandinavia. Another 15 million immigrants arrived between 1890 and 1914, mostly from eastern and southern Europe—Poles, Russian Jews, Ukrainians, Slovaks, Croatians, Hungarians, Romanians, Italians, and Greeks. Laws requiring attendance not only sent truant officers chasing after resistant children, youth, and families, but also forced schools to handle large numbers of new students who often did not fit neatly into traditional school structures and social habits.

Many school districts developed special classes and schools for remedial or immigrant children as a way of retaining the homogeneity and traditional practices of the general classroom. The new, segregated programs typically served as "dumping grounds" (Kauffman, 1976, p. 343) for the new students, who failed to fit the middle-class ideals of attitude, appearance, and behavioral style. These special programs took on a wide range of forms, each designated to a specific type of student. Many of these types parallel similar programs today. Schools for the blind, the deaf, and feebleminded (those with developmental disabilities) were direct forerunners to current special education programs. Supporting the construction of many of these types were the new mental measurements, such as the IQ test, that exploded into widespread use after World War I (Baritz, 1960; Winzer, 1993).

The educational and psychological descriptions of the socially maladjusted child of the early to mid 20th century continue the prior tendency of middle-class professionals to view the children of either the lower/working class or immigrants as morally deficient primarily because of incompetent parenting (Baker & Traphagen, 1935; Laycock & Stevenson, 1950; Slawson, 1926; Stullken, 1950) and economically deprived social conditions (Baker & Traphagen, 1935; Slawson, 1926; Stullken, 1950). It was common among psychologists and educators to conceptually link weaknesses in parenting skills with economic poverty, almost as if parents would have somehow provided more materially for their children if they were truly "good" parents. Poverty itself was often viewed as indicative of moral failure.

Although the conditions of poverty were often lamented as unfortunate, the professional descriptions of these children and their problems generally lacked a serious address of prevailing issues of social inequality in society at the time.

Political inequalities that stood as vital aspects of the social context of a child's life were absent from the educational and psychological discourse. The current practice of localizing complex social problems "in" a child who is said to psychologically carry that problem as a form of individual pathology had already captured the professional imagination (see Heck, 1940; Stullken, 1950).

AFTER WORLD WAR II: PSYCHIATRIC DIAGNOSES FOR CHILDREN

> The classification of mental diseases was an important part of the effort to substantiate the medical validity of psychiatry. (Richardson, 1989, p. 168)

After World War II, the field of child psychiatry still had much work to do to become a respected medical specialty. Child psychiatry (and the other mental health professions) still lacked a vital part of typical medical practice: diagnosis. Many psychiatrists and researchers had developed ways of classifying childhood behavior problems, but they had not yet been gathered up and formalized in a complete, authoritative way.

Throughout the 1950s, the Group for the Advancement of Psychiatry (GAP) worked to develop a formal set of diagnoses for childhood emotional and behavioral illnesses. This work culminated in the 1966 publication of *Psychopathological Disorders in Childhood: Theoretical Considerations and a Proposed Classification*, a complete manual of childhood mental illness (GAP, 1966). For the first time, mental health professionals could diagnose children with the same authority with which they diagnosed adults. This initial classification document was later incorporated into multiple editions of the *Diagnostic and Statistical Manual of Mental Disorders,* or the *DSM,* which is the backbone of diagnostic practice.

Richardson (1989) describes the development of childhood diagnoses as a boon to the status of mental health professions. Fields of research and practice that had always seemed soft and subjective suddenly had diagnoses that appeared as reliable as any medical disease diagnoses. In the decades to follow, the number and range of childhood diagnoses expanded dramatically. Gradually, the number of childhood disorders "found" among children, even so-called normal children, has proliferated greatly as the mental health professions and the American public have become increasingly accustomed to defining childhood difficulties as medical illnesses. Fears that childhood troubles could lead to adult failures ranging from unemployment to criminal activity to bad marriages have led to an enormous mental health industry of catching and treating problems early. Growing up in America has become a medical concern.

Since the 1970s, the field of psychiatry has emphasized the use of medications to alter behavior and mood. This was spurred by the pharmacological revolution that started in France in 1952, when physicians found that a medication called chlorpromazine produced a state of incredible calm, reducing agitation

and overexcitement among psychiatric hospital patients. Soon thereafter, pharmaceutical companies played the primary role in the development and popularization of other psychiatric drugs. Initially, these efforts focused on severe conditions such as schizophrenia. Gradually, pharmacology found a market for drugs that alleviated the suffering of the "normal" population, the common depressions and everyday anxieties that plagued workers, parents, and even children. Living itself became a pharmacological concern (Shorter, 1997).

EMOTIONAL DISTURBANCE AND THE SPECIAL EDUCATION BOOM (1960–1980)

Conceptualizing the problem behavior of children and adolescents as a medical problem within the field of psychiatry set the stage for special education to do likewise (Carrier, 1983). After World War II, the field of special education worked to develop categories of disability that borrowed greatly from the field of psychiatry. Types of disability were "diagnosed" through the use of "objective measures" and "clinical judgment." The disabilities themselves were conceptualized as consisting of series of characteristics or symptoms manifesting underlying disorders or diseases. In true medical fashion, disabilities were documented in medical terms of "incidence" and "prevalence." Educational programs were framed as "treatments" or "prescriptions." The knowledge base of special education was crafted in the language of medicine, thereby borrowing the scientific authority of medical science.

Of particular note was the construction of the disability category called "emotional disturbance" (ED), the educational diagnosis for students with dramatically deviant or disruptive behavior. Nationally, in recent decades, less than 1% of all public school students have been labeled ED. Schools have dealt with misbehavior through a broad range of programs, punishments, interventions, and special schools. ED programs have become a central, consistent element within the framing of behavioral difficulties in American schools.

During the 1960s and 1970s, federal legislation spurred dramatic increases in both the number of students considered emotionally disturbed educated by public schools and the number of corresponding special education teachers for these students. Public Law 87–294 in 1961 supported the education of teachers for students with visual impairments. This law was expanded 2 years later to provide federal funding for the education of teachers for students with a wide variety of disabilities, including emotional disturbance. Although political activism and legislation on the state level brought about the rapid development of special education in most parts of the country during the 1960s, in 1972 more than 30% of the states had no laws mandating the education of students with special needs (by one definition or another, varying greatly across states) (Abeson, 1972). The federal government estimated in 1975, at the time of the passage of the landmark Education for All Handicapped Children Act (Public

Law 94–142) mandating special education across the nation, that 1.75 million children were being excluded from public education because of disability (Zettel & Ballard, 1979).

Whereas PL 94–142 brought about sweeping developments in all areas of special education by requiring local districts to provide an education for all children regardless of disability, it had a particularly large effect on the growth of public school programs for students considered emotionally disturbed. A 1980 study (National Rural Research and Personnel Preparation Project, 1980) found that PL 94–142 had brought about an immediate 478% increase in the number of students labeled ED in American public schools in less than 5 years. This sharp jump in the number of ED-labeled students in public education was a combination of the acceptance of this excluded group into the public schools and the new diagnosis of ED among many students who had been considered nondisabled prior to the implementation of PL 94–142.

The sudden five-fold jump in the number of ED-diagnosed students created a desperate need for new teachers. Universities and colleges across the nation scrambled to turn out teachers specially prepared for ED programs, typically self-contained classrooms and segregated schools. Federal funds poured into university research and professional preparation programs. The public schools clamored for teachers able to bring order to these newly created classrooms populated by students with histories of disruptive and aggressive behavior. The schools looked to the universities to send them teachers who could some-how keep a lid on these classrooms.

TEACHING METHOD NEEDED:
NEO-FREUDIANS AND BEHAVIORISTS

Prior to the sudden boom in ED programs, the neo-Freudian or psychodynamic model of teaching troubling students held a prominent place in teacher education programs. Teachers of ED children were often educated as teacher-counselors, a dual role requiring the standard instructional abilities of a general classroom teacher and the psychotherapeutic insight and skills of a trained therapist. The neo-Freudian theory and practice (a mainstay of the mental hygiene movement) was a delicate social art that required a depth of theoretical understanding and years of supervised practice in clinical settings such as psychiatric hospitals, residential facilities, and therapeutic camps.

Many neo-Freudians were the disciples of Fritz Redl (e.g., Morse, 1993; Redl, 1966; Redl & Wineman, 1951, 1952). Redl devoted his professional life to translating the traditional theory and practice of psychotherapy into practices that could be used with children. Vital to this new application was the rejection of the traditional idea that children and adolescents could benefit from lying on the therapist's couch for 50 minutes twice per week in order to gain new insights into their confused psyches. Although the importance of having insight into one's own feelings and internal conflicts was not rejected, the couch was.

Working in residential programs in both Austria and the United States, Redl and his followers developed on-the-fly counseling techniques that could be used by teachers during the moments in the average day when children displayed raw emotion and aggressive behavior.

The central idea was that children and adolescents tended not to simply open themselves up to therapeutic intervention upon entering the therapist's office. Their emotional worlds opened up within the spontaneous course of daily events, within conflicts with peers and anxieties over academic learning. The neo-Freudians held that opportunities to "do therapy" occur as brief 2-, 5-, or 10-minute windows during the day—moments when self-esteem falters, anger flares, sadness overwhelms, anxiety freezes, or trust crumbles. Redl and his disciples believed that mental health and even education professionals could be trained to take advantage of these therapeutic opportunities—moments when young persons can receive and benefit from on-the-spot counseling.

The desperate need for ED teachers in the late 1970s combined with the public school's emphasis on authority and order turned the neo-Freudian emphasis on the subtleties of psychological insight into an anachronism and a perceived luxury. Schools had little patience for the heavy jargon, high-brow theory, and humanistic sensitivity of the traditional approach to working with ED students. What many schools wanted was a teacher with a firm hand, someone who could speak a direction from the front of the class in such a way that 10 angry boys did what they were told. This kind of order and authority did not call for counseling skills. It called for powerful techniques that could get students to behave in compliant ways whether they wanted to or not. It called for behavior modification.

The behaviorists (e.g., Brown, 1972; Patterson, 1965; Philips, 1968; Whelan, 1966) claimed that attempting to understand the inner psychic world of the child was a superstitious walk down a nonproductive pier. What they had to offer was behavior modification—a science of behavior and an applied technology for precise and sure change. To the behaviorist, human behavior occurs as a response to an external stimulus in the environment. The key to improving behavior lay not in therapeutic talk about issues and conflicts but in altering the external stimuli of the classroom to promote different behaviors from the students. Typically, this meant devising programs of incentives and rewards to encourage desirable behaviors.

The victory of behaviorism over neo-Freudianism within the field of ED was not due to the intellectual or practical superiority of behavioral theory and methods. Neo-Freudian theory was complex, language-heavy, and difficult to learn. Grasping the ideas and developing the subtle clinical judgment necessary to apply those ideas in practice with students took years of intense education, training, and ongoing professional development. Mastery of this theory-practice was only possible within a few elite, fully developed, university teacher preparation programs.

The rapid growth in ED school programs in the 1960s and 1970s brought about a parallel boom in teacher education. Universities high and low suddenly launched programs to prepare and certify the many ED teachers needed. In

sharp contrast to the complexity and difficulty of learning the neo-Freudian approach, behavior modification as a program of systematic rewards could be taught quickly and easily to large groups of teachers. The theory—increase a behavior by rewarding that behavior—could be explained in half a sentence. The very simplicity of the behavioral approach made it the theory of the day in the new ED public school programs that desperately needed something to do and new university teacher preparation programs that desperately needed something to teach teachers to do.

Neither the neo-Freudian nor the behavioral school of thought questioned the way that schools had established the customary practice of locating complex social problems within the psychological or moral character of specific students said to be "disordered" or "disturbed" (see Kugelmass, 1987; Rhodes, 1977). Issues of race, social class, and gender were not raised as serious questions for examination within the profession (J. L. Johnson, personal communication, 2000; W. C. Rhodes, personal communication, 2000). As a result, ED as a disability category has remained an uncontested explanation for deviant or unruly behavior. That lack of critical analysis allowed ED programs to continue as segregated settings primarily for boys of working-class, lower-class, and/or minority group status, a state of affairs that still exists today (U.S. Department of Education, 1998).

In recent years, the overrepresentation of African American males in special education, especially in classes for students categorized as "mildly mentally handicapped" and ED, has been well-documented (e.g., Dunn, 1968; Harry, 1994; Patton, 1998). Less attention has been paid to the parallel overrepresentation of lower- and working-class students in special education and emotional/behavioral disorder (E/BD) programs (Danforth, 2000). Yet the predominance of ethnic minority and working-/lower-class males in ED programs is obvious. Wagner (1995), in an analysis of a large national data set, concluded that "students with disabilities in general and those with SED [serious emotional disturbance] were significantly more likely than students as a whole to be male, African American, and to experience a constellation of factors associated with economic disadvantage" (p. 95). One need not access a large national database to come to this conclusion. A day spent visiting the local E/BD programs in your local area will easily convince you that it is only a mild overstatement to say that in most school districts, ED is virtually synonymous with "angry black male" or "angry poor male." With only occasional exceptions (e.g., J. L. Johnson, 1968), the special education field of ED has neglected a serious address of social class and racial issues.

MISBEHAVIOR AND STUDENTS FROM DEVALUED GROUPS

Different groups at different points in the social order tend to have their own typical forms of socialization and interaction and tend to use different preferred mental styles and forms of behavior in different social

settings. . . . Educational practices tend to favor the preferred mental styles and forms of behavior of certain groups over others, the standard patterns of the dominant social groups. (Carrier, 1983, p. 961)

At the beginning of the 20th century, the public schools were troubled by the behavior of working-class and immigrant boys. At the beginning of the 21st century, the public schools are troubled by the behavior of working-class and African American (and, to some extent, Latin American) boys. Research evidence points to three primary ways that schools have dealt with these male students. First, working-class and African American males are punished with out-of-school suspensions at a disproportionate rate (McFadden, Marsh, Price, & Hwang, 1992; Rossow, 1984; Skiba, Peterson, & Williams, 1997). This indicates that many public schools are biased in the treatment of African American and working-class boys. At the very least, it demonstrates the degree of conflict between these males and the authority and order of the public schools. Second, schools that use systems of ability tracking place African American and working-class boys in lower or remedial tracks at a disproportionate rate (Bowles & Gintis, 1976; Chunn, 1987; Lee & Bryk, 1988; Oakes, 1985, 1990). Ability tracking is the practice of grouping students according to assessed ability level. Most public high schools operate a hierarchy of tracks, ranging from the college-bound classes for students assessed to be high achievers to remedial programs for those considered less academically able. These classes tend to be light on academic content while placing a heavy emphasis on compliance with authority (Oakes, 1985, 1990).

The third option, although not wholly separate from the institutional basis for the first two, deserves our more focused attention. As noted earlier, there is an overabundance of African American and working-class males in special education ED programs. We'll conclude this history by looking more closely at this specific way of handling this group of students within the public schools.

Although special education often seems like a separate education system with little relationship to the mainstream, it is helpful to view special classes and schools as a particular form of tracking within public education. In the case of ED classrooms and schools, we find "behavior tracking," which is an extension of existing ability-tracking structures in public schools after the passage of PL 94–142. Tyack and Cuban (1995), in their analysis of the history of educational reform movements, point out that programmatic and curricular reforms undertaken by public schools do not end up looking the way the reformers originally envisioned their projects. Instead, as the various structures, practices, and concepts of the new reform become part of the public school culture, many aspects of the reform tend to take on the shapes and colors of traditional schooling. The public school culture assimilates the new forms into the old forms, thereby enacting the "new" reform in a manner that often leaves the public school barely distinguishable from the way it used to be. Basically, if the reformers want to paint the classroom walls blue, and the walls are currently yellow, then chances are, the reform will leave the walls in some shade of greenish yellow.

When programs for students categorized ED were initiated in the late 1970s as part of the historic PL 94–142, ED programs did not merely attach to the edge of the public schools. They were developed as new elements within the public schools, where the long-standing tradition of ability tracking had historically isolated working-class and minority students from their middle-class peers. The overwhelming evidence from empirical research demonstrates the preponderance of working-class, poor, and ethnic minority students in remedial tracks (Bowles & Gintis, 1976; Chunn, 1987; Lee & Bryk, 1988; Oakes, 1985, 1990).

To this public school tradition of social sorting by class and race, PL 94–142 brought a new, powerful concept and terminology, the idea that an individual's poor academic performance or problematic behavior may be attributed to an underlying psychological disorder. This new individual pathology concept, the emotional disturbance or disorder, was woven together with the prior tendency of schools to segregate nonwhite minority and working-class children into special classes.

Whereas the traditional ability tracks sort and exclude students under the official justification of grouping by academic performance, ED classrooms and special schools sort and exclude students under the justification of grouping by behavioral performance. ED programs provide the tracks specifically designed to house students who engage in dramatic and frequent acts of opposition to school authority. In this light, ED classrooms may serve as a tool of social exclusion for economically disadvantaged and minority culture students who often conflict with the dominant cultural codes of student conduct embraced by school professionals.

Further complicating matters is the apparent ineffectiveness of most ED programs. While undoubtedly some teachers, classrooms, and schools provide quality support and instruction to students labeled ED, the overall picture of ED special education services is not impressive. Fifty-five percent of all students labeled ED leave school without a high school diploma (U.S. Department of Education, 1998). In comparison to students of other disability classifications, few students categorized ED are mainstreamed back into general education classes (U.S. Department of Education, 1998). There is little evidence that current programs and approaches to serving students considered ED in public schools are successful in helping these students improve their lives and futures (Knitzer, Steinberg, & Fleisch, 1990; Wagner, 1995).

In one of the most comprehensive studies to date, Greenbaum et al. (1998) looked at the psychological functioning and educational attainment of more than 800 adolescents and young adults who had been served by public school ED programs and mental health centers. They found that these young people were frequently involved in criminal activity and drug abuse while either dropping out of school or performing far below grade level in academic subjects. Given the complexity of the problems faced by students and families, we cannot claim that the ED programs cause these negative life paths or outcomes. However, we can admit that there is little reason to believe that current efforts in public schools contribute to improved academic, emotional, and social lives for kids called ED.

SUMMARY

The general purpose of this chapter has been to trace the American history of behavior and social problems of childhood in the public schools, the deep and winding roots of our current way of thinking about and dealing with child behavioral issues. The reason for doing this lies in the assumption that the conventions of current educational practices are the combined culmination of the historical development of the family, the public school, and the helping professions (psychiatry, psychology, social work, education). It took a long time and many twists and turns to arrive at our current place. Retraveling that path allows us to better understand where we stand today in relation to the social, political, and professional challenges that face us.

The public schools and the helping professionals of the 20th century tried to create a more moral democratic citizenry by molding and influencing children. The development of schools and the helping professions effected a shift in responsibility for child rearing, casting doubt on the traditional folk expertise of mothers by claiming that scientific expertise was necessary.

As the helping professions developed into full-fledged professions during the 20th century, they found themselves drawn toward both a moral purpose of serving children and families in need, and the rewards of professional prestige and power. Often, the moral purposes have been idealistic and unrealistic given political and economic realities. For example, the early child guidance clinics attempted to heal society of delinquency through methods of individual and family treatment while ignoring the economic problems and ethnic discrimination faced by lower-/working-class, immigrant families. Frequently, the professionals have displayed a middle-class, Anglocentric bias as they have developed goals and programs that did not fully value the perspectives and needs of the lower-/working-class, immigrant, or minority families with whom they worked. The professions have tended to view certain classes of people—immigrants speaking languages other than English, African Americans, the poor and working class—as morally suspect and as the causes of social disorder in communities and schools.

Currently, special education services under the "emotional disturbance" or "emotional/behavioral disorder" heading echo the historical biases and tensions brought about through the development of public schools and helping professionals. In recent decades, the theoretical victory of behaviorism over neo-Freudian psychology within the field of ED has reduced many public school ED programs to systems of behavior modification. The ED field has failed to seriously question the development of segregated ED classrooms and schools as a dumping ground for disaffected African American and lower-/working-class males. This is especially problematic given the apparent lack of success of most ED public school programs.

We may draw three specific lessons from this history that serve as challenges in current work. First, educators and other helping professionals have often focused heavily on developing and using authoritative knowledge. This effort has effectively amounted to building a knowledge base about students and families that we then say supercedes the knowledge of students and families

about themselves. Our reasons for listening carefully to students and families have been unfortunately diminished by our own scientific knowledge. Second, educators and helping professions have often viewed social problems in a depoliticized way. Rather than becoming aware of complex dimensions of social inequality that surround so many troubling students, we have often defined the problem as an individual disorder needing treatment. This approach has allowed us to ignore the unequal and unjust social and political conditions that many of our students face in their daily lives. Finally, we find within our professional history a very hopeful and very old strand of wisdom. Mental health workers and educators since the early 1900s have been building deep, caring relationships with young people and their families. These relationships are vital to the helping task. We embrace and continue this tradition in this book.

CONSTRUCTING PERSONAL MEANINGS

1. Find a local administrator or teacher who has worked with troubling youth for 20 years or more. Interview this professional to learn about how programs, service, and ideas have changed over the years.

2. Find a local psychiatrist, psychologist, or social worker who has been doing psychotherapy with families and children for many years. Interview this professional to learn about how psychotherapeutic treatment and the problems facing families have changed over the years.

3. Conduct historical research on a local residential program for children considered ED that has operated for many decades. Many communities have programs with very deep roots in local charities and religious groups. Often, this kind of research involves reviewing old records and documentation as well as interviewing retired employees and administrators. Find out how the mission, practices, and service population of the institution have changed over time.

4. Use the university library to seek professional and/or popular publications on child behavior problems from the early 1900s. Many books on behavior problems and delinquency were written before World War II. Also, leading women's magazines such as *Ladies' Home Journal* published articles that translated professional beliefs into popular form for mothers to read.

5. Ask local school district and/or state administrators for data on race, gender, and social class (or socioeconomic status) among students labeled ED. Many areas collect data on race and gender, but very few have information on social class. They will have information on the number of students enrolled in free and reduced-price breakfast and lunch programs. That can serve as a means for finding students who live in poverty. Is the ED category in the local area and/or state disproportionately filled with minority and working-/lower-class boys?