The Roles of Race and Behavior as Determinants of Punishment versus Diagnosis of Childhood Behavior Problems

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Recent work suggests that many of the social institutions responsible for defining and managing the behavior of children have adopted the terminology and practices of crime control institutions (Hirschfield 2008; Simon 2007). For example, public schools across the country have adopted zero tolerance policies that increasingly rely on suspension and expulsion as tools for punishing and deterring even minor classroom disruptions (Hirschfield 2008; Kupchik 2010). Furthermore, as criminalized disciplinary practices increase in schools across the nation, these consequences overwhelmingly impact the lives of young African-American males. Over the past three decades, the suspension rate of African-American boys has more than doubled, from 12 percent to 25 percent, while remaining relatively stable for White boys over the same period (Losen and Martinez 2013). Despite little evidence that African-American children are more likely that White children to misbehave in school or other social settings, they are more than three times as likely to be suspended or expelled from school (Losen and Martinez 2013). While White children with behavior problems have in large part avoided these trends in school discipline, evidence from medical sociology and the study of population health suggests that they are being labeled by other, less criminalized, institutions of social control (Conrad 2013; Zola 1974). That is, the behavior problems of White children are being defined using medical terminology (i.e., medicalized) and managed using therapy and pharmaceutical treatment.

Research rarely, if ever, considers school punishment and behavioral health treatment as alternative responses to childhood behavior problems. Despite common theoretical and conceptual histories, scholarly work examining criminalization and medicalization of behavior problems has been apportioned to separate literatures and isolated from one another. Recently, however, scholars have suggested that a "layering of social control" may better explain how behavior is labeled in the United States (Hiday 2010; Medina and McCranie 2011). In brief, as institutions of social control, both the criminal justice and healthcare systems provide models for defining and managing behavior (Medina and McCranie 2011). As social control efforts, punishment or medical diagnosis might reflect different attempts by parents, teachers, and health professionals to supervise children's behavior and potentially reduce the risk of future life difficulties, including criminal involvement, substance abuse, and poor mental health. While school discipline seeks to rehabilitate through deterrence, medical diagnosis seeks to curb the persistence and escalation of behavior problems through treatment and therapy (Kupchik 2010; Conrad 2007).

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The primary objective of this project is to explore how two potential behavioral outcomes, school punishment (suspension or expulsion) and medical diagnosis and/or treatment, vary across African-American and White school-aged children. Specifically, I answer several important questions. First, controlling for behavior problems, are there racial disparities in the odds of punishment versus non-punishment and diagnosis versus non-diagnosis? Second, for children whose behavior problems are labeled by teachers or doctors, are racial

disparities, are African-American children more likely to be punished and White children more likely to be diagnosed and treated? Finally, do racial disparities in punishment versus diagnosis increase or decrease with the severity of behavior problems, identified by two measures of (Cooksey, Menaghan, and 1997)?

CONCEPTUAL FRAMEWORK

While both school punishment and medical diagnoses can disrupt the education process and result in stigma, there are reasons to believe that the latter may be a "better" label in that medical diagnosis and treatment may enable children with behavior problems to "disavow" their deviance and maintain social status (Conrad 2007; Paternoster and Iovanni 1989; Thoits 2005, 2011). For example, diagnosis and treatment provides short-term reductions in the display of behavior problems and improvements in classroom performance, limited culpability and blame, and reduced social exclusion by potentially strengthening family and friendship ties (Conrad 1992; Kupchik 2010) Consequently, racial disparities in the labeling of child behavior could mean that African-American boys are at a greater risk of social exclusion and isolation through strict disciplinary measures (Hirschfield and Celinska 2011; Hirschfield 2008; P. J. Hirschfield 2008; Kupchik 2009, 2010; Rios 2006, 2011). Alternatively, White children are more likely to receive a clinical diagnose for behavioral disorders, allowing them to receive treatment for their behavior and possibly avoid any potential negative consequences of harsh school discipline (Leslie and Wolraich 2007; Pastor and Reuben 2005; Schneider and Eisenberg 2006; Wolraich et al. 2012).

To test whether racial disparities in the labeling of children's misbehavior are due to differential involvement or differential treatment, I measure the odds of punishment and diagnosis in a large sample of White and African-American children ages 6 to 14. First, I hypothesize that kids with higher levels behavior problems will be more likely to receive both school punishments and medical diagnosis and treatment. Second, while children with severe behavior problems will be more likely to be labeled for their behavior, severity of behavior problems does not explain racial disparities in school punishment diagnosis and/or treatment. Specifically, after controlling for behavior, African-Americans will be more likely to be punished while Whites will be more likely to receive medical treatment. Third, Black/White disparities in the odds of school punishment will exist at all levels of behavior problems. However, the odds of diagnosis and treatment will increase for African-American children with extremely high levels of behavior problems relative to White children with similar behavior problems. Specifically, at lower levels of behavior problems, White kids will be more likely to receive treatment versus punishment while African-American kids will be more likely to receive punishment and not labeling.

DATA AND METHODS

To examine racial disparities in school punishment and medicalization across childhood and adolescence, I rely on data from the National Longitudinal Study of Youth, 1979 Cohort – Child and Young Adult Sample (NLSY79-CYA) for the years between 1988 and 2010. The NLSY-CYA provides a wealth of longitudinal information on children's behavior, school punishment, and reports of medical diagnosis or treatment for a number of behavioral disorders spanning childhood and adolescence. Furthermore, the timing of the NLSY-CYA

corresponds with both an increase in use of suspensions and expulsions in school punishments as well as the increase in medically diagnosed cases of behavior disorders such as ADHD, oppositional defiant disorder, and emotional disturbances (Conrad 2007; Losen and Martinez 2013). While the NLSY-CYA does not include school-level measures, including racial composition, socioeconomic status, and disciplinary climate, it does provide measures of academic achievement, classroom and school behavior, and maternal and child academic expectations. More importantly, it provides a wide array of data on family composition and socioeconomic status, along with important demographic and behavioral factors associated with the social control of children offers many advantages over school-based or offender-based studies of school punishment. Furthermore, the rich information provided regarding important life-course events, particularly early life-events predicting behavior problems in childhood, makes the NLSY-CYA an ideal dataset for studying the medicalization of individual behavior over the life-course.

DEPENDENT VARIABLE

My dependent variable includes measures of both punishment and medicalization. The first measure, *school punishment*, is captured with a dummy variable indicating whether or not the child has ever been suspended from school, taken from the Mother's response to the question "Has your child ever been suspended or expelled from school?" and coded "one" if the mother responds "yes." The second measure, *medical treatment*, is coded 1 if the child answered yes to one of two questions: (1) whether or not the child had seen a psychiatrist or psychologist for troubles in school or for tantrums, hyperactivity, or disruptive behavior and; (2) whether or not the child was taking drugs to control his/her behavior.

INDEPENDENT VARIABLES

The two central independent variables in this paper measure race and behavior. Race is captured with a dummy variable equal to 1 for African-American respondents and 0 for White respondents. To capture child behavior, I use a measure of *oppositional action*. The oppositional action scale (Cooksey, Menaghan, and Jekielek 1997) is taken from the Behavior Problems Index and includes maternal reports of antisocial and externalizing behaviors, including bullying, disobedience in the home and school, and getting along with others.

ANALYTICAL STRATEGY

To capture the labeling experiences of African-American and White children in the United States, I employ logistic growth-curve models in Stata 12.0 using robust standard errors to account for heteroskedasticity and nonindependence of error terms. Logistic growth-curve models allow me to predict the odds of labeling, school punishment, and medicalization in childhood and early adolescence. This approach allows me to measure the influence of time invariant measures, such as race and potentially important pre- and post-natal factors, along with time-varying measures of behavior and academic achievement, as well as family socioeconomic status and composition.

RESULTS

Results from logistic growth-curve models suggest that children displaying more oppositional behavior problems are more likely to be labeled for their behavior. Moreover, African-American boys are more likely to be labeled than White boys, even after controlling for behavior and other important social factors. Once different types of labeling – punishment versus treatment – are considered, a different pattern emerges. Specifically, White children with antisocial and oppositional behavior problems are more likely to be treated with therapy or psychotropic medication than African-American children while African-American children with similar behavioral problems are more likely to receive school suspensions or expulsions than White children. Among boys having been labeled as a result of their behavior, these disparities are magnified. African-American boys are more than six times as likely to be suspended or expelled as White boys are to seek treatment. Interactions between race and oppositional behavior problems suggest that these disparities are due to subjective measures associated with racial bias in the labeling of children and not the prevalence or severity of behavior itself. Specifically, for children who display only a few oppositional behavior problems, the odds of suspension and expulsion for labeled African-American children are much higher than they are for White children. However, these disparities subside for children displaying large numbers of oppositional behavior problems.