Ideological Reflections on the DSM-IV-R (or Pay No Attention to That Man Behind the Curtain, Dorothy!)

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ABSTRACT: Exclusive North American reliance on the Diagnostic and Statistical Manual of Mental Disorders 4th Edition-Revised (DSM-IV-R) to determine diagnoses such as Conduct Disorder or Attention-Deficit Hyperactivity Disorder occurs without sufficient critical regard for its ideologically and historically situated assumptions. The author argues for a parallel theoretical framework to guide interventions that is provided for children's practitioners through ongoing implementation of the United Nations Convention on the Rights of the Child. Rather than relying solely upon the deficit labelling of the DSM-IV-R with its underlying deterministic beliefs about child development, this holistic, rights-based approach assumes young people to be competent social actors whose lives are worthy of study in their own right. The author draws upon comparative theory within the sociology of childhood, practice insights and three case studies for support.

KEY WORDS: DSM-IV-R; rights-based approach; sociology of childhood.

Introduction

Like characters in the 1939 movie when the Wizard admonished Dorothy to "Pay no attention to that man behind the curtain!", child and youth practitioners are being asked not to question inaccurate and culturally inappropriate beliefs about children supporting the Diagnostic and Statistical Manual of Mental Disorders—4th Edition, Revised (or DSM-IV-R, American Psychiatric Association, 1994). The author contends this diagnostic tool is inadequate in its approach to understanding various contexts for behaviours associated with diagnoses such as Conduct Disorder and Attention-Deficit Hyperactivity Disorder.

Rather than a full discussion about the features of these diagnoses,

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or indeed their very existence (see Coppock, 2002; Fewster, 2002; Richters and Cicchetti, 1993), a critique is presented towards their underlying ideological and theoretical foundations. In contrast, the author argues for a parallel adoption of the United Nations Convention on the Rights of the Child (CRC) to counter "deficit labelling" (Gergen, 2000; Fewster, 2002) of children and young people based upon invalid assumptions regarding children's developmental incompetence. The author further contends the Convention offers an alternative theoretical stance for interventions that are holistic and contextually sensitive, a stance founded upon ideological and theoretical notions of a child's inherent capacity and dignity. To support these arguments, the discussion is initially framed with an overview of current critical thinking influencing the global study of childhood, and secondly with the author's insights from front-line child and youth care in mental ill health. To close, elements from three case studies from the United Kingdom and Canada are reviewed as successful practice applications of a "rights-based approach" (Collins, Pearson, and Delaney, 2002).

Challenging Ideologies of Child Pathology

Manning (in Baldock, Manning, Miller, and Vickerstaff, 1999) has noted that ideologies are sometimes biased sets of beliefs held because they are in the interests of the groups articulating them. While Bell (1960) announced postmodernist arguments such as the end of ideology, Freire (1999) disagreed by maintaining that a hierarchical, authoritarian "ideology . . . remains quite alive, with its power to dull reality and make us nearsighted" (p. 90). In a similar analysis of the power relations embedded within particular ideologies, Rose (1999) describes the prerequisite process of thinking critically as:

> [P]artly a matter of introducing a critical attitude towards those things that are given to our present experience as if they were timeless, natural, unquestionable. . . . It is a matter of introducing a kind of awkwardness into the fabric of one's experience, of interrupting the fluency of the narratives that encode that experience and making them stutter. (cited in Moss and Petrie, 2002, p. 11)

As Rose suggests, let me introduce an awkward *stutter* with this notion of 'ideology' then, in an effort to interrupt some of its influences upon children and childhood in our present historical and cultural contexts. While underlying ideologies may be implied to be complete and static over time, the assumptions presented within the DSM's various versions are, in fact, dependent upon incomplete and transitory notions that involve definition, ambiguity and interpretation (Wiener, 1981, p.

17). This point is best highlighted by recalling how 'homosexuality' was constructed as a mental illness by the American Psychiatric Association in its second revised edition of the DSM from 1968 to 1973. Since its introduction in 1952, the DSM's standards have been surrounded by considerable controversy, and "published criticisms on the specifics of the DSM on philosophical, theoretical, scientific, and even administrative grounds would fill shelves of library space" (Richters and Cicchetti, 1993, p. 22). Arguments for adopting alternative theoretical approaches to the DSM's interpretation of psychiatry have been advanced most notably by thinkers such as Thomas Szasz (1960, 1971) and cultural psychologist Kenneth Gergen (1985, 2000; Gergen, Gulerce, Lock, and Misra, 1996).

Gergen (2000) maps out the extent of the ideological ambiguity with a challenge to the DSM's conceptual framework.

> [We must begin by] removing the existing demands for diagnostic categorisation, and enabling clients to receive therapeutic help without deficit labelling. Current practices of psychodiagnostics (i.e. DSM categorisation) represent the conceptions of psychological process shared by a small and rarefied sector of the population; they function without empirical warrant. . . . Increasingly these standards are being questioned within the population at large (consider for example the spate of books criticising the burdening of our children with the Attention Deficit Hyperactivity diagnosis). (available at *http://www.newtherapist.com* and accessed May, 2003)

Where children and young people are concerned, diagnostic-free therapy such as Gergen advocates would be viewed as radical in present-day mental health settings, or for that matter, within most service delivery structures for children presently influenced and shaped by medical-model thinking (see Moss and Petrie, 2002 for an alternative view to these service 'structures'). When considering the alternatives, it appears reasonable to adopt a moderate, culturally respectful ideology based upon current theoretical and empirical understanding of how children grow through interaction within their families and the rest of society (Christensen and James, 2000; James and Prout, 1997). Woodhead (1999) has taken some courageous "first steps" towards a reconstruction of developmental psychology that show how this freedom from deficit categorisation might be further accomplished. He discusses

> the growing interests amongst psychologists in studying children's development as a socio-cultural process. . . . Psychologists are beginning to embrace the possibility that liberal individualistic Western models of child development (including Piagetian cognitive development as well as theories specifically about personal and social development) might be founded on a culture-specific and epoch-specific image of human boundedness. (pp. 9, 11)

With regard to children's behavioural diagnoses for attention and conduct problems, Richters and Cicchetti (1993, p. 20) emphasize the "need for an integrative framework within which individual functions and their failures can be conceptualized in the broader context of development and functioning." They dispute the DSM's assumption that mental disorder always underlies behavioural concerns. Their approach stands

> in stark contrast to the complex, inherently developmental questions raised. . . . It is useful to remind ourselves occasionally that the DSM is fundamentally an administrative classification system for the human problems and conditions treated by mental health professionals . . . provid[ing] a common language for communicating about these conditions. (p. 21)

Indeed, the whole notion that young people's most distressing behaviours may only be interpreted only as 'disordered' seems untenable when examined critically. In fact, the DSM-IV-R's 'common language' has been translated through use of deterministic theories that view young people as objects and not subjects, as non-competent rather than competent, and as adults-in-miniature rather than citizens in their own right.

Moss (1996) has also argued for this alternative approach to the dominant developmental perspective in his discussion of quality perspectives in early childhood care (see also Pence and Moss, 1994; Dahlberg, Moss and Pence, 1999). He declares the process by which terms such as *quality* in childcare are defined and measured, and *by whom*, are critically important concerns, with "experts from government, certain professions and academic research" dominating children's discourses to date. Discussion, description and evaluation in child and youth care have

> involved the exercise of power based on claims of academic or professional expertise and knowledge. . . . This 'exclusionary approach' often involves an assumption, usually implicit, that quality is an objective reality, a sort of Holy Grail to be discovered and brought back by a select order of suitably qualified and technically equipped specialists. This . . . can be contrasted with an 'inclusionary approach': a new paradigm . . . based on participation by a broad range of stakeholders, and recognition of values, beliefs and interests underpinning definitions. Within this alternative paradigm, the roles, processes and principles . . . are transformed: limited participation is replaced by broad access to the process of definition; power concentration gives way to power distribution; few voices make way for many. (Pence and Moss, 1994, in Bernstein and Brannen, 1996, p. 254)

This issue of power, and the ideological assumptions about who may exercise and share power outlined by Moss, are at the heart of the

DSM-IV-R. In addition, at this historical juncture for child and youth care practitioners, late modern issues of ideology, power and the dominant discourses defining the field are integral to professional growth, perhaps even survival. A broader awareness and a deeper appreciation of the ambiguous theories influencing practice must be emphasised for growth and development to occur in the field overall. For example, what, if any, alternative theoretical approaches are there to deficit-focused, future-oriented constructions of childhood? Are there culturally valid ways of defining children's behaviours outside or beyond constructions of 'pathology' such as Attention Deficit and Conduct Disorder?

Reconstructing Developmental Theory

Of course there are—this is the nature of theoretical and conceptual development in all fields. Similar to Pence and Moss (1994), and Moss (1996), Woodhead (1999) maintains that cultural and social contexts should be more paramount in thinking about children's theories—those currently supporting various DSM-IV-R diagnoses for example. He declares the dominant ideology in psychology is illustrative of those "thinking locally, acting globally" (p. 7). Oakley also critically comments with regard to dominant developmental theories:

> We learn not about children's perspectives, but about adults' concepts of childhood. This is why the assumption of children's non-competence is generic to all such theories, so that it becomes their prime distinguishing feature. In this sense, most work on the concept of childhood is adultist . . . also overwhelmingly classist, and tends to present a masculine view of who children are and will become . . . If children have no place of their own in theory, and do not give rise to their own concepts, their value is not in *being* but in *becoming*—in their status as would-be adults. (in Mayall, 1994, pp. 22–23)

In her analysis of Norwegian efforts to include children in policy and planning, Kjørholt (2002) suggests the "socialization paradigm emphasizing children's development towards becoming mature human beings in the future . . . may . . . be seen as contradictory to the construction of the child as a right-holder in modernity, stressing children's rights as citizens here and now" (p. 70). In striving to counter narrow, Western constructions of children, Woodhead (2000) maintains various images of 'normality' need to accommodate a more "inclusive understanding of a range of perspectives. . . . [I]t is essential to keep firmly in mind that 'child development' is a body of knowledge constructed by adults for other adults, and used in order to regulate children's lives" (pp. 118, 122; see also Prout, 2002). This future-oriented developmental construction of young people has led Moss and Petrie (2002) to conclude

> that a different understanding of children and their place in society and of the purposes of public policy in relation to children leads not to a new approach to, or transformation of, 'children's services.' It leads instead to the possibility of quite a different concept . . . [that of] children's spaces. (p. 9)

The authors' subtle distinction between 'services' and 'spaces' for young people implicitly invites and honours participation of children and young people in co-constructing these new arenas. In light of this paper's thesis, the author's proposal to balance dominant DSM-IV-R thinking with a child rights-based approach could take this transformation another step forward. Starting with the simple knowledge that children are citizens and rights-holders now, along with notions that they may actively participate in their own therapeutic plans and education, young people could actively facilitate this movement away from 'service delivery' model that is envisioned by Moss and Petrie (2002). The global adoption of the CRC (Human Rights Directorate, 1991) by over 190 nations—now only the United States has chosen not to ratify (Pearson, 2003)—offers one alternative, culturally respectful framework for accomplishing this partnership. Moss and Petrie conclude that children's professionals—for example those solely engaged in deficit labelling of the behaviourally 'disordered'—have thus far avoided this transformation. They further decry the present individualistic frameworks for children:

> with no recognition in the discourse that children might be understood as a social group and no reference to concepts such as children's culture or children's rights or indeed the possibility of children themselves having agency. . . . Childhood emerges as a state of adulthood in waiting . . . the discourse of 'development' producing adulthood as a completed state of being. (2002, p. 7)

They highlight an inclusive, holistic view of the changing conditions of children's existence and their potential contribution as competent, social actors. "We offer such examples . . . more as lenses through which we may view ways of doing things and the assumptions that underpin them. We argue . . . that working with different theories offers another set of lenses" (p. 10).

Late modernist theorists within the "new sociology of childhood" (Corsaro, 1997; James and Prout, 1997; James, Jenks, and Prout, 1998; Mayall, 1994; Qvortrup, 1994, 2000) have argued for some time for a competency-based set of lenses through which to view children's lives and their interactions. James and Prout note that the acceptance of "childhood as a social construction" is now identified as an "industry standard" (1997, p. x) in ever-growing areas of children's research, social policy and practice. James, Jenks and Prout (1998, p. 171) assert:

"If . . . childhood is socially constructed, then as childhood researchers we must acknowledge that the interpretations of children's lives which we offer are just as marked by the social context of their generation as any of those from a previous era." They view this new departure in the understanding of childhood with "three major landmarks in the works of Jenks (1982b), Stainton-Rogers, et al. (1989), and James and Prout (1990b):

> To describe childhood, or indeed any phenomenon, as socially constructed is to suspend a belief in or a willing reception of its taken-for-granted meanings . . . for social constructionists . . . such knowledge of the child . . . depends on the predispositions of a consciousness constituted in relation to our social, political, historical and moral context. In their exploration, social constructionists have to suspend assumptions about the existence and causal powers of a social structure that makes things, like childhood, as they are. (*ibid*., pp. 26–27)

Various "taken-for-granted meanings" supporting behavioural constructions of pathology are found throughout the DSM-IV-R diagnoses for children, and are in fact, culturally and historically embedded. By recalling one of the dominant theories underpinning the document, consider how Sigmund Freud's approach transformed child and adult relationships "from rational personal motive to mindless biological instinct by being given the label of an Oedipus complex—a term which is likely to be pretty meaningless to a child" (Oakley, 1994, p. 23). In light of the continued ubiquity of child sexual abuse a century on, children's therapists can no longer accommodate such mechanistic notions uncritically or with an unquestioned allegiance (see also Kitzinger, 1997). Alderson (1994) notes further:

> Freud's work on the 'narcissistic infant' was continued by Piaget . . . [who] envisioned the young child as a lonely scientist struggling to solve intellectual problems, isolated from social and emotional ties. . . . Adult perceptions of children are inevitably context-bound, partial and disputed, influenced by their time and place. . . . Detailed observations of 1- and 2-year-old children have found that they show intense empathy with other people and moral appreciation of others' approval or distress. (in Mayall, 1994, pp. 49–51)

Clearly, Freud and Piaget are two of the most dominant theorists underpinning current assumptions regarding child and youth mental health. However, these deterministic constructions within the DSM-IV-R's assessment framework are now open to reinterpretation through collaborative and democratic practice. With new approaches towards children and young people based upon their competency and their participation as rights-bearing citizens, who is better placed to advance these ideas in practice than child and youth care professionals?

Child Care Practice Insights

During two decades as a practitioner, I encountered many children and young people whose existence was circumscribed by the notions of pathology found within various versions of the DSM. I was also frequently struck by the absence of young people's own views in the variety of intervention plans within education, protection, health care or the courts. While it holds true that young people are often initially consulted, their views are then commonly subsumed in the discourses of therapy or justice, while documents controlling pharmacological treatment and the conditions of their lives upon return to the community further reflect this silence (see Smith, 1974). At the same time, other theoretical traditions and notions are dismissed as irrelevant (see also Cicchetti, 1990, 1991; Szasz, 1960, 1971; Wakefield, 1992).

Through dialogue with young people regarding issues of poverty, gender, sexuality, ethnicity, power, and physical and sexual abuse, I came to look beyond ideas of pathology, beyond viewing children as adults-in-waiting, or "human becomings" rather than "human beings" (Qvortrup, 1994, in Kjørholt, 2002). I adopted a more reflexive, ethnographic approach towards both research and practice (Christensen and James, 2000), one comfortably grounded within the rights-based approach. This ethical and practice stance was a natural fit for child and youth care practice in a residential treatment program (see also Trieschman, Whittaker, and Brendtro, 1969).

While listening to the views of children and young people, my beliefs and values gradually shifted from those predominant in the field notwithstanding considerable professional and academic tension. I eventually came to embrace the CRC as the most congruent ethical and theoretical framework for both practice and research. While accounting for my own professional and personal viewpoint (Smith, 1987, 1990), I make the argument that the pervasive stance in children's mental health is based upon expert-driven, top-down theoretical views, and has not shifted since I came to the field two decades ago. At the same time, I also want to highlight my intention not to trivialize the real anguish that legitimate mental and emotional suffering create for children, young adults and their carers. Most psychiatric professionals with whom I have engaged were focused upon 'the best interests' of children and young adults as their own paramount concerns as well. However, I have the sense that new theoretical and ethical approaches are now being called forth to advance professionalism within child and youth care and to counter-balance a field so dominated by DSM-IV-R deficit thinking.

The main departure from DSM Piagetian or Freudian assumptions through adopting a rights-based approach is found within its underly-

ing democratic values and views of children as *subjects* and not *objects* of concern. This theoretical 'stutter' enters practice when the primary consideration of the "best interests of the child" (CRC Article 3[1]) is conceptually combined with participation in "all matters affecting the child" (CRC Article 12), two of the four core principles woven throughout the treaty. While professionals frequently argue their decisions are always taken in the best interests of children, without an active listening and acting upon the views of young people, a stance occurs that is simply authoritarian and paternalistic. Utilizing a rights-approach offers a reflexive, democratic style of thinking and praxis that facilitates the emergence of children and young people as collaborative co-participants in research, policy and practice settings (see also Carter and Osler, 2000; Woodhead and Faulkner, 2000).

Rights-Based Reconstruction of Child and Youth Care

In fairness, critical challenges to sharing power with children through this rights-based approach abound. Judgments about its ideological shortcomings also abound despite the decade-long exercise in international consensus-building the treaty represents. James, Jenks and Prout (1998, p. 141) suggest that the universalist model of the child embedded in the document illustrates an example of "transitional theorizing" about childhood. Pupavac (1998, 2001) and Freeman (2000) criticize the apparent domination of northern, industrialized constructions of children within the treaty. Pupavac decries its "misanthropy" (2001), its universalization of Western ideals of childhood and its implied "infantilization of the South" arguing that "few writers have critically examined the implications of the CRC and that to do so has been described as modern day heresy" (in Steiner and Alston, 2000, p. 517). Wyse (2001, p. 209) reflects that "the remarkable early success" of CRC implementation "has more recently been followed by a realisation of the demanding challenges" still to be faced with monitoring its impact. Regarding the fundamental 'participatory' principle of CRC Article 12, Lee (1999) observes that "abstract principles are all well and good, but unless they are seen to be applicable they can scarcely amount to a policy directive" (p. 457).

Notwithstanding these concerns, there is growing international and intellectual legitimacy for adopting a rights-approach in contrast to the increasingly contested notions of the community of practitioners within the American Psychiatric Association. The Convention was drafted between 1979 and 1989 by a representative UN committee of 42 nations—a factor certainly influencing its wide-spread, cross-cultural adoption in the 1990s. A further salient feature is the ongoing monitor-

ing and evaluation procedures that occur after 'ratification' with Canada's Second Report on the CRC to be heard in Geneva in 2003 (see UN High Commission for Human Rights, 2003).

James, Jenks and Prout (1998) observe the current concern within social science "to place children more centrally within its remit . . . is still in its infancy" and "a coherent theoretical focus" (p. 169) has not yet been achieved. Could a rights-based approach offer theorists and practitioners an alternative understanding of various distressing children's behaviours now situated solely within the DSM-IV-R? Adopting the four core "principles" referred to in Article 42[2] as an interconnected therapeutic stance would provide a different starting point, along with sharing basic *knowledge* of the CRC with all young people and their families. During my clinical experience supporting children's and young people's mental and emotional well-being, this approach remained virtually untapped by mental health professionals.

I would argue that the CRC's ideology of participation and underlying values of mutual respect for children provide the widest international reference points supporting theoretical constructions of children as competent. It is also important to highlight here that North American children's mental health providers are also more likely to be ideologically influenced by the continued singular lack of US support for the CRC (Pearson, 2003) in contrast with global neighbours adopting rights-based legislation, policy and practice (Mitchell, 2002). Michael Ignatieff, Canadian historian, broadcaster and Director of Harvard University's Carr Centre for Human Rights Policy maintains the human rights discourse provides a "language of empowerment" (2001, p. 70). He contends the proliferation of human rights instruments has "gone global by going local, empowering the powerless, giving voice to the voiceless," in order "to protect human agency and therefore to protect human agents against abuse and oppressions" (ibid., 2001, p. ix; for opposing views see Donnelly, 1989). On the tenth anniversary of the adoption of the CRC by the United Nations, the journal *Childhood* (Editorial, 1999) observed that the Convention had become a "touchstone for research about, as well as activism on behalf of, children . . . provisions of the Convention obligate participating nations to provide factual updates on the legal, material, health, family and educational circumstances of children living within their borders" (p. 403).

"Rights, and the related concept of citizenship, constitute one of the most powerful discourses in today's world . . . definitions of children's rights, and debates around them, are reliant on two concepts—of 'childhood' and of 'rights'—and how these two are combined" (Hill and Tisdall, 1997, p. 21; see also Qvortrup, 1994, 2000; Petrèn and Hart, 2000). While discussing most of the present-day frameworks being utilized for conceptualising childhood Woodhead (2000) argues

> the case for rethinking the paradigm for global promotion of child development within a framework of children's rights. This paradigm emphasises the plurality of pathways through childhood, the respects in which development is a sociocultural process, and the status of children as active participants with their own perspective on child development issues. (in Verhallen, 2000, p. 113)

In her review of children's rights in health care and consent in UK nursing, Lowden (2002) concludes: "Until adults develop a more pragmatic ideology in relation to children's rights then a true respect for children's autonomy will not be achieved" (p. 100). Within the DSM-IV-R, reliance upon deficit labelling is antithetical to Lowden's call for a "more pragmatic ideology," for example those within alternative sociological or rights-based frameworks. Adopting an ideology based upon theoretical views of young people as fully competent, rights-bearing citizens will take time, and is in direct contrast to the well-entrenched deficit labelling dominant in mental health, education, justice and protection arenas. While it remains the responsibility of licensed psychiatrists to formally diagnose mental and emotional crises in young people, they frequently depend upon child and youth care personnel for much of their assessment information (Trieschman, Whittaker, and Brendtro, 1969). In this context, I stress again that parallel use of the CRC's four core principles to assess children's most distressing behaviours appears a feasible and quite modest proposal. Three case studies from the United Kingdom and Canada are reviewed as practical examples of how a rights framework in local governance, education and health has been practically applied.

Three Rights-Based Approaches in Practice

While none of the following case studies are fully applied in a diagnostic setting as argued throughout this paper, in the continued absence of domestic theoretical or empirical child rights research (Mitchell, 1996, 2000), they do have common features from across a continuum of services and illustrate well how mental health professionals might proceed.

In the first case study "Investing in Children," Cairns (2001) provides an account of a broad-based initiative undertaken to translate CRC rhetoric into reality in an English local authority. These local systems of devolved governance play the dominant role throughout the UK in directly implementing children's rights through CRC-based statutes, policy and practice (for a comparative overview with Canada, see Mitchell, 2002). The values that guided Cairns' insider view of the project

"are consistent with the UN Convention on the Rights of the Child and the Children Act 1989."

> The thinking behind this was clear, and in hindsight, extremely powerful. By making explicit what we thought was important and why, we would have an invaluable tool to help us agree on what action we should take. Three key agencies, the County Council's Social Services Department and Education Department and the Health Authority committed funds . . . almost every major agency in the County, including all of the district councils, the police, the environment department and the major children's voluntary organisations have signed up . . . a further three years of funding extended the project. (p. 349)

As in most local authorities throughout the UK, "children's rights officers were employed by social service departments [whose] emphasis was on those children and young people for whom social services had a statutory responsibility." However, young people who were not in care but who were involved in the new initiative began to ask critically: "Are all children and young people . . . being treated with respect and dignity and receiving the services to which they have a right?" An important process occurred between the adults and young people in the initiative and underscores the shift to dialogue from consultation (p. 355)—'consultation' often passing for Article 12 'participation' in the minds of policy- and decision-makers. In contrast, *dialogue* takes time, resources and a practical grasp of the broadest parameters for healthy development of children and young people. When supported, young people showed the capacity to shape and influence local policy and practice using a rights-based agenda to promote their own views and actions.

> We had a fair idea of the adult agenda—for example, concerns about the health and safety of children in relation to substance misuse or sexual behaviour, educational achievement, youth crime, etc. What we did not know was whether children and young people themselves shared this agenda, or whether another set of priorities existed. (ibid., p. 352)

This kind of community-based process provides policy-makers who share a direct remit for young people's services with the opportunity to address children's traditional lack of power. While the case shows one practical roadmap for local CRC implementation, Cairns declares: "*Investing in Children* is not being held up as a model to be adopted elsewhere, but we would suggest that some useful lessons can be learned from the way the project has developed and in particular, how young people themselves have shaped this development" (p. 347).

A second case study from England reviews research from education that developed a human rights culture in the classroom with important conclusions regarding the phenomenon of bullying (Carter and Osler, 2000), and implications for supporting mental health beyond the clinic.

Using an action research methodology, the project designers chose to examine the dynamics of classroom relationships and perceptions of how rights and identities operate in an all-boys secondary setting. The researchers sought to shed light upon the interstices between rights, identities and the realization of participation/citizenship as outlined in the CRC. Similar to the first rights-based initiative, the study set out to breathe life into the CRC with the premise that "education provides one important way forward in turning a rhetorical commitment to human rights into reality" (p. 337).

The authors judged action research to be the "most appropriate approach as its intrinsic aim is to enhance practice, rather than to demonstrate knowledge" (p. 342). At the same time this methodology permitted the 'teacher as researcher' to work collaboratively with her students to develop democratic research practice in keeping with human rights principles. They found that while "regular institutionalised aggression and verbal abuse" had become the norm, they were "not immutable." Since the school plays a key role in the development of student identities, "teachers cannot afford to under-estimate the effects of the social scaffolding of schools in the production of sexual and gender subjectivity" (p. 342). Their research further reveals some of the institutional constraints encountered when engaging high-school students with a rights approach, and suggests that realising human rights within school settings requires a fundamental change in school culture (p. 353).

The authors highlight an important insight supporting this paper's thesis: their reflexive research practice reduced "the chances of the subjects being viewed in stereotypical or pathological ways" (p. 343). This rights-based intervention methodology shows a potential for adaptation across practice settings within residential or mental health care for example, possibly leading to an amelioration of socio-emotional factors contributing to developmental and social crises for young people.

The final case study reviews some of the author's previously published results from applied research in British Columbia which implemented the CRC in a healthcare context (Mitchell and Bramly, 1999; Mitchell, 2000). This research included some common methods and dimensions from within the previous two case studies—from the first, a broadly based public awareness campaign and the second, an action research methodology. As a practitioner in a child and youth mental health setting, I brought the issue of child rights and CRC promotion to the attention of my employers. A two-year project was subsequently undertaken under the auspices of the Chief Medical Officer with the main focus of the initiative grounded in an interagency, public education rights campaign. Analysis of the findings suggested that the collaborative, power-sharing approach provided by the Convention offers policy makers both an integrated and common ideological stance for

reconstructing children's experiences in health care and education, 'service' systems predominantly managed by adult-agendas.

Most saliently, Article 42 of the CRC provided the entry point for the research which was guided by the question "How have the principles and provisions of the CRC been interpreted and used by a committee of child advocates in the Capital Health Region of British Columbia?" (CRC Article 42 has also been adopted as the starting point for a pilot study in child rights curriculum development by Nova Scotia educators Covell and Howe, 1999, p. 171, and 2001, p. 41).

In the British Columbia case study, CRC Article 24.1 provided a second relevant starting point for medical-model professionals attempting to build capacity with young people: "States Parties recognise the right of the child to the enjoyment of the highest standard of health . . . shall strive to ensure that no child is deprived of his or her right of access to such health care services." When Article 24.1 concerning mental health provision was joined up with the four core CRC principles noted previously from Article 42, that is, children's rights applied on the basis of *non-discrimination, best interests, maximum development* and *participation*, a "local model" for implementing the CRC in healthcare was established (Mitchell, 2000, p. 334).

Summary and Conclusions

So Dorothy, it certainly doesn't look like Kansas anymore in the field of child and youth care! Will diagnoses such as Attention-Deficit Hyperactivity Disorder and Conduct Disorder be reconstructed and redefined in subsequent DSM versions? Are child and youth practitioners willing to critically reassess underlying ideological and theoretical assumptions regarding the nature of childhood promoted through the smoke and mirrors of the DSM-IV-R? This paper has traced a variety of arguments for a parallel adoption of the UN Convention on the Rights of the Child in assessment and treatment of mental and emotional health concerns for children and young people. To accomplish the author's thesis, the dominant constructions within child mental health and their underlying beliefs will require a thorough-going and rigorous re-examination using a more contextualized, multi-disciplinary conceptual framework. To facilitate this process, I have argued a modest case for a competency-based framework to guide child and youth therapeutic interventions.

This contention is supported throughout by experience from my own clinical and community-based child and youth care practice, and a theoretical stance found within the new sociology of childhood. A trio of case studies utilizing a rights-based approach in applied research

in the United Kingdom and Canada outline how this might look within local, multi-disciplinary rights-based initiatives in partnership with children and young people. The final case study is perhaps most germane to ongoing discussions concerning the over-used and highly contested diagnoses of Conduct Disorder and Attention Deficit Hyperactivity Disorder.

The largely untapped potential for adopting this competency based framework by front-line practitioners is given emphasis by recalling that all DSM revisions are fluid, historically located, and taken as such, should engender ongoing ideological debate. Concurrent implementation initiatives for the UN Convention on the Rights of the Child also appear well suited to assess young people's psycho-social and socio-emotional status through professional adoption of its four core principles in all matters affecting them. While these ideological values may contrast with pathologically-oriented and deficit-based assumptions, ethical practice in the field demands a new approach for a new century.

Notes

1. The interdependency and interconnectedness of all Articles in the document enlighten those who adopt this approach—especially when applying *Article 3*'s 'best interests' principle with *Article 12* which refers to the right of children and young people to "express views freely in all matters . . . the views being given due weight in accordance with the age and maturity of the child." Clearly, children and youth must themselves be primary sources for information regarding adult interpretations of their 'best interests.' The four core "principles" of the CRC obliged in *Article 42*, e.g. *Article 2* 'without discrimination'; *Article 3* 'the best interests'; *Article 6* 'maximum survival and development'; and *Article 12* 'participation' provide practitioners with a *minimum standard* rights-based approach.
2. Article 42 of the CRC obliges that all nations who ratify will "undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike"—arguably the most straight-forward, uncontestable notion within the entire document.

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