REVIEW ARTICLE

What does the term childhood behavioural disorders mean in the context of Aboriginal culture within Australia? Part 2: Historical and social context

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Childhood behavioural disorders (CBDs) are a common reason for referral to paediatric services and are associated with negative individual and societal outcomes. This article addresses how childhood became a distinct entity and how historical changes shaped its definition. Thereafter, the evolution of diagnostic criteria for CBD and associated limitations will be summarised. This will be followed by a discussion about Aboriginal culture, and the impact of colonisation on social and emotional well-being. This will provide a contextual frame for understanding how social and cultural context influences diagnoses of CBD in Aboriginal children. From this, a conversation about the journey moving forward will begin.

Key words: Aboriginal social and emotional well-being (SEWB); history of childhood behavioural disorders; mental health.

Childhood behavioural disorders (CBDs) are a common reason for referral to paediatric services.[1] The impact of CBD is significant and is associated with negative educational, employment, personal and relationship outcomes as well as contributing to intergenerational trauma, particularly for people of Aboriginal and Torres Strait Island background (the term 'Aboriginal' will be used hereafter).[2,3]

To understand the concept of CBD this article will address how childhood became a distinct entity and how historical changes shaped definitions. Thereafter, how the diagnostic criteria for CBD evolved and associated limitations will be summarised. This will be followed by a discussion about family life, culture, and the impact of colonisation on the social and emotional well-being

(SEWB) of Aboriginal people. This will reveal how the paths of Aboriginal children collided with 'modern' Western concepts of behavioural disorders and the positioning of medical professionals in relation to this. Finally, a conversation about how health professionals can work in partnership with the Aboriginal community for the journey forward will begin.

Childhood as a Distinct Entity in Western History

While in the modern era, there is a recognised distinction between childhood, adolescence and adulthood, this has not always been the case.[4] Up until the middle ages, children were generally perceived as being small adults who would often work and have responsibilities.[5] Similarly, adults would participate in children's activities such as games.[6] By the 17th century, the distinction between a child and adult began developing with concepts like mature and immature, and experience versus innocence forming.[7] In many respects, it has been suggested that as the adult world changes so too does the evolution of childhood whereby 'children become children when adults become more adult'.[8]

By the 18th century, Western family life started shifting from a communal structure to a more insular one. There was more value placed on instructing, educating, and nurturing children with behaviour that deviated from the norm often perceived as the result of inadequate parenting.[6,9]

During the 19th century, legislation against child labour was passed. Economic goals saw a demand for children to acquire knowledge and skills to supplement the workforce.[5,10] Thus, compulsory schooling was introduced. This changed societal

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Key points

1 Definitions of childhood behavioural disorders have been influenced by history, society and medical classification systems.
2 These definitions can collide with how childhood behaviour is viewed amongst Aboriginal people.
3 It is important for health professionals to work in partnership with the Aborignal community to address these issues.

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norms dramatically. Children lingering on the streets were seen as a problem that needed to be controlled.[5,11] These views were echoed in a report from the Parkes Royal Commission (1860):

> The streets of Sydney are infested by a large number of vagrant children; … the evidence abundantly shews that a large class exists to whom the possession of parents is of no value in giving direction to their lives, and who are growing up to be an incumbrance and a curse to society.[12]

A new era had emerged. Truancy officers were employed to ensure that children stayed in school. Those children who did not conform to the rules were considered to be disobedient and delinquents.[11] In Australia, these children were called 'gutter class' and 'gutter children'.[11,13]

Parallel to these shifts was a change of focus within the criminal justice system where a rehabilitation approach was taken towards youth rather than a punitive one. Juvenile courts were established and acted under '*parens patriae*', meaning that the state had the responsibility to act in the best interest of the child.[14] This often led to the removal of the child from their home to state institutions including detention centres and industrial schools.[15]

In Australia, the first specialised school for behavioural issues was established in 1913. Based in Melbourne, it was termed a 'School for Feeble-Minded Children'.[13] Subsequently, Travancore School was established in Victoria (1933). It specialised in 'the reception of children who, although mentally defective, are capable of receiving benefit from special instruction'[16] and was staffed by teachers and mental health professionals.[17]

By the 20th century, society was rapidly changing.[4] The 'modern nuclear family' was formed with stereotypical parental roles. These roles were centred on child rearing and protecting children from the harshness of the adult world.[6,9] Heywood discussed how this increased the period between infancy and adulthood and that as a result American youth had been 'increasingly infantilized in efforts to keep them out of the workplace, to repress their sexuality, and to prolong their education'.[9]

During the 1960s to 1970s, divorce rates increased and youth actively remonstrated traditional norms. People re-located for work opportunities, worked longer hours, sought qualifications to secure their positions, and more women joined the workforce.[18] These changes culminated in disrupted connections between families and communities. Parents became increasingly insecure about raising children and began seeking out professionals, rather than family and community, for answers.[4]

Simultaneously, there were rapid developments within the psychological field with a growing understanding of how family dynamics and society influenced the individual.[6,8] Mook stated, 'In our post-modern, overly busy and fast-paced families our children tend to be hurried along and pressured into achievement'.[6] Additionally, adolescents were expected to behave more adult-like, with a lesser degree of adult guidance. Mook argued that this marked a return to a medieval 'levelling' of the adult-child relationship.[6]

Every era is shaped by historical and social influences. This creates shifts in values and expectations, which arguably occurred more rapidly in the last century.[4] When we consider the expectations placed on children, we begin to see how these are a product of the time, and that behaviour and behavioural disorders are less distinct than we may have otherwise perceived. If this is the case, then what becomes of children who do not conform or who resist attempts at dominance and control? Are these children then vulnerable to labels such as a behavioural disorder? Do these labels legitimise channels of power and control over resistance asserted by young people?[4,11]

Classification of Childhood Behavioural Problems

The term CBDs evolved with the development of medical classification systems. In 1853, the first such system was produced by William Farr and Marc d'Espine. It was called the 'International List of Causes of Death in Brussels', and was revised around every 10 years.[5,19]

By the 1930s, a growing demand for non-fatal diseases to be included in classification systems led to the World Health Organization (WHO) producing the International Classification of Disease Six (ICD-6; 1946).[20] While this provided a more comprehensive description of disease, there was a need for a more detailed understanding of mental disorders. In 1948, the American Psychiatric Association (APA) began working on the Diagnostic and Statistical Manual over Mental Disorders (DSM; 1952).[21] Thereafter, the WHO and APA began to work collaboratively so that subsequent versions of DSM and ICD were more closely aligned.[5,19]

Conduct disorders first appeared as subcategories of behavioural disorders in ICD-8 (1969) and DSM-II (1968).[19,20] The term 'Conduct Disorder' (CD) was introduced in ICD-9 (1977) and DSM III (1980).[19,20]

In its time, DSM III was more widely used than ICD-9. This was because its use of a multi-axial system improved the validity and reliability of making a mental health diagnosis.[21] Furthermore, in the United States (U.S.), medical insurance companies adopted DSM-III because the specific definitions could be incorporated into reimbursement models.[19] Research based on DSM-III led to a marked understanding of the prevalence, course of illness and pathophysiology of mental health disorders. Research also revealed inconsistencies and unclear or invalid criteria in the manual. This led to an extensively revised version, DSM-III-R, being produced.[19] In 1992, the WHO published ICD-10. It soon became clear that these manuals were being used clinically but for this purpose more clarity and instruction were required. As such, the ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (CDDG) was developed.[19] The CDDG was more descriptive and included flexible diagnostic guidelines, particularly relating to various cultural settings.[19]

DSM-5 was released in 2013. It sought to rectify issues relating to the specificity of the diagnostic criteria. This specificity had led to insurance companies, funding bodies and researchers taking a two-dimensional approach to diagnoses and strictly adhering to criteria. The specificity of the criteria meant that clinically many individuals sat in the grey areas of diagnostic criteria with a high rate of nonspecific diagnoses ('Not Otherwise Specified') reflecting that in clinical practice many people had disorders that did not meet specific categories.[19]

DSM 5 sought to address issues relating to cultural validity.[19] For example, using DSM-IV, there was a 34-fold variation in prevalence of anxiety disorders across countries.[22] This suggested that the diagnostic criteria were failing to identify different cultural expressions of the same disorders, while concerns were raised about generalising western-based psychiatric ideas to other cultures.[23,24] In DSM-5, a separate section, 'Culture-Related Diagnostic Issues', was added to facilitate the application of the manual.[19]

In 2022, WHO will release ICD-11. The goals of this version will be to use the best evidence to determine which mental and behavioural disorders should be prioritised by member states and how to define and collect information on these. These goals are closely tied to reducing global mental health gaps, in particular poor access to effective treatment. Proposed changes in ICD-11 are intended to improve its clinical utility and allow more flexibility in different cultural contexts.[19]

Limitations of Classification Systems

Forming mental health diagnoses is a complex process.[19] They are not as distinct as other physical conditions and finding a single aetiological 'cause' can be futile. Rather, acknowledging biological, behavioural, psychosocial and cultural factors over time allows a complete understanding of the individual.[19]

Tools that help categorise mental health disorders are useful. In accepting such systems, it is important to resist trying to fit individuals into categories, or to think of disorders, their severity or thresholds as distinct entities. There are often significant overlap between them with cut-offs made on a semi-arbitrary basis.[19] The definition of mental disorders has changed over time and is likely to continue to do so. This can have an impact on individuals who may move in and out of these definitions. Consequences include stigmas and eligibility for services. Adding to the complexity of mental health diagnoses is comorbidity. Again, while it may be tempting to think of individuals as having one particular disorder, this is often not the case. Comorbidity is common and is thus likely to be the norm as opposed to an outlier.[19]

While classification systems are helpful in advancing clinical knowledge, communication and service development, they do have limitations.[19] It is thus important to take a flexible approach to definitions particularly when considering regulatory, legislative, and legal processes. There is also a need to simply acknowledge that forming mental health diagnoses is complex and that endeavouring to fit individuals neatly into categories is unlikely to be helpful.[5]

Understanding Health and Well-Being in the Context of Aboriginal Culture

Culture is central to the happiness and well-being of Aboriginal people.[25] One definition of culture is the 'ideas and self-concepts such as artefacts, attitudes, beliefs, customs, norms, symbols and values, of a group. It also encompasses the influence of historical events and standards of behaviour that evolve and change over time'.[26]

In Western cultures, health tends to be compartmentalised as being either mental or physical. In Aboriginal culture, health is understood more holistically and includes the concepts of physical, mental and emotional health as well as social, spiritual and cultural connection, and connection to country.[27–30] This is true of CBD as well.[31]

Past and ongoing injustices associated with colonisation have had an impact on the SEWB of Aboriginal people.[25,31] This includes the effects of intergenerational trauma, cultural disconnection and family disruption which have led to high levels of disadvantage within Aboriginal families and communities.[28]

The impact of colonisation on Aboriginal culture

Colonisation led to drastic changes and interruption of the lifeways of Aboriginal people.[29] This included acquisition of land and power through 'bloodshed, warfare, massacres and poisoning'.[30] Many Aboriginal people were forcibly removed from country onto missions and reserves. This disrupted kinship systems, degraded spiritual connections to land and suppressed the use of Aboriginal languages.[29]

Colonisation involved imposing the values of the colonisers on Aboriginal people, who were defined as the 'other' or 'savage'.[32] Systems of laws enforced colonial ownership of land and the development of values and beliefs that devalued the existing culture.[29,32] This introduced a deficit way of thinking whereby Aboriginal practices including family life were seen in the negative or as lacking in some form.[29,33]

Family life-ways within Aboriginal culture

For Aboriginal people, there is a strong emphasis on relationships with the extended family which includes a communal or shared approach to raising children.[25,28] This involves care of children and sharing of material resources such as money and food.[28,32]

The role of elders in Aboriginal culture is significant. Elders are highly respected and provide wisdom, leadership and education about aspects of life and society.[28] This lives on in modern times with supportive grandparents, particularly grandmothers, seen as a cornerstone to family life. Featherstone[32] describes a grandmother's presence as being 'centred on helping their daughters to develop comfort in parenting their children'.

The role of children in Aboriginal culture differs from Western concepts of childhood.[28,29] For Aboriginal people, infants are included 'as accepted and valued members of the family' and are involved in all activities.[34] The 'child–adult relationship is one of greater equality than typically seen in non-Aboriginal families'.[35] In Aboriginal culture, there is an emphasis on children learning by exploring and experiencing the world.[28] As the book 'Walking with the Seasons in Kakadu' states:

> 'This is a story that has got to be told to children so they know country-no good just sitting in the classroom all day. You've got to get outside and discover the bush, feel the changes, see what's there'.[36]

Children are expected to have responsibilities within their families. They are encouraged to care for each other, to be independent, autonomous and self-reliant but also value the strength of community coherence.[29]

Aboriginal families have strong value systems based on their relationship to community and country.[32] Central to this is teaching children the interconnecting values of autonomy and caring

for others.[28] These characteristics impact on the resiliency of Aboriginal people and are important to build on when working in partnership with Aboriginal people.[32]

There has been little acknowledgement of the differences and integrity of the parenting characteristics of Aboriginal people.[32] Dunstan et al.,[33] in examining Australian national and state policy frameworks, discuss how Aboriginal family life continues to be positioned as deficient and dysfunctional.[32,33]

CBDs amongst Aboriginal People

Aboriginal people are particularly vulnerable in the context of mental health disorders, with a higher reported prevalence of disorders and lower access to services.[37,38] CBD in Aboriginal children are influenced by adverse childhood experiences such as abuse, neglect, the experience of racism and the ongoing grief, loss and disadvantage associated with colonisation.[39] These experiences have a cumulative effect on development, health and SEWB.[31,40]

Despite the effect of adverse experiences, the impact of these are not set in stone. Factors that can mitigate these negative effects include secure caregiver relationships, family encouragement to attend school, having someone to talk to, and regular exercise.[41] Building a sense of self-efficacy and empowerment, strengthening abilities to self-regulate, as well as the protective benefits of sources of faith, hope and cultural traditions act as resiliency factors.[31,42]

People understand a diagnosis within their social, cultural and environmental circumstances.[43] For parents, having a child who misbehaves is associated with stigma and feelings of shame and guilt. Parents often feel pressured to seek a medical diagnosis for what they often believe is a social problem, in order to receive support.[44] In many ways, a power differential exists whereby the clinician not only defines and labels behaviour but also acts as a gateway to accessing resources.[43] An example is attention-deficit/hyperactivity disorder. Aboriginal children have a higher risk of hyperactivity problems (15.8%) than non-Aboriginal children (9.7%).[45] While parents want to see improved behaviour, they are hesitant about medication, mainly because of perceived differences between Aboriginal and non-Aboriginal children. For many Aboriginal families, hyperactivity has been perceived as being mischievous, rather than a disorder. Families saw a need for interventions and resources that recognised these differences and involved the wider family unit.[46]

Deficit-focused, Western-based assumptions about Aboriginal health including CBD can have negative implications for Aboriginal people. It is important to continue to advocate for the voices and knowledge systems of Aboriginal people to be recognised.[31,43]

Summary and the Journey Forward

History and culture are intertwined. For Western cultures, the last century accelerated knowledge and industry. Those influences shaped society, the place of children and expectations about their social roles and behaviour.[4–6]

Aboriginal culture has evolved over an estimated 65 000 years prior to Western colonisation.[25] Connection to culture is a strength, and is a protective force for children and families.[27]

Many of these connections were disrupted by colonisation and have left a legacy of intergenerational health and social inequities. Furthermore, there has been little acknowledgement of the differences between child-rearing amongst Aboriginal and non-Aboriginal cultures with Aboriginal ways of life often seen as the one in deficit.[32,39] CBD in an example of health inequity with Aboriginal children being more likely to receive a diagnosis in this category.[47]

As we endeavour to understand these social and historical influences on behavioural diagnoses, we need to recognise how the field of mental health has developed, particularly in the last century. The evolution of classification systems such as DSM and ICD have helped professionals communicate and manage mental disorders. In an attempt to standardise medical practice, the limitations of this approach became apparent, particularly when applying these systems across cultures.[19]

Classification systems became a tool in a complex diagnostic process that required a holistic approach. Gradually a need for flexibility in diagnostic processes has become evident, in opposition to a process which endeavours to fit people into imperfect diagnostic criteria.[19] Yet, external pressures often dictated this approach including reimbursement from insurance services and criteria to access treatment. Today, these pressures still exist. Health professionals frequently find themselves at odds between the needs of individuals and the criteria for accessing various supports and sources of funding.[38] There is a growing understanding that a single diagnostic manual will not capture all that is needed to know in the field of mental health and that innovative ways to approach mental health is required.[19] Integral to this will be building flexibility at a regulation level within health and mental health systems.

In Australia, there remains tension about acknowledging the life-ways of Aboriginal people. Health care is not immune to this with CBD often perceived as a product of ongoing colonisation, whereby underlying social and cultural factors are not accounted for.[24] Understanding of these concepts is integral to the success of any programs and services for Aboriginal people.[27] A key theme that emerges is that 'cultural wounds require cultural medicines'.[48] This requires a commitment at a policy level to empower communities to build on existing strengths, culture and connections to build effective services.[27,28,30] The right to self-determination means that Aboriginal people must actively participate in every aspect of the design and delivery of policies and services that affect them.[31] Services need to be encouraged and funded to be responsive to the holistic needs of Aboriginal people. This includes addressing sources of stress such as finances and housing.[31] It is also vital for assessment tools and treatments to have been validated in Aboriginal populations.[25] For those working in health and education, there is a need for ongoing training and everyday implementation of culturally-safe practices.[25,27] Health and well-being for all are likely to improve when cultural elements are acknowledged, practised and incorporated into people's lives.[25]

Acknowledgement

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The World of Disney by Clara Noh (aged 15) from "A Pop of Colour" art competition, Youth Arts, Children's Hospital at Westmead