

Full Length Research Paper

Mental health and inclusion seen from the children's and teachers' perspectives: A case study in Spain

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Inclusive school requires the coexistence of what is perceived as normal and what is seen as pathologically different. Considering the growing pathologization of childhood, attempt is made to know the view of the students that do not have any diagnosed mental disorder on the ones that do have and the teachers' view on the inclusion of these children. A case study was conducted in a Spanish public primary school that has an inclusive pedagogical project. Semi-structured interviews and questionnaires were used to explore the participants' views on the inclusion of children with mental health disorders. The results show that the psychopathological disorders work as differentiating elements, although most of the children have shown an openly integrative and empathic attitude. The teachers pinpoint the difference in the children that have a diagnosis of mental disorder and fail to recognize or question the pathologization of the childhood, its consequences and the role of the school.

Key words: Pathologization of childhood, medicalization of childhood, inclusive schools, mental health discourses, special educational needs.

INTRODUCTION

Inclusion in education means recognising and accepting all students' particularities, motivations, abilities and educational needs. Amongst such particularities, we find the mental disorders, which, due to their growing prevalence, are an increasing topic of debate in the educational context. The inclusion of children with a diagnosed mental disorder requires an environment which accepts them and in which coexistence and difference can coincide. Bearing in mind that coexistence among schoolchildren depends on the degree of labelling of what is normal and what is pathologically different

(Graham, 2015), arises the need to enquire into the views and thoughts of children with no diagnosed pathology towards those who have mental health difficulties (MHD) (Bellanca and Pote, 2013).

There is no lack of controversy in the mental health field. Ranging from the critical views of antipsychiatry (Szaz, 1976) to the current critique of the pathologization and medicalization of childhood (Conrad, 1992; Timimi, 2002, 2010), and including Foucault's extensive opus (1984, 1996, 2005, 2010), much has been written about psychiatry's power, commercial interests and lack of

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scientific rigour. However, diagnoses and descriptions from psychiatric discourse now form part of the public domain (Malacrida, 2004), and since no special or analytical tests are usually necessary, it is not difficult to try one's hand at diagnosing one's own problems or those of others. Further, several studies (Bailey, 2010; Graham, 2007; Malacrida, 2004; Prosser, 2008; Singh, 2011) have found that schools, and more specifically teachers, are behind many Attention Deficit Hyperactivity Disorder (ADHD) diagnoses. It is also clear that lack of information or biased/limited information on some aspects of the topic can create labelling, pigeonholing and stereotyping rather than fostering an understanding of each person's complexities.

The goal of this study was to determine how difference is constructed socially and discursively based on MHD (Graham, 2006) and how children and teachers experience this in a supposedly inclusive educational context. The approach in this study was a constructionist one (Atkinson and Gregory, 2008) and did not seek to confirm the correctness or otherwise of mental disorder diagnoses among children or of the information available on these disorders. It was started from the supposition that the diagnoses contribute to tracing lines of difference between some children and others. Also, it seemed to us particularly interesting to study how teachers and students in an inclusive school spoke about difference based on mental health diagnoses.

SPECIAL EDUCATIONAL NEEDS AND INCLUSION

Over the last few decades, schools have increasingly catered for children who cannot adapt to an education system created for those seen as normal. Currently, under the heading of special educational needs (SEN, Department of Education and Science, 1978), there is a wide range of distinct conditions from psychopathological disorders to sensorimotor limitations, from learning difficulties to social exclusion, etc. At the same time, society's awareness and sensitivity towards SEN and approaches to working with them have changed over the years.

A good example of this is the shift in the nomenclature of the International Classification of Impairments, Disabilities and Handicaps (ICIDH-WHO, 1983) to the International Classification of Functioning, Disability and Health (ICF-WHO, 2001), a new categorization which now refers to what individuals can do and how society enables them (or not) to participate (Cáceres Rodríguez, 2004). This more dynamic view does not see a person's barriers to participation (handicaps) solely as consequences of personal limitations (impairment) and the inclusion of the role of social groups when defining SEN also radically changes our vision of education, which is now not seen merely as an instrument for compensating or managing individual impairments.

Inclusive education and cooperative learning also reflect changes in ways of thinking about the education of people with or without SEN. The concept of inclusion gained ground in the 1990s in the wake of a wide international movement (Torres, 2000). It had been preceded by that of integration, which emerged in the 1960s with an approach more geared towards integrating the person into the education system and the wider society. Integrative methods essentially sought to compensate and adapt people with SEN (Carrington, 2017; Thomazet, 2009), but a shift in the prevailing methodological and political view (Vislie, 2003) led to the substitution of integration by inclusion, with the Salamanca Statement (UNESCO, 1994) marking the watershed turning the political agenda towards inclusive education. Inclusive education is defined as a process (Vislie, 2003) that seeks to embrace all students, recognizing their particularities, valuing them all and giving them the chance to participate in school in accordance with their abilities (Thomazet, 2009). Inclusive education is currently widely accepted as the best way of educating all children and changing society so that other barriers can be removed and prejudices eradicated (Booth and Ainscow, 2002). While integration attempted to address the exclusion of students with SEN in special education centres, inclusion instead sought a significant reorientation of educational quality towards valuing the educational needs, interests and potentials of all students and rethinking previous curriculums and methods such as competitive learning. Cooperative learning has been considered by different studies to lead to higher academic achievement than competitive or individual approaches for both low- and high-ability children (Hornby, 2009). Cooperative learning has proliferated in inclusive education for different academic purposes (Klavina et al., 2014). Besides fostering students' agency and cooperation, it increases interactions between peers with and without disabilities (Klavina and Block, 2008).

In Spain, public schools have clearly followed an inclusive orientation since a 1990's general law on education (LOGSE, 1990), although this orientation has faced contradictory decisions and processes (Martínez Abellán et al., 2010). For instance, there are still schools which classify and separate students into levels using euphemisms like 'flexible groups' to obtain more homogeneous groupings and reduce pressure on teaching staff (Graham, 2015).

MENTAL HEALTH IN SCHOOLS AND THE PATHOLOGIZATION OF CHILDHOOD

The Diagnostic and Statistical Manual of Mental Health, published by the American Psychiatric Association and currently in its fifth edition (DSM-5, APA, 2013), has become the main diagnostic reference in Western

countries over the last 30 years (Schwartz and Wiggins, 2002). Although it does not group mental disorders diagnosed in childhood and adolescence into a special category,¹ disorders such as Autistic Spectrum Disorder and Intellectual Disability are mostly diagnosed before adulthood and others such as ADHD and Oppositional Defiant Disorder (ODD) are statistically more significant in childhood (APA, 2013).

The pathologization of childhood directly affects how a child is understood, if the child behaviour is interpreted as psychopathology or not (Harwood and Allan, 2014). The growing criticism of psychiatry for pathologizing and medicalizing childhood (Conrad, 1982, 1992; Harwood, 2009; Harwood and Allan, 2014; Prosser, 2008; Timimi, 2002, 2010) and of the colonization of mental health by the biological model (Read, 2005; Singh, 2002; Visser and Jehan, 2009) is due to factors such as the notable rise in prevalence of disorders such as ADHD (Sánchez et al., 2008) and Autism Spectrum Disorder (ASD) (Melillo, 2013), reductively biological explanations of these conditions, and the growing number of children needing psychiatric medication in order to attend school (Graham, 2007).

According to Cererols and Caparrós (2009), scientific and technological advances have changed the way professionals see children with MHD, favouring decontextualisation and biologization. On one hand, there are now more resources and tools for attending children and more instruments for diagnosis and treatment. On the other hand, the quest for fulfilment through consumption, technology and individualism creates unfavourable conditions which foster the increasing pathologization of society and childhood. Dueñas (2013a) argues that children are not syndromes; she criticizes the approach to reeducation that solely seeks signs allowing us to fit them into the DSM's catalogue of disorders, without taking their personal history and living conditions into account.

Many behaviours which disrupt the smooth functioning of a class are often interpreted as MHD with biological causes, and not linked back to social practices in family upbringing (Read, 2005). Undesirable effects that teachers observe in pupils are not given their appropriate relationship to profound social and cultural changes (Dueñas, 2013b; Harwood and Allan, 2014) or to the school itself (Graham, 2007). As written by Foucault (2005), a disorder begins as something which causes social unease and finally becomes a classification taking the form of a diagnosis. Thus, mental disorders, when they are given the same status as medical illnesses, are stripped of their potential to call social practices into question. Instead of this, school children are labelled, because of teachers' suspicions of disorders which, due to their supposedly biological causes, do not require pedagogical but medical action (Graham, 2007).

¹ This category in the DSM-4 disappeared when it was replaced in May 2013 by the DSM-5.

This labelling according to psychopathologies in schools correspond to what Conrad (1982, 1992) describes as the medicalization of childhood by non-medical personnel, and contributes to the stigmatisation and self-stigmatisation of those diagnosed (Corrigan et al., 2009).

Understandably, disorders are not all diagnosed in the same way. While cases of ASD and intellectual disability are now almost always diagnosed before school age, ADHD is increasingly considered to be a disorder linked to education (Bailey, 2010; Graham, 2007). Many families seek ADHD diagnoses after complaints from the school (Malacrida, 2004) and discontinue medication on weekends and holidays (Martins et al., 2004).

Here, we start from the assumption that many childhood mental disorders stem from some deviation from school rules and/or some difficulty in adapting to a non-inclusive context (Harwood, 2009). Clearly, some more than others, given similar marks, an inattentive child may cause less alarm and disruption than one who is both inattentive and hyperactive (Grizenko et al., 2010; Marshall et al., 2014). Adapting school routines to the SEN caused by MHD may involve explaining to the whole class the reasons behind the changes and where the differences lie. Explanation requires the deployment of a discourse accounting for the supposedly special characteristics of some and putting them in relation to others, that is, it entails a discourse on what is considered normal and what is perceived as pathological.

Equally, it was assumed that it is important to listen to what children themselves have to say (Hadfield and Haw, 2001); if we are to determine the characteristics of their relationships with classmates diagnosed with MHD. Like Singh (2013a, b), it is our view that despite their contact with adult explanations, children have enough independence and agency to explain their experiences for themselves.

METHODOLOGY

Objectives

Due to our interest in the inclusion of children with MHD and in how differences in mental health are established discursively, we chose to work with the two groups who related most directly to these children: their teachers and their classmates with no MHD. Our first overall objective was to determine the views of the children without MHD towards those with MHD. More specifically, we wished to know their stance on classroom diversity, what sources of information about MHD they had, and the nature of the relationships between the two groups of children.

Regarding the teachers, our second overall objective was to enquire into their professional stance on mental health disorders and educational inclusion, not only because of their possible influence on the school children but also to explore how they defined differences in mental health and presented them to the students.

Methodological approach

When planning our study's methodology, we had in mind a school

fulfilling the minimal requirements of inclusivity (that is, where diagnosed children were not separated from others), but it was not easy to find a school willing to participate. School heads' avoidance of mental health issues stemming from fear of how families might react seemed to be behind the rejections (3) we received.

The methodology we adopted was exploratory-descriptive, consisting of a case study undertaken in a state infants and primary education school with an inclusive educational policy. Our objectives were not to investigate whether children diagnosed with mental health disorders were included or not. Neither did we wish to use a psychometric approach such as that of Bellanca and Pote (2013) or Ogg et al. (2013) to investigate the preferences of non-diagnosed children regarding their diagnosed classmates. What we did wish to study was how the students without MHD and teachers described the differences based on mental health criteria and the inclusion of children with MHD. We did not aim for results that could be generalized to other schools, but we did seek significant variables and possible relationships between them (Yin, 2014).

The educational context where the study was carried out was a school in Sant Cugat del Vallès (Barcelona), inaugurated in 2003-2004, with two classes per age level (except for 2013-2014, which had three classes in the sixth year of primary), averaging 24 pupils in each class. Although all Spanish public schools are inclusive by law, the school was remarkable for its wide diversity, consisting of many nationalities, and because it had a Special Education Support Unit (USEE in its Catalan initials) for children who could not be educated normally. Apart from the tutors and specialists, the USEE teaching team included an educator, a speech therapist, an educational psychologist, a physiotherapist and a monitor.

Participants

Seven members of the school's teaching staff participated in the study, along with 15 primary-school pupils aged 10 to 12, 6 from the fifth year and 9 from the sixth. Six were boys and 9 girls. To be eligible for the study, the children had to have no diagnosis of any established mental disorder and to be in contact with children with MHD in the educational context. The teachers taking part were those who had agreed to answer our questions on their work with disorders and inclusion. Both participant teachers and students had at least five years of experience in inclusive contexts. Following ethical clearance procedures, a document explaining the study's purpose and methods was given to and signed by all participants (or parents and legal guardians) during the project presentation.

Data collection and analysis

For the school children's survey, we designed a semistructured interview since, due to the nature of the research topic, we deemed it necessary to allow the interviewer some flexibility, to shape the interview according to participants' responses (Bleger, 1985), and to preserve the spontaneity of answers in order to learn from the unexpected (Cifali, 2005). At the same time, there were clear, specific and important topics to be included and a set of questions that acted as a guide: (a) what the children thought of their classmates with MHD; (b) what their sources of information on differences were; and (c) what their relationships with children with MHD were like. Following recommendations from the school management team, we decided to use ADHD and ASD as examples because these disorders were well-known to pupils.

The teachers were sent an online questionnaire which featured open questions whose objective was to obtain replies in their own language, without limiting length and using open question words and phrases (how, what, in what situations, etc.). At the same time, the questions were closely directed to make sure the teachers gave information on relevant issues; in other words, we enquired

objectively about what they did, how they made certain decisions and their posture towards certain situations. The questionnaire comprised ten questions on five topics: (a) the teachers' position on the diagnoses; (b) how they treated this issue with their students; (c) their impressions of children's reactions to the issue; (d) their views on medication; and (e) their experience of and posture on inclusion in the classroom. Some examples are: 'In what way do pupils without mental health disorders relate to those with diagnoses, in your view?' 'How and what would you explain to your students about a mental health disorder such as ADHD, Autism or Intellectual Disability?'

The data went through two distinct thematic analysis (Braun and Clarke, 2006). The students' semistructured interviews and the teachers' questionnaires were analysed and two sets of categories were constructed. Later, both sets were compared and organised into four topics: school children's views on classmates with MHD, information sources, relationships between children and teachers' views on the educational inclusion of children with mental health disorders.

RESULTS

School children's views on classmates with mental health disorders

All the school children interviewed recognised at least one of the mental health disorders mentioned (ADHD and Autism), particularly when some of their more typical symptoms were described. The most easily identified of these symptoms were hyperactivity and fixation on an object or activity.

Enquiring into the equality or difference between participants and their classmates with MHD, we discerned three distinct ways of seeing the issue in their responses. A first group of children saw the others as different due to their conditions. They experienced the unusual behaviours (strange movements, not accepting jokes, being nervous, etc.) as important discrepancies, and expressed opinions such as, 'I don't have any disabilities, I don't think they're like me,' (P, 10) or, 'Their language and movements are really different, so they can't be kids like me' (A, 11). In the second group, we found the children who, while they did perceive differences, did not see them as so significant or as an issue for concern. On the one hand, they saw their diagnosed classmates as equal but on the other as somewhat different. 'They're kids like us, but they have problems like getting annoyed more easily' (L, 12); 'Although they're like us I think they're a bit different because they've got an illness, but not much' (S, 11); 'They're people, like everyone, but they're a bit different as well [...] it's just they need peace and quiet to do things properly' (S, 11); 'They're different, but I don't know how to explain it, they're like a bit odd [...] but not very different' (M, 12). The third group of children did not see the differences or disorders as separating factors: 'They're normal people, there's no reason to treat them any differently' (J, 12); 'I think the differences are normal, maybe they can behave differently, but I don't think

they're different' (V, 12); 'We're all different, but that's not bad' (P, 12).

However, their responses could sometimes be slightly contradictory. For example, the same pupil (P, 10) who said that he did not see them as equal also commented that he could learn from them and since he could play with them he didn't see them as distant. Despite our attempt to classify the responses into three categories, the children's views of the differences were highly nuanced and thus it was difficult to make them fit into only three possibilities. The difference marked by the diagnoses was present, it might represent a clear barrier or be minimized by the possibility of joint participation in games and activities, but it was not ignored by the children. Likewise, the diagnoses were not questioned and functioned as more or less accurate descriptions of the behaviour of the diagnosed children.

Information sources

The schoolchildren's main sources of information were: (a) their parents; (b) the school staff; (c) their classmates; and (d) media such as the television. Also, if they had family members and/or friends with some type of MHD or other condition such as Down's Syndrome it seemed to contribute greatly to their general knowledge of mental health. We should also note that some participants (4) told us they had not discussed the issue with any of the aforementioned sources or did not want to talk about it with their parents, although they had heard it discussed in other contexts.

It was also clear that the presence of pupils with these conditions combined with related incidents at school had led many teachers to explain the topic of diversity in the classroom. As M (11) told us: 'There was some trouble between some kids in my class because of insults and that's why the teacher explained to us what was happening;' and 'in our school there are kids with disorders, some other kids imitated them and the teacher talked about it.'

In general, information on mental disorders among children and adolescents is reasonably public and although it is a subject avoided by many adults, it was not exactly a taboo topic among the children participating in this study. More specifically, explanations of mental health may become necessary and turned into an issue precisely when there is a difference which becomes disruptive and needs some kind of containment. It seems that similar behaviours would be punished without further explanation, since they would have no supposed mental disorder behind them to explain or justify them. A mental health disorder diagnosis thus seemed to be used to account for a difference which had negative consequences but which remained on the level of a personal condition and was seen as independent of the person's will.

Relationships between children

The great majority of the children (12) were in favour of having friendships with their classmates with MHD. Nevertheless, it was true that many of them (5) did not see this as the same type of relationship that they would have with a non-diagnosed child. This difference became clear in the children's most essential activity: play. Many (7) tried to put themselves in other's shoes and chose games that the children with MHD would like. Others attempted to empathise with them, initiating relationships to prevent their isolation: 'Yes, I'd be friends because I could help them feel better and not be lonely, maybe nobody would want to stay with them and be their friend' (M, 11). Others even defended the children with MHD: 'We'd be good friends, there'd be no problem, I'd help her and I'd defend her. Do you think they need to be defended? Yes because sometimes people can be really horrible to them and they can't defend themselves on their own' (L, 12). In some cases they recognised that play would be very difficult for them because of issues such as language and nervous movements: 'With a kid with autism you can play but it would be more difficult because you don't understand them much when they talk, I wouldn't know how to get together with them and be with them' (M, 11); 'It's more difficult to get their attention because they can't communicate and express themselves, they can play but with people who're more patient' (J, 12); 'a kid with autism would be a bit more difficult and more complicated because some things can affect them and make them annoyed, the game wouldn't be the same but the friendship would' (L, 12).

It should also be noted that there was a small group (3) that would neither relate to these children nor saw play as an activity to share with them. 'You can play with them but they don't listen to you, it's a bit tiring when you're playing with someone and they don't take any notice of you' (V, 12); 'You can, but it's really difficult because they're in their world, I think it's really difficult to get to play with them' (D, 11); 'With a kid with autism it would be a bit difficult because they make weird movements and they don't listen to you, we wouldn't play together the same way because they're different, they don't speak properly and they've got a strange expression' (A, 11).

The great majority of the children (12) said that they did not see any difficulty in establishing friendships and playing with children with MHD: 'I'd play in the same way with them, I don't understand why not when they're just people like us' (E, 11); 'I'd play with them like with anyone else, we'd be friends in the same way, I don't mind if they're like that' (P, 12).

Another factor which appeared important in establishing friendships was the other's personality: 'If I think they're nice, yes' (P, 12). Rather than psychiatric labels, the children we interviewed seemed to base their choices on their own experiences when deciding whether and how to relate to or play with children with MHD.

Some seemed to take into account factors affecting the relationship such as personal chemistry or the possibility of sharing the game or understanding the other, while others seemed not to mind the differences. Whatever the case, it was not easy to distinguish a clearly inclusive stance from a more segregating one, since those who said they would not play because they wouldn't feel understood or because they were not empathetic enough to adapt themselves to the other's play could not consistently be categorized as segregators. Likewise, those who were more empathetic or protective did not necessarily always take up the same stance of equality towards the other.

Teachers' views on the educational inclusion of children with MHD

The teachers who participated in our study considered inclusion to be important, and that it should be privileged over many other educational movements. However, they stressed that the lack of resources made its implementation difficult or even impossible in some cases. They also argued for the combination of two approaches: working with the whole class and individually, but constantly adapting to each individual and sharing resources appropriately. Even so, one teacher remarked that working with the whole class had many advantages since having two teachers in the classroom benefited not only the children with SEN but also the others.

Regarding MHD, all teachers stated that children must understand that diversity is the norm and that around them there are people with varying personal characteristics with which they all had to coexist as equals. 'It is the social reality that each and every one of us forms part of'. They also remarked that it was very important to be straightforward about personal differences and MHD in groups that have children with SEN. Using this approach, they would be able to discuss these pupils' difficulties and empathize more with them. The teachers argued that this approach would favour positive classroom dynamics and bond all the children in the class since they would then understand the particular actions undertaken to help those with MHD.

The discursive construction of difference by teachers thus involved communicating the nature of the daily life of children with SEN and explaining their most disruptive behaviours and their problems and needs so that the other children could help them. In this way, the pupils without MHD would understand better the behaviour and the reactions of children with MHD and everything could be explained quite naturally and in a language they could understand. The teachers also thought that the explanations of difference and changes made in class needed to be constantly readjusted due to variations in the schoolchildren's reactions over time and bearing in

mind the characteristics of children with SEN and the real problems they encountered and had to live with.

The teachers' views had points of agreement and consistency with those of the children, but there were also certain differences. They unequivocally confirmed what we noted in earlier, that is, that information on the SEN of the children diagnosed with mental health problems was necessary to justify the interventions made in dealing with the most disruptive behaviours. The diversity which was supposedly presented as the norm, however, seemed always to be the diversity of others, not our own. That is, diversity was presented as a part of society, but the differences and special needs belonged only to the children diagnosed with MHD. The teachers' discourse traced a difference between those who needed adjustments and adaptation and the majority group which should embrace, understand and accept the former. Changes and adjustments were necessary to integrate them, but under no circumstances are we talking about inclusive education, since there was a deficit discourse and the difference was perceived as essentially that of the other (Graham, 2006). Nor did the teachers mention cooperative learning, which is one of the cornerstones of inclusive education. In fact, the teachers' discourse was clearly integrative and sought to make the adjustments necessary to integrate the children with mental health disorders into the class. Interestingly, this discourse seemed to be quite distant from that of some of the children, who observed that we are all people and all different.

DISCUSSION

The pathologization of childhood, with its accompanying descriptions covering ever more childhood behaviours, enables teachers and children with no MHD to construct a reasonably clear and accurate discourse on children seen as mentally ill. For the teachers taking part in our study, informing their pupils about the symptoms and disorders of some children favoured inclusion because it fomented understanding and tolerance. In fact, all the participant pupils characterized the children with MHD based on their symptoms while the great majority of them stressed the common features of both groups and the possibility of full integration. The diagnosis of children with MHD involves a description of specific characteristics which everyone should understand to enhance coexistence. Such descriptions allow the development of better-adjusted approaches which teachers can put into practice and adapt to foster more effective inclusion. However, it is also true that they can restrict the understanding of these children to that of their symptoms (Dueñas, 2013a). Further research should address this issue: how much do children with no MHD limit their perception of children with MHD to their symptoms?

Despite recognising that a growing number of children are being diagnosed and seeing this as a reality, the teachers taking part did not question either the diagnoses or the abnormality of the children with MHD. The pathologization of childhood was not acknowledged as such, its effects (more children with MHD) were naturalized and the role of schools in this pathologization was not called into question (Graham, 2007). However much it was said that children with MHD should be treated, accepted and tolerated like children with no MHD, the differences and limitations which teachers attempted to compensate or lighten through integrative approaches were always presented as those of the other (Graham, 2006). Hence, the teachers' discourse was essentially integrative: adapting oneself to deal with the limitations of pupils with MHD.

One of the surprises of our study involved the nature of the differences stemming from mental disorders. The need to explain measures adopted in dealing with the behavioural problems of pupils with MHD revealed the place that the psychopathological conditions occupied. The need to explain why school discipline and supervision were not applied equally to all pupils implicitly involved discussing responsibility and blame (Singh, 2012). It was claimed that children suffering from a disorder could not control some of their behaviours, and that this was why they received differential treatment. Therefore, their pathology was seen as a condition external to their will (Singh, 2013a), and this in turn justified tolerance and relaxation of the rules. This discourse, however, could undermine school discipline if it addressed the subjective conditions and needs of all schoolchildren. In contrast, an inclusive model would entail questioning the strictness of school rules and considering the subjective needs and limitations of every child. The integrative discourse allows some routines and rules not to be touched on, thus making the minimum changes necessary to integrate the children diagnosed with MHD. Moreover, current psychiatric diagnoses ease things since they leave aside the subjectivity of these children and reduce their disorders to clearly classifiable abnormal conducts (Harwood, 2009; Harwood and Allan, 2014). Considering each child's subjectivity and the complexity of the diagnoses would threaten the clearly defined border between those who do not have MHD and those who are pathologically different.

However much the discourse of some of the children we interviewed repeated segments of the teachers' integrative discourse, it would be inaccurate to claim that they limited themselves to reproducing it. Neither can we say that each child had an internally coherent discourse which could be identified unequivocally as segregating, integrating or inclusive. Some seemed to stress the differences while others looked more for what was common to all and recognised everyone's diversity. The great majority (12) showed a discourse of tolerance towards their classmates with MHD, even of protection

and aid. Even so, a small group (3) seemed to see the differences as separating factors.

Aside from this, what seemed most relevant for the children, rather than ideals of integration or inclusion, was what emerged from their living together. Being able to talk to and play with others suffering from disorders, combined with more attitudinal factors (if they were 'nice' or not), seemed to be more salient when deciding the possibility of coexistence. Certainly, there were issues hampering relationships with children with mental health disorders, since they were perceived as 'a bit different,' but while the pupils with no MHD could play with them, live alongside them without difficulty, accompany them, help them in their needs and get on well with them, they seemed to have no prejudices or barriers towards being friends.

Some schools' unwillingness to participate in our study was at first interpreted as a more or less predictable response to a possibly taboo topic. However, from what we now know about the pathologization and medicalization of childhood, the supposed deficiencies in some children's mental health may not be such a taboo subject in schools, but rather a legitimising alternative explanation of disruptive behaviours (Lakoff, 2000; Bailey, 2014; Singh, 2011). Consequently, the pathologization of childhood assists teachers in explaining some disciplinary issues and reducing them to personal pathological conditions, but also marks certain limits to the inclusive education attempted by some schools, since the separation between children with and without MHD is introduced at the price of disregarding the subjectivity of both and focusing only on adjustment (or lack of it) to school routines.

This study has mainly three limitations. First, it is limited to one school with an inclusive tradition. Other case studies in less inclusive scenarios would certainly yield different results. Second, since we were concerned with how children with MHD were seen by their colleagues and teachers, we did not interview them. Contrasting their views with the others' might have been useful to have a broader picture of the school. Last but not the least, this study was limited to the participants' discourse, it would be interesting to do a more in-depth research about how these discourses relate to the day-to-day reality.

Based on the findings, three recommendations could be made:

- (1) Teachers training should address critical views on pathologization of childhood. Although teachers are familiar with mental health diagnoses, their view seems limited to recognizing symptoms without further questioning.
- (2) The viability of inclusive schools without cooperative learning must be debated. It seems that teachers still try to implement inclusive classes using individual or competitive approaches just to discover that they cannot handle a class with children with SEN on their own.

(3) Since children seem to have some information on MHD and use it in their relationships, it would be interesting to discuss with them how everybody has their own particularities and issues independently of having a mental health diagnosis. In this way, children would truly realize the diversity of all people and not only the ones that have a formal diagnosis.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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