



**WHERE HAVE ALL THE BOYS GONE?  
HOW THE SYSTEMATIC LABELING OF YOUNG MALES IS AFFECTING  
SCHOOL PERFORMANCE, ATTENDANCE, AND GRADUATION RATES  
IN AMERICA**

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**ABSTRACT**

*Two decades of data indicate that females outperform males in the American education system. Moreover, more recent data indicate an unprecedented shift has occurred in American higher education: women, regardless of race or socioeconomic status, are significantly more likely to enroll in college, to graduate from college, and to earn degrees—including advanced degrees. Few scholars are analyzing why this unprecedented shift has occurred. This paper will explore the various corollaries related to the deteriorating performance of males in the American education system and will challenge the existing structures that perpetuate the systematic failure of males in the academic setting. In addition, specific strategies aimed at improving the declining status of males in the education system will be discussed.*

**Keywords:** boys in school, males in education, failure of boys in school, gender differences in school performance.

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## INTRODUCTION

Data from the last two decades has indicated that a monumental shift has occurred in the American education system. Beginning at age three, females outperform males on a wide range of standardized tests. Females receive better grades throughout elementary school, middle school, high school, and college, and are significantly more likely to outperform males on SAT and ACT tests (Hoff Sommers, 2015; United States Department of Education, 2018). Interestingly, data collected over the last two decades has confirmed that males are disproportionately labeled with learning and/or psychiatric disorders as the vast majority of children and adolescents in the American public-school system who have been labeled as “learning disabled” or “behaviorally disordered” are male (Stolzer, 2008). Furthermore, males are significantly more likely than their female cohorts to retake a grade, to be suspended from school, and to drop out of school (Peter & Horn, 2006; United States Department of Education, 2018.)

For the first time in American history, females are more likely to enroll in college and to graduate with a degree, including advanced degrees such as Ph.D.’s, law degrees and medical degrees (Rosin, 2012; United States Department of Education, 2018). According to the United States Bureau of Labor Statistics (2014) by 27 years of age, 32% of women had received their bachelor’s degree, compared with 24% of men. 70% of women had either attended some college or received a bachelor’s degree compared to 61% of men, and women are more significantly more likely to finish their college degree. In addition, significantly more women have graduated with advanced degrees from American Universities.

In order fully to understand these shifting education demographics, one must closely examine the changes that have occurred in the education setting. One of the most noteworthy changes in the American education system is our collective acceptance of feministic doctrine over the past 20-30 years. One of feminism’s major postulates that has been accepted by the masses is that gender is merely a social construct that can be recalibrated at will (Hoff Sommers, 2015). Rather than recognizing and celebrating the difference in males and females, this postulate simply refuses to acknowledge that differences exist. According to orthodox feminist doctrine, human beings are born as “blank slates”, lumps of clay if you will, with no innate predisposition that can be attributed to gender (Bartkey, 1990; Stolzer, 2012). This refusal to acknowledge distinct male and female differences has resulted in the demasculinization of males

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in the American education system and has led to millions of young males being labeled as learning and/or behaviorally disordered simply because they do not follow traditional female trajectories (Stolzer, 2012).

Conventional feminist ideology is cleverly summed up in a quotation by Bartkey (1990): “human beings are born bisexual in our patriarchal society, and then, through social conditioning, are transformed into male and female gender personalities” (pg. 50). According to this widely disseminated worldview, males and females are essentially the same, yet develop differently as a result of specific socialization processes and pressure to conform to culturally dictated gender scripts. This reductionistic paradigm completely negates the decades of scientific literature that confirms that gender differences are innate, quantifiable, and can be seen across historical time (Bjorklund & Pellegrini, 2002; Buss, 2004; Gurian, 2011).

In direct opposition to feminist theory, evolutionary biology insists that males and females have followed divergent developmental trajectories since the beginning of the hominid species (Bear, Connors, & Paradiso, 1996; Buss 2004). However, over the last two decades, there has been a concerted effort in the public-school system to demand that young males follow traditional female trajectories—behaviorally, socially, cognitively, and emotionally. For those boys who cannot or will not follow these newly mandated scripts, there are often times consequences, including, but not limited to behavioral and/or learning disability labels that will remain for the young male for the rest of his life (Breeding, 2002; Stolzer, 2016).

## **CORROLARIES RELATED TO DECLINING MALE PERFORMANCE IN SCHOOL**

In order to comprehend fully why American males are lagging behind their female cohorts in higher education, one must first examine the processes that are occurring during childhood and adolescence in the American educational setting. From the founding of America until the late 1970s, psychiatric disorders in child and adolescent populations were extremely rare (Baughman, 2006). Furthermore, the term “learning disability” was unheard of in America until 1990 when the Individuals with Disabilities Education Act (IDEA) was passed by congress. As a direct result of this law, millions of American boys have been officially labeled as “learning disordered” and/or “behaviorally disordered” (Stolzer, 2012). In addition, public school personnel now have an economic incentive to label as many children as possible with behavioral and/or learning disorders as the more children are labeled, the more money the individual school

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receives (Baughman, 2006; Stolzer, 2012) Of course, since the inception of compulsory schooling in America, there have been children who struggled academically in school. However, children did not perceive themselves as “learning disabled” because that label did not exist—nor did individual schools have an economic incentive to label children.

In addition to millions of American boys being labeled as “learning disordered”, an unprecedented number of boys have been diagnosed with a plethora of psychiatric disorders. ADHD, Conduct Disorder, Autism Spectrum Disorder, and Oppositional Defiance Disorder are commonly diagnosed in young males across America (Breggin, 2014). ADHD is by far the most commonly diagnosed psychiatric illness in young males in America as published data has indicated that approximately 10-11 million American boys have been diagnosed with this disorder (Baughman, 2006; Breggin, 2014). Interestingly, data indicates that the vast majority of referrals for psychiatric diagnoses in young males come directly from the United States Public School System (Baughman, 2006). Currently, teachers and other school personnel routinely refer “problem” children for psychiatric evaluation, as children who do not sit still, are rambunctious, do not pay attention, are messy, are defiant, and/or do not follow directions are oftentimes assumed to have a psychiatric disorder (Phillips, 2006; Stolzer, 2016).

It is important to note that that teachers are not now, nor have they ever been, trained as psychiatrists, psychologists, or neurologists, yet they are the very people who are responsible for the majority of psychiatric referrals in child and adolescent populations (Baughman, 2006; Stolzer, 2010). According to the United States Department of Education (2018), 80-85% of students who have been diagnosed as “learning disabled” are male and 80-90% of students who have been diagnosed with a psychiatric disorder (i.e., ADHD, Oppositional Defiance Disorder, Conduct Disorder, etc.) are male.

From the very beginning of the American education system, the school’s role has been to teach children reading, writing, and arithmetic. However, over the last 20-25 years, schools have taken on the unprecedented role of brokers for the pharmaceutical industry by referring millions of children (and the majority of these children are male) for psychiatric evaluation (Baughman, 2006; Stolzer, 2010). The federal government has joined this effort by increasing mental health funding to schools, including providing 130 million dollars to train teachers to recognize subjective and unsubstantiated signs of mental illness in children and adolescents attending

public schools in America (Citizen's Commission on Human Rights-CCHR, 2015). Meanwhile, sales of psychiatric drugs have skyrocketed across America, with profits reaching 40 billion dollars a year (CCHR, 2015). Data indicates that young males are disproportionately diagnosed with mental illness, and the standard method of treating those diagnosed with a mental illness in daily doses of dangerous and addictive psychiatric drugs (Baughman, 2006; Stolzer, 2008).

Across cultures and across historical time, childhood and adolescence were collectively understood to be quantitatively different than other life stages and it was universally understood that childhood and adolescence were fraught with behaviors that would be defined as maladaptive in adult populations (Stolzer, 2012). Children by their very nature are distinct from adults. They run, jump, and climb. They have short attention spans, they often overreact, and they are messy and inattentive. They are moody and disorganized, and they exasperate adults with their energy, defiance, lack of focus, and exuberance. Throughout human existence, these and other child and adolescent behaviors were defined as normative life stages that would pass with time and maturity. However, over the last two decades, these, and other normative child behaviors have been operationally defined as valid indicators of a psychiatric illness (Breggin, 2001; Stolzer, 2012).

## **EFFECTS OF PSYCHOSTIMULANT DRUGS**

While the United States has witnessed a meteoric rise in psychiatric drug prescriptions in child and adolescent populations, very little attention is paid to the effects of these drugs (Baughman, 2006). According to the published literature, children and adolescents prescribed Methylphenidate (the most commonly used prescribed drug to treat symptoms of ADHD) have higher rates of depression, are more socially isolated, have lower self-esteem, and have a more negative self-perception than those not taking daily doses of Methylphenidate. Furthermore, data indicates that children prescribed Methylphenidate do not do as well academically as their non-drugged peers. Children prescribed Methylphenidate are found to perform at a below-age level by a factor of 10.5 times when compared to same age peers who were not prescribed drugs. Data also indicates that children and adolescents do not demonstrate a significant improvement in attention or externalizing behaviors when taking drugs to control ADHD symptoms (Government of Western Australia, 2009).

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Although ADHD is the most commonly diagnosed mental illness in young males in America, no empirical evidence exists to substantiate that this condition has a biological or neurological cause (Breggin, 2014; Whitley, 2010). Certainly, running, jumping, climbing, fidgeting, inattention, messy work, and failure to pay attention exist in child populations—particularly in young males – of this there can be no doubt. However, to define these behaviors as pathological is a relatively recent phenomenon. (Jensen et al., 1997; Breggin, 2014). Breggin (2014) asserts that symptoms of ADHD are oftentimes triggered by boring classrooms, poorly disciplined classrooms, lack of grade level educational skills, problems at home, poverty, insomnia, and/or chronic illness.

Psycho-stimulant drugs are most often prescribed for young males diagnosed with ADHD and include amphetamines (Adderall or Dexedrine), or Methylphenidate (Ritalin or Concerta). These classifications of drugs are highly addictive and are required to carry a “black box” warning label as scientific evidence has demonstrated that these drugs produce serious and potentially life threatening effects (Breggin, 2014). Some of the effects of Amphetamine and Methylphenidate include insomnia, seizures, nervousness, agitation, confusion, visual disturbances, disorientation, aggression, personality changes, apathy, social isolation, depression and suicidal thoughts and actions (Novartis, 2015; Stolzer, 2013).

Amphetamines and Methylphenidate also cause a wide range of psychotic behavior, including mania, paranoia, and violent feelings toward others. In addition, these drugs have been found to induce a lack of empathy towards others, lack of impulse control, heightened reactions to stress, acute anxiety and abnormal thoughts, feelings, and behaviors (Physicians’ Desk Reference Manual (PDR), 2009; Stolzer, 2016). Published Scientific data documents that methylphenidate and amphetamines significantly suppress growth in human populations – including brain growth. These drugs also alter specific hormone production which has been shown to be particularly dangerous in young males due to the increased testosterone and androgen production associated with puberty (Breggin & Cohen, 1999; Stolzer, 2013). Numerous studies have confirmed that stimulants such as amphetamines and methylphenidate cause TICS (i.e., uncontrollable muscle movements), obsessive-compulsive behaviors, compulsive meaningless behaviors, apathy, indifference, a reduction in spontaneous behaviors, and a decrease in creativity and self-motivation (Arakawa, 1994; Breggin, 2014). In addition, these

drugs have been found to produce “persistent biochemical abnormalities in the brain” (Breggin, 2014, pg. 232). Other researchers have documented widespread brain damage in adults who had been diagnosed with ADHD and treated with amphetamines and/or methylphenidate during childhood (Proal et al., 2011). According to the published literature, the long term effects of ADHD drugs are unknown in child and adolescent population and the safety of long-term use (i.e., longer than 2 weeks) is unknown at this time. In addition, the mode of therapeutic action is also unknown (Breggin, 2014; Novatis, 2015). Numerous studies conducted over the last 30 years have found that not only are these drugs dangerous and addictive, they are also ineffective (Baughman, 2006; Breggin, 2014, Government of Western Australia, 2009).

### **NEGATIVE SOCIO-EMOTIONAL EFFECTS OF LABELS**

A review of the literature indicated when children are told by adults that they are “learning disordered” or suffer from a “psychiatric illness”, the children begin to believe they are abnormal and that they have little control over their feelings and/or behaviors (Breggin, 2014). Labels can cause a myriad of alterations in self-perception, decrease personal responsibility, and negatively affect the internalized self-efficiency of the child (Bandura, 1997). Bandura (1982) hypothesized that children and adolescents who view the self as highly efficacious think, feel, and act differently than those with low self-efficacy. Self-efficacy is critically important as it is the engine that drives motivation, belief in self, task completion, well-being, and personal accomplishment (Bandura, 1986). Breggin postulated that once the label is affixed, the child no longer views themselves as responsible for their actions, or as capable of controlling outcomes in the social, emotional, or academic setting (2014). Bandura (1997) was adamant that self-efficacy is directly tied to a person’s belief in the self to overcome obstacles and to face challenges with optimism: “A person’s level of motivation, affective states, and actions are based more on what a person *believes* than on what is objectively true” (p. 2). Bandura’s (1997) assertion clearly implies that belief in the self is critical in the pursuit of goals and aspirations and that to create fissures in belief in the self can disrupt not only the initial pursuit of a given goal, but can also negatively affect later outcomes.

Bandura stated unequivocally that schools have the power to alter student performance and to influence self-esteem. Teacher’s beliefs about a particular student impact student motivation, beliefs regarding competency, and academic success (1993). Children by their very

nature are especially vulnerable to suggestion from adults. Beliefs about what grade they can achieve, what goals they should attempt, and cognitive capabilities are often times influenced by parents, teachers, and other significant adults (Bandura, 1997). Numerous studies have indicated that children are heavily influenced by adult perceptions (Bandura, 1997). Carrying a “mental illness” label or a “learning disability” label can affect not only the child’s belief about ability, but can also impact motivation and determination (Bandura, 1997; Breggin, 2014). “Perceived self-efficacy influences the level of goal challenge people set for themselves, the amount of effort they mobilize, and their persistence in the face of difficulties” (Zimmerman, Bandura, & Martinez-Pons, 1992, p. 665).

According to Bandura, self-efficacy beliefs are the nucleus of human aspirations and performance (1997). It is not enough for individuals to acquire knowledge or skills; they must first and foremost believe that they can achieve what they set their mind to and that they have the ability to reach their goals (Artino, 2012). The meteoric rise of psychiatric illness and learning disabilities in young males over the last 20-25 years has clearly impacted not only school performance, attendance, and graduation rates, but has also impacted young male’s motivation, effort, perseverance, and belief in the self (Breggin, 2014; Hoff Sommers, 2015).

Self-efficacy theory assumes that individuals acquire information regarding the self from four primary sources: 1. Actual performance 2. Observations made by others 3. Verbal and non-verbal persuasion and 4. Personal physiological and affective states (Bandura, 1997). With regard to actual performance, data indicates that young males are significantly outperformed by their female cohorts on a variety of measures including, but not limited to grades, advanced placement tests, SAT and ACT scores, and college enrollment, attendance, and graduation rates (United States Department of Education, 2018). Self-efficacy is also negatively impacted by official and non-official perceptions of significant others (i.e., school personal and parents) who both affirm and support the labeling of young males in the American education system. These labels affect the child on both the micro and macro levels, including the child’s perception of the self, self-determination, aspiration, and locus of control (Bandura, 1997; Breggin, 2014). Verbally, and non-verbally, throughout childhood and adolescence, many young males are reminded throughout the day that they are “disordered” and therefore are incapable of forming a secure and stable self-efficacious mind set.



Lastly, according to Bandura (1997), the child's personal physiological and affective states are mechanisms that influence self-efficacy. Numerous researchers have reported that psychiatric drugs produce chronic biochemical abnormalities in the brain, including growth suppression and brain atrophy (Breggin, 2014; Stolzer 2016). Certainly, psychiatric drugs directly influence physiological and affective states as the literature documents these drugs cause a wide range of serious effects including apathy, disorganization, indifference, decreases in creativity and spontaneous behaviors, irritability, nervousness, confusion, aggression, disorientation, personality changes, social isolation, depression, abnormal thoughts, lack of empathy, violent feelings towards others, lack of impulse control, and suicidal ideation (Breggin, 2014; Novartis, 2015; Stolzer, 2013).

Self-efficacy, at its core, influences every sphere of human consciousness, and determines what a human being believes they can achieve (Bandura, 1982). During childhood and adolescence, research indicates that the school functions as one of the primary shapers of an individual child's internalized self-concept (Bandura, 1997). Labeling children with learning and/or psychiatric disorders profoundly effects child outcomes and clearly impedes the development of self-efficacy (Bandura, 1993). The child that believes he is "learning disabled" thinks and behaves differently than the child who believes he is academically capable. He is likely to rationalize that academics are not important, thus he avoids academic pursuit, and disengages from other children who value academics (Bandura, 1997).

The child who believes that they suffer from a psychiatric illness and require daily doses of psychiatric drugs are led to believe by the adults in their lives that they cannot control their thoughts, feelings, or actions, and that they cannot function as a normal human being without psychiatric drugs. Psychiatric diagnoses in child and adolescent populations discourage personal responsibility, decreases motivation, and chemically alter the functioning of the human brain (Breggin, 2014). In spite of the millions of boys who have been diagnosed with a mental illness, there are no long-term studies which indicate the psychiatric drugs increase academic goals and aspirations (Breggin, 2014; Whitley, 2010). While the labeling of boys with psychiatric and/or learning disorders continues to dramatically increase across America, the number of young males enrolling in college and earning degrees continues to decrease. Clearly, the systematic labeling of young males is related to the declining rates of males in higher education. Once the label is affixed,

significant adults in the child's life begin to view the child as "disordered", and the child then internalizes this "disordered" label. As the child grows, the perception of the self as "disordered" intensifies, and academic aspirations are significantly decreased (Artino, 2012; Bandura, 1997).

## **GENDER DIFFERENCES**

Although the data have been available for decades, very few scholars are asking *why* are the vast majority of American children and adolescents who have been labeled as "learning disabled" or as "psychiatrically disordered" male? Since the overwhelming majority of referrals for these types of diagnoses come directly from the United States public school system, it is a distinct possibility that teachers (and other school personnel) are not being educated properly in the area of gender differences (Baughman, 2006; Stolzer, 2012). Decades of scientific data reveals that males and females follow divergent neurological, hormonal, behavioral, and cognitive trajectories (Buss, 2004). However, this confirmed scientific data is often times ignored in teacher colleges across America and has been systematically replaced by more politically correct feminist doctrine (Stolzer, 2012). According to this widely accepted doctrine, the girl way of learning, behaving, and responding has become the "gold standard" in the classroom and boys that do not follow this "gold standard" are often times perceived by teachers to be either learning and/or psychiatrically disordered (Stolzer, 2010; Tyre, 2008).

Since the 1970's, feministic theory has infiltrated the halls of higher education. The prevailing ideology taught in the colleges of education across the United States insist that gender is merely a social construct that can be shaped and molded at will (Hoff Sommers, 2015; Stolzer, 2012). This reductionistic world view, although politically correct, refuses to acknowledge the decades of the empirical, quantifiable data which demonstrates unequivocally that males and females are different hormonally, neurologically, and emotionally (Stolzer, 2012; White, 2005). There is also substantial scientific evidence indicating that males and females learn, process, encode, and synthesize in distinct ways (Gurian, 2011). While feminist theory continues to dominate in teacher's colleges across America, the fields of neurobiology, evolutionary psychology, neuroscience, and evolutionary biology are conveniently ignored (Stolzer, 2012). According to Moir & Jessel (1990), continuing to insist that males and females are the same in aptitude, predilection,

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disposition, aptitude, behavior, and/or learning styles is nothing more than a blatant scientific fallacy.

There are distinct and quantifiable differences that can be detected in males and females across cultures and across the lifespan. Beginning with fetal development, males are significantly more active in utero and remain so throughout childhood and adolescence. In addition, during early childhood, males speak later and use less complex sentence structures than their female cohorts (Fogel, 2010). During infancy, males prefer mechanical or structural toys, while females prefer soft cuddly toys. Infant males are more active; more easily angered, less bothered by loud noise, and are less able to recognize emotional nuances in others (Gurian, 2011). From Kindergarten through grade three, males are more aggressive, dominant, competitive, and territorial. Rough and tumble play is the norm here, and involves high levels of bodily contact and various other forms of rigorous play activity. Boys in this age group typically use dolls as weapons and are more likely to prefer male play partners. Furthermore, boys in this age range are significantly more likely than their female cohorts to be diagnosed as speech delayed, learning disordered, and behaviorally disordered (Gurian, 2011; United States Department of Education, 2018). Young males are more likely to express emotions through actions and are less sensitive to social and personal context. They also have significantly lower levels of attention span and empathy when compared to female children. In addition, males take longer to attain reading mastery, but are better than females at pre-mathematical concepts and general math (Gurian, 2011).

During middle childhood, males exhibit more hormonal fluctuations than females and are highly aggressive. They are better at directionality (i.e., map reading, and deciphering directions). By middle school, there is a 20-fold increase in testosterone which has been associated with aggression, territorialness, combativeness, and competition. Throughout childhood and adolescence, males are more likely to be in special education classes, to be labeled with a learning and/or a psychiatric disorder, and to retake a grade (Gurian, 2011; Stolzer, 2012). By high school, pursuit of power becomes a universal male trait. Males are significantly more likely than females to report that aggression solves problems and they are significantly more likely to commit suicide. They graduate from high school at lower rates than females, have lower academic aspirations, lower GPAs and are more likely to drop out of school (Gurian, 2011).

Neurologically, major differences exist with regard to male and female development. While it is certain that outliers exist, the fact remains that the brains of males and females are quantifiably distinct (Bear, Connors & Pardiso, 1996; Donaldson & Young, 2008). Neurological data indicates that the amygdala, which is part of the limbic system controlling emotional processing (especially anger and aggression), is significantly larger in males. The arcuate fasciculus which controls activity levels is larger and engaged more rapidly in males and the prefrontal lobes, which have been shown to impact impulsivity control, are not fully developed in males until 21-24 years of age (Donaldson & Young, 2008; Stolzer, 2012). In addition, the “Fight or Flight” system is more rapidly engaged in males, which accounts for males responding more often with aggression when they feel threatened or under stress (Gurian, 2011; Bear, et al, 1996).

Scientifically speaking, both males and females produce all of the known human hormones, yet the levels of hormones produced vary dramatically depending on gender (Buss, 2004; Gurian, 2011). The female’s dominant hormone is estrogen and the male’s is testosterone. “These distinct hormones affect all of the neurological systems, and in doing so, create the vast gender differences that have been documented across cultures and across mammalian species (Stolzer, 2012, p. 86). According to decades of scientific data, testosterone significantly increases aggression, territorialness, competitiveness, dominance posturing, defiance, self-reliance, sex drive and self-assertion (Buss, 2004; Jensen, et al, 1997). Testosterone has also been found to increase risk taking behaviors, activity levels, and physical reflexes (Arnold, 2009). Furthermore, according to Auyeung & Baron-Cohen, testosterone levels have also been found to influence the rough and tumble play that is seen universally in young males (2009).

The fact of the matter is that males and females are distinctly different - hormonally, socially, neurologically, emotionally, and cognitively. Mounting scientific evidence dispels the politically correct ideology permeating American schools which states that gender is socially constructed. Evolutionary neurologists have demonstrated time and time again that regardless of socialization processes, brains differ by gender due to distinct primordial processes, including evolutionary adaptations (Bjorklund & Pellegrini, 2002; Buss, 2004; Jensen, et al., 1997). Interestingly, the United States Department of Education continues to claim they are promoting “gender education” while at the same time, systematically ignoring the

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decades of scientific data which demonstrates empirical and quantifiable neurologically based gender differences (Hoff Sommers, 2015).

## **FUTURE DIRECTIONS**

What is glaringly clear at this time is the need to address the boy crisis in the American education system. Boys account for 80-90% of special education students, are on average a year and a half behind their female cohorts in reading and writing, and have significantly lower academic aspirations than females. Females receive better grades from Kindergarten through College and are more likely to be placed in advanced classes regardless of socioeconomic status (Hoff Sommers, 2015). In addition, males' enrollment and graduation rates at American Universities continues to plummet, and the Department of Education predicts that this trend will continue unabated in the future if nothing is done to correct this unprecedented disparity. (Hoff Sommers, 2015; United States Department of Education, 2018).

The time has come to address the boy crisis in America collectively and systematically. Scholars from various fields have suggested the following solutions:

- Insist that teacher education programs require thorough and scientifically validated instruction on brain research, neuropsychology, and evolutionary theory, in addition to the feministic theories that dominate current-day teacher colleges (Stolzer, 2008).
- Require continuing education credits to ensure that all school employees understand and respect typical boy-typed behavioral and learning predilections (Stolzer, 2012).
- Demand that diversity training in the American education system includes empirically based gender differences (Baughman, 2006).
- Provide boys with tension relieving strategies in schools (Gurian, 2011).
- Recruit more male teachers- Kindergarten through 12th grade (Gurian, 2011; Tyre, 2008).
- Implement and encourage healthy competition in schools (Hoff Sommers, 2015).
- Allow reading materials that include high action, male dominated, adventure based stories (Hoff Sommers, 2015).
- Offer gender segregated classrooms (Gurian, 2011).
- Demand that regardless of inclement weather, children have access to unstructured outdoor activity throughout the school day (Hoff Sommers, 2015).

- Significantly reduce sedentary learning activities; increase high activity, large motor learning opportunities (Stolzer, 2008).
- Increase the number of recesses per day (Gurian, 2011).
- Require daily physical education classes (Stolzer, 2008).
- Abolish policies that ban rough and tumble play (Bjorklund & Pellegrini, 2002).
- Ban federal policies that provide additional monies to schools based on the number of learning and/or psychiatrically disordered children enrolled (Stolzer, 2008).
- Call for widespread public service announcements and initiatives that raise public awareness about the academic, emotional, social, and physical needs of American boys (Hoff Sommers, 2015).
- Refuse to allow boys to be labeled as “learning disordered” or “psychiatrically disordered”; instead, demand educational policies that meet the complex cognitive, social, emotional, and physical needs of boys (Stolzer, 2008).
- Work towards fixing the education system so that it meets the multifarious needs of boys instead of concentrating on how to “fix” boys so that they conform to the present day education system (Tyre, 2008).
- Identify teachers that understand and respect the unique social, cognitive, physical, and psychological needs of boys; base classroom assignments on goodness of fit rather than random selection (Tyre, 2008).
- Expect and encourages high activity levels in the classroom (Gurian, 2011).
- Discontinue boring and tedious seatwork in the educational setting (Bjorklund & Pellegrini, 2002).
- Include as part of public school curriculum gender tailored learning strategies that are based on the most current neurobiological data (Gurian, 2011; Tyre, 2008).
- Challenge the “disordered American boy” hypothesis and instead concentrate efforts on overhauling the disordered public school environment (i.e., extended seat work, lack of physical activity, financial incentive to label children, lack of physical education and recess, and lack of teacher education in the area of biologically based gender differences) (Stolzer, 2008).

## CONCLUSION

There is clear and incontrovertible evidence which demonstrates that boys in the American education system are immersed in an unprecedented crisis. Females are significantly out performing males at every level of the American education system, and if current projections are correct, this trend will continue to worsen over the coming decades (Hoff Sommers, 2015; United States Department of Education, 2018). Socially and emotionally, males are faring much worse than their female cohorts in the American education system. The labeling of young males with learning and/or psychiatric disorders has reached epidemic proportions with data indicating that one in five American children and adolescents have been labeled as “learning disordered” or “psychiatrically disordered” and the majority of this “disordered” children are male (Breggin, 2014; Stolzer, 2012). With regard to academic performance, females outperform males at every level of the education system—from kindergarten through graduate school (Rosin, 2012).

The unprecedented failure of boys in the American education system over the last twenty years should come as no surprise, as education scholars have been warning the public of the deleterious effects associated with the de-masculinization of males in the education system since the early 1900’s. Froebel’s (1904) ground breaking work insisted that forcing a child to conform to artificial environments that were at odds with his bioevolutionary heritage would cause severe developmental disruptions and impede academic performance. Furthermore, Froebel castigated his contemporaries for perceiving children as mere lumps of clay that could be molded at will. Froebel insisted that for education institutions to be successful, the institution must enact policies that respect innate gender differences. These policies, according to Froebel, must be characterized by unobtrusive, attentive, protective educators who understand childhood and its unmitigated complexities. Policies that are, at their core, dictating, circumscribing, and interposing are inclined to fail. Writing over one hundred years ago, Froebel predicted that the American education system would fail miserably if it continued to interfere with bioevolutionary based behavior patterns. Froebel also insisted that educational institutions that are apathetic to our evolutionary heritage and the laws of nature are bound to produce individuals who are cognitively and psychologically impaired (1904).

If we are sincere in our efforts to address the current boy crisis in the American education system, a call to action is required. Enough of labeling boys as “learning disabled” and crushing self-efficacy before it has a chance to blossom. Policies must be enacted that respect and celebrate the young male’s unique and complex learning trajectories. He is not “disabled”: he is a boy that thinks, learns, responds and acts differently than his female cohorts. The time has come to demand that schools are restructured to meet the needs of boys instead of continuing to try to restructure the boy to fit in with politically correct curriculum. Enough of labeling boys with psychiatric illnesses that just a generation ago were unheard of. Fidgeting, running, jumping, climbing, not paying attention and messy work as valid indicators of a psychiatric illness? This is absurd. This is not mental illness – this is boyhood. Enough of drugging millions of American boys with dangerous and addictive psychiatric drugs so that they can conform to the endless hours of monotonous and boring seatwork that permeates the education system in America.

Boyhood has not changed at all over the course of evolutionary time (Buss, 2004). It is the bio-evolutionary heritage of the young male to be extremely active, inattentive to that which does not interest him, defiant, messy, aggressive and attuned to the physicality of the natural world (Bjorklund & Pellegrini, 2002; Stolzer, 2010). Young males across all cultures and across all mammalian species are highly active, nonconforming, spontaneous, restless, impetuous, inquisitive, constantly on the go, and are continually engaging in activities that befuddle adults (Stolzer, 2010). What has been unequivocally altered is our perception of boyhood and what constitutes normal-range boy behavior, and nowhere is this more apparent than in the American education system (Stolzer, 2010). American boys are systematically and routinely referred for psychiatric evaluation at the request of public school personnel. As a direct result of these referrals, millions of American boys have been diagnosed with a plethora of psychiatric illnesses and are required to take daily doses of dangerous and addictive psychiatric drugs. For the first time in recorded history, we, as a nation, have collectively agreed that ancient, bio-evolutionary-based boy behavior patterns are valid and reliable indicators of a psychiatric illness. If we are to reverse the boy crisis in the American education system, the neo-psychiatric model that is rampant in schools across America must be dismantled and replaced by a paradigm based on bioevolutionary science.



Our collective and unadulterated acceptance of the medicalization of boyhood has blinded us to the fact that we as adults are responsible for the failure of boys in the American education system (Stolzer, 2010). We enact and maintain policies that strip young males of their bioevolutionary heritage and self-efficacy. We insist that the maleness itself is pathological and that the cure to maleness can be found in official labels and psychiatric drugs. Even the prestigious American Psychological Association (2018) is on record stating that masculinity is harmful. The time has come for compendious change at both the micro and macro levels of the American education system. We must begin to demand change that includes the implementation of policies that focus on the cognitive, physical, social, emotional, and academic needs of our boys. Let us begin today. Our boys are counting on us.

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