

## **Too Young to Be Mad: Disabling Encounters with ‘Normal’ from the Perspectives of Psychiatrized Youth**

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### **Abstract**

In this paper, the psychiatrization of children and youth is explored, as well as their representation within Mad and Disability Studies. Presented are the outcomes of a photo voice project conducted with seven ( $N=7$ ) youths between 14 and 17 years old constructed as having a “serious mental health issue.” The self-identified research question the young people asked and answered was: *What is ‘normal mental health’ for children and youth?* Through the photographs and explanations of the images, we learn that ‘normal’ is a matter of perspective, an ambiguous and shifting standard against which young people are compared, and from which constructions of ‘mental disorder’ as difference and abnormal are imposed on their experiences of distress. As a mechanism for psychiatrization, the difference becomes the rationale for prejudice and discrimination at the intersections of childhood and adulthood, distress and sanism, and (in)competence and ableism. The implications of expanding children’s theorizing and activism for Mad and Disability studies are discussed.

*Keywords:* children, Disability Studies, Mad Studies, psychiatrization, youth

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Mad and Disability Studies challenge oppressive social structures and processes by advocating for the meaningful inclusion in research—as a structure and process for creating knowledge—of the very people whose lives are at the centre of their studies (Curran, 2013; Goodley, 2011; LeFrançois, Menzies, & Reaume, 2013). In agreement, I choose to start this particular piece of theorizing with the experiences of the people who have been at the centre of my work on the stigma of ‘mental illness’ in child and youth mental health. For an eight-month period using a participatory action research (PAR) approach, I worked collaboratively to study self and family stigma with a group of seven youths diagnosed to have a “serious mental health issue.” As collaborators, the youths had knowledge situated in their day-to-day realities of what it meant to be “young,” “diagnosed with a mental health issue,” and “active mental health service users.” I locate myself as a person who does not identify as either Mad or Disabled; however, I do consider myself a person with lived experiences of psychiatrization as a child and adult witness to my mother’s encounters with psychiatry and as a mental health therapist, that is, a person who was professionally engaged in the psychiatrization of young people and their families.

I open with an excerpt from an interview conducted with one of the youth collaborators, Brandon,<sup>1</sup> 15 years old:

In today's society, there are boxes like "rich people," "poor people," people that are "middle class," "junkies," "sports players"... They try and force you in a box ... For mental health, they try to put you in a box like "psycho," or "freak," or "throw away"... they see "schizophrenia," or "depression," or "anxiety," or "autism"... and so if people are to see "that," they see "it" and they stop looking at "you"... The label is with them ... they don't actually look at you as the person you are ... they don't look at you as unique. They don't listen to your opinion. They don't actually look at you as a person.

In this narrative, Brandon describes what happens when a young person comes into contact with mental health classification and diagnostic systems, and specifically with the category of 'mental disorder'. For Brandon, the person is not heard or seen and their opinions are discounted. The person is placed in a box, their personhood replaced by a label, and they are no longer related to as a person. In the case of psychiatrization, the category is negative and associated with being a "psycho," "freak," or "throw away." Essentially, Brandon describes the unmaking of a person and the making of a disorder, poignantly drawing our attention to psychiatrization.

*Psychiatrization* refers to the processes and mechanisms through which certain persons, adult or child, come into psychiatry as a political realm (Kecmanovic, 1983; Malacrida, 2009; Mills, 2014a). Persons come into psychiatry when their body, their psychology, and/or particular expressions of emotional and psychological distress are constructed as 'mental illness' or 'disorder.' The primary effect of psychiatrization is the construction of the young person as 'abnormal' (Bell, 1993). As active users of mental health services involved with multiple mental health professionals (i.e., psychiatrists, psychologists, and social workers), all the youths with whom I worked were told they had a "serious mental health issue," but none were told what was 'normal mental health.' Yet, according to their experiences 'normal' was an ideal that dominated their lives, having profound effects on their relationships with family and peers, on their sense of selves, and on their treatment within systems, i.e., school, child welfare, or police. Constructed as abnormal, young people deemed mentally ill encounter various forms of personal and institutional prejudice and discrimination (Corrigan, Kerr, & Knudsen, 2005; Hanrahan, 2008; Hinshaw, 2005; Liegghio, 2013).

In this paper, I explore the psychiatrization of children and youth—the unmaking of a person and the making of a disorder—by presenting the outcomes of a photo voice project in which the youths scrutinized the 'normal/abnormal binary' by answering as a research question: *What is 'normal mental health' for children and youth?* Within both Mad and Disability Studies, the normal/abnormal binary as an oppositional framework of categorization is revealed as a regulatory structure in support of particular relations of power—specifically, in support of sanist and ableist

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<sup>1</sup> To protect confidentiality, all the names used are pseudonyms

normativity (Baker, 2002; Goodley & Runswick-Cole, 2010; LeFrançois, 2013b; LeFrançois & Coppock, 2014; Perlin, 2000; Perlin, 2003; Poole et al., 2012). By prioritizing *What is 'normal mental health'?* as their self-identified question, Brandon and his peers signalled the importance of the binary to their lives. However, beyond the interrogation of the binary, I explore what Mad and Disability studies have to offer young people, like Brandon, who on a day-to-day basis experience marginalization related to their subordinate social statuses both as children/youth and as having a mental health issue (Brannen & O'Brien, 1995; Dalrymple, 2005; Kellet, Forrest, Dent, & Ward, 2004; LeFrançois, 2008; Petr, 1992). Turning to the Mad and Disability literatures, I begin by exploring the ways psychiatrized children and youth are represented.

### **Literature Review: Madness, Disability, and Childhood**

#### **Too Young to Be Mad and Not Necessarily Disabled**

Overall within both Mad and Disability Studies, the scholarship about the psychiatrization of children and youth is emerging. In some instances, the experiences of psychiatrized young people are represented in the accounts of adults (practitioners or researchers) about young people's treatment within different mental health settings (Chapman, 2014; Mills, 2014b; Voronka, 2013) or represented tangentially across different areas, such as childhood studies in the sociology of childhood and children's rights (Brady, 2014; Curran, 2013; LeFrançois & Coppock, 2014; Liegghio, Nelson, & Evans, 2010) or in critical psychiatry and critical mental health (Spandler, 2001). Examples of such research include exploring children's experiences of ADHD and medication (Brady, 2014) and exploring young people's experiences of self-harm (Spandler, 2001). In other instances, childhood is discussed retrospectively as psychiatrized and/or disabled adults look back on their lives as psychiatrized and/or disabled children (Haraldsdottir, 2013; Malacrida, 2009; Skitteral, 2013).

In the case of Mad scholarship, young people's exclusion has been attributed to the adultism that permeates broadly throughout mental health discourses and practices (LeFrançois et al., 2013). According to LeFrançois (2013a), "adultism refers to the oppression experienced by children and young people at the hands of adults and adult-produced/adult-tailored systems" (p. 47). It is the tendency to view, construct, and treat young people—their lives, mental health, distress, and well-being—through the worldviews, perspectives, values, and beliefs of adults and not necessarily those of young people (LeFrançois, 2013a; LeFrançois & Coppock, 2014; Petr, 1992). In adultist practice, children and youth and their lives become objects acted upon by adults (Petr, 1992), instead of agents and subjects uniquely positioned in childhood to inform and act in their own right as social actors (LeFrançois, 2008). The effects of this are an unequal power balance and the discrimination occurring at both the individual and systemic levels (LeFrançois, 2013a). While attention has been paid to young people's experiences in areas such as the sociology of childhood, within Mad Studies "childhood" as an organizing category of their encounters remains under-represented. Instead, children and youth

appear to be treated as though they are too young to be Mad; and Mad activism has yet to fully engage more wholesomely with their experiences. This is beginning to change with calls from within Mad Studies for young people's organizing and activism (LeFrançois, 2010; LeFrançois & Diamond, 2014).

On the other hand, within Disability Studies, through the emerging sub-field of Childhood Disability Studies, disabled children are understood to be uniquely positioned from disabled adults to inform about their experiences of disability. Adulthood is challenged through research that actively theorizes from the perspectives of disabled children (Curran, 2013; Goodley & Runswick-Cole, 2010; Watson, 2012). Disability as a category appears to be associated primarily with physical and learning impairments rather than psychological and/or emotional impairments (Goodley, 2001, 2011). So while too young to be Mad, in Disability Studies psychiatrized children and youth are not necessarily considered disabled—and thus again excluded from the gains made through Disability activism. In many ways, for childhood a similar relationship is reproduced that has existed at the adult level between the psychiatric survivor and disability movements (Beresford, 2000; Withers, 2012).

Historically, the relationship between the two movements has been tenuous, with claims and counterclaims that each is not responsive to the activism or issues of the other (Beresford, 2000; Goodley, 2011). There are several points of contention related to the ways disability, as impairment and disablement, is understood. Within Disability Studies, from a medical/individual model of disability, *impairment* is understood as a biological or physiological condition locating difficulties within the person's physiology (Goodley, 2011). Alternatively, social models of disability assert that impairment is the result of exclusionary structures and processes imposed on an individual by a disabling society (Chappell, Goodley, & Lawthom, 2001; Goodley, 2001; Hughes & Paterson, 1997; Williams & Heslop, 2005). *Disablement* is understood as the interpretations made about disability that shift over time as the cultural values and beliefs of a society change (Goodley, 2011). Despite the influence of social models for understanding the ways personal difficulties are connected to the barriers imposed by a disabling society, mental health issues are still understood primarily through a medical, specifically psychiatric model of impairment and disablement (Williams & Heslop, 2005). Thus, for some psychiatrized and Mad-identified adults the association that any impairment they experience is a biological condition is considered problematic. Underlying assumptions reducing psychological, emotional, or psychiatric impairments to "biology" or a "biologically rooted condition" negate the body as a site where certain interpretations are produced and reinforced. Biological explanations of mental distress negate that the characteristics attached to certain bodies are also socially and culturally determined (Areheart, 2012; Williams & Heslop, 2005). In other words, the interpretations, meanings, and characteristics attached to young, Mad physiologies are also socially constructed and change over time as cultural values about, for example, appropriate conduct change within societies (Coppock, 2005; Freud, 1999).

In addition, dominant constructions of disability are criticized for replicating sanist understandings of mental illness and disorder as a physiological, medical

condition—as a tragedy, defect, or deficiency rooted in the individual (Areheart, 2012; Beresford, 2000; Beresford, Harrison, & Wilson, 2002; Cooper, 2013). Finally, the social meanings attached to Mad bodies have different implications, for example, in the ways psychiatric distress is used to justify certain interventions that restrict rather than expand freedoms and equality (Areheart, 2012; Beresford et al., 2002). So while persons with physical impairments fought for the expansion of their equality rights, impairment was used with Mad persons to restrict their freedoms and force certain interventions, such as forced hospitalizations in cases of perceived harm to self or others (Beresford et al., 2002). Despite this tension, from their different positions an important contribution Mad and Disability Studies have to offer psychiatrized youth, like Brandon and his peers, is the challenge to the normal/abnormal binary as central to their psychiatrization.

### **Challenging the Normal/Abnormal Binary**

Under critical and social models of Madness and Disability, ‘mental health/mental illness’ and ‘able body/disabled body’ are understood to be binary frameworks of categorization that emerge from various social processes and mechanisms operating in support of sanist and ableist normativity (Baker, 2002; Goodley & Runswick-Cole, 2010; LeFrançois & Coppock, 2014). For example, as a regulatory structure, the ‘mental health/mental illness’ binary operates in two main ways. First, the binary regulates “who” a person can be based on the classification of their psychology and/or expressions of emotional and mental distress. Under the binary only two classes or types of persons are possible: “those with mental health” and “those with mental illness.” Each class of person is defined according to the signifiers that delineate the categories. Mental health is delineated as “normative and valued,” and mental illness is “counter-normative and devalued.” The effect is that alternative interpretations or constructions of the person—their psychology and/or distress—falling outside of the two categories become inconceivable (LeFrançois & Diamond, 2014; Liegghio, 2013). Consequently, to have a mental illness is to always be conceived as counter-normative and devalued (Daley, 2010). Similarly, within disability studies the “able body” is held as normative and valued, against which all other bodies are held as counter-normative and devalued.

While the normal/abnormal binary is the organizing mechanism for psychiatrization, “diagnosis” is the social process central to deciding and marking who is disabled and who has a mental illness. Professional texts, such as the *Diagnostic Statistical Manual (DSM)* and professional practices based on the *DSM* are the technologies (Rose, 1998) that maintain ableist and sanist normativity. The *DSM* is the text through which details of a person’s life—their thoughts, moods, and behaviours—are compared. Persons meeting the specified criteria can be classified to have a mental disorder, marking certain mental and emotional states and experiences of distress as different, abnormal, and pathological against preconceived notions of ‘normal mental health’ (Freud, 1999; LeFrançois & Diamond, 2014; Rusch, Angermeyer, & Corrigan, 2005; Vanheule, 2011). In the case of children and youth, mental health issues are also scrutinized against conventional standards of ‘normal’

child psychological development. Young people who do not meet the expectations for their age and stage of development are classified with psychopathology (Bell, 1993; Horwitz & Wakefield, 2009; LeFrançois, 2008; LeFrançois & Coppock, 2014; Reese, 1999). Inherently connected to these *psy* discourses are other discourses about the nature of childhood, discourses premised on certain values, beliefs, and social expectations about what it means to be a ‘normal child’ living a ‘normal childhood’.

### **Psychiatrized Child(hood): Competence, Innocence, Risk, and Criminality**

Psychiatrized young people threaten and disrupt notions of the ‘normal child(hood)’. However, the problem with standards of normality is that they are defined, not in terms of what a ‘normal’ child is, but in terms of how a child is perceived to be different from what is expected (refer to Poole et al., 2012, for the fuller discussion about constructions of ‘*normal*’ as being in the absence of illness—what is conceived as ‘abnormal’). In other words, normality depends on how deviance is defined; and the extent to which a child’s behaviour is considered unacceptable influences the ways the child is labelled, and the treatment or action undertaken (Rousseau, Measham & Bathiche-Suidan, 2008). Those expectations are based on the values, norms, and beliefs of the particular culture or society (Freud, 1999; Silk, Nath, Siegel, & Kendall, 2000; Skovdal, 2012; Timimi, 2002; Timimi & Maitra, 2006) and change over time as society’s values, norms, and expectations about children shift. Central to the psychiatrization of young people are childhood discourses about competence, innocence, risk, and criminality.

Generally, competence is understood as a capacity that distinguishes childhood from adulthood. Competence in young people is associated with certain cognitive abilities at certain ages (Bell, 1993), intelligence, knowing the difference between right and wrong, and the capacity to understand the consequences of one’s actions (Ekman-Ladd, 1996). As a social group distinct from adults, young people are generally seen as “victims of their passions” (Ekman-Ladd, 1996, p. 8) inclined to choose immediate gratification and finding it difficult to resist the influence of those around them, such as their peers (Bell, 1993). Even when a young person is believed to have the capacity and competence (i.e., the cognitive abilities to know right and wrong and to understand the consequences of their actions), they are viewed as not having the experience to apply that competence well because, lacking experience, they cannot predict the consequences of their actions (Ekman-Ladd, 1996).

For psychiatrized children and youth, their competence and capacity are considered diminished by their mental and emotional distress (LeFrançois, 2008). The mental health issue then becomes the justification for treating young people as though they were incompetent. In turn, notions that a young person does not have the wisdom to predict the consequences of their decisions exacerbate concerns about their capacity. The result is to deny psychiatrized young people their autonomy (Bell, 1993) and full participation in treatment decisions over their mental health care (LeFrançois, 2008). In practice, a unique generational-based danger exists that “being young/a child” and/or “being deemed to have a mental health issue” become the justification for denying psychiatrized children and youth their autonomy and full

participation in decisions about their lives. In other words, in the lives of young people, adultist and sanist practices intersect.

Similar to competence, innocence is framed as a trait that distinguishes childhood from adulthood. Innocence is a feature of a ‘normal child’ living a ‘normal childhood’ and evokes images of a playful, happy, carefree, co-operative, non-sexual, and unspoiled child living in a safe and protective family (James & Jenks, 1996) and community (Schissel, 2006). Young people who behave in ways that disrupt these notions of innocence are understood to have lost their innocence (Bell, 1993; James & Jenks, 1996)—they are considered spoiled, corrupted, and/or corrupting. Psychiatrized children and youth disrupt the image of the innocent child. For example, young people constructed as having “internalizing issues,” such as those associated with depression or anxiety, disrupt the notion of a happy, carefree childhood (Horwitz & Wakefield, 2009). The innocent child is replaced with images of a child “spoiled” by their sadness or worries. Young people constructed as having externalizing issues, such as those associated with attention-deficit/hyperactivity disorder or oppositional defiant disorder, similarly disrupt notions of the innocent child but for different reasons. Behavioural issues in children can evoke attitudes of fear and can be perceived as dangerous among members of the general public (Coppock, 2005; Martin, Pescosolido, Olafsdottir, & McLeod, 2007; Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007). Behavioural issues are associated with being out of control, aggressive, and non-compliant, and therefore are potentially “dangerous” to self and others.

Intertwined with the constructions of innocence and “innocence lost” are notions about risk and the need to protect young people and society from harm. Difficulties in childhood are understood to manifest in adulthood, and protecting the stability of future adult society depends on intervening early in the lives of young people who either face risks that can derail them (James & Jenks, 1996), or are already considered derailed (Horwitz & Wakefield, 2009). In this framework, the focus of mental health prevention programs is to identify and intervene as early as possible in the lives of “at-risk” and “troubled” young people (Browne, Gafni, Roberts, Byrne, & Majumdar, 2004), ultimately, to treat “pathological” children and divert them from becoming “pathological” adults. Competence, innocence, and risk discourses all interconnect in ways that allow for the justification of interventions under the guise of being in the “best interest of the child.” As noted by LeFrançois (2008), even when a child was deemed mentally competent, young people were denied their full participation in their mental health treatment if the decisions the child was making were viewed by professionals and other adults as acting against their best interest. More broadly, when members of the general public believe it is in the best interest of the child and family, they endorse the use of coercion, such as forced treatment and medications (Pescosolido, Fettes, et al., 2007; Pescosolido, Perry, Martin, McLeod, & Jensen, 2007). In other words, by claiming that one is acting in the best interest of the child, other actions can be taken on behalf of young people, including restricting their rights, participation, and self-determination, as well as imposing treatment through coercive means. In these actions under the

umbrella of “best interest,” young people are situated as passive recipients of adult decisions (instead of active social actors in their own right; LeFrançois, 2008).

Finally, intertwined with risk discourses are those about crime and criminality. Mental health, risk, and criminal discourses locate the problem of youth crime in the young person as “flawed either biologically and/or culturally and by consequence morally flawed” (Schissel, 2006, pp. 80–81). Criminal behaviour in young people is associated with psychological and behavioural issues, and, vice versa, mental health issues are associated with criminal behaviour, reinforcing images that young people with mental health issues are “bad kids” (Bell, 1993; Coppock, 2005; Schissel, 2006). As mentioned, central to these discourses are certain values, beliefs, and expectations about the ‘normal’ child(hood). By prioritizing *What is ‘normal mental health’?* as their self-identified research question, Brandon and his peers signalled the importance of the binary to their lives.

### **Methodology: A Photo Voice**

#### **Answering: What Is ‘Normal Mental Health’ for Children and Youth?**

The photo voice presented here was part of a larger funded study that consisted of both quantitative (surveys) and qualitative (interviews, focus groups, and participatory action research) methods to explore self and family stigma as individual and intersecting sanist experiences of prejudice and discrimination from the perspectives of psychiatrized youth, caregivers, and siblings.<sup>2</sup> The photo voice was part of the participatory action research (PAR) initiative that consisted of convening a group of seven ( $N=7$ ) youths, 14 to 17 years old, diagnosed with a mental health issue to form a research team to work alongside myself as the (adult) principal investigator to explore stigma in child and youth mental health.<sup>3</sup>

Members for the youth PAR team were recruited through a community-based child and youth mental health service agency located in a large urban area near Toronto, Canada. The agency housed the PAR and provided private meeting space and administrative support. Recruitment consisted of connecting with frontline managers and mental health therapists (i.e., social workers, family support workers, psychologist, and psychiatrist) and asking that a letter introducing the project be passed along to potential youth participants and their caregivers. Prospective youths and their caregivers were guided to contact me directly. Once contact occurred, brief information about the study was provided, and appropriate youths and their legal guardians were invited to participate in an in-person information meeting. In separate meetings each youth and their caregiver were provided with the full details of the study, and informed consent was obtained from both.

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<sup>2</sup> Funding was provided by the Mental Health Commission of Canada.

<sup>3</sup> I extend my sincere appreciation to all the participants, but especially to the seven youth members of the PAR team and their caregivers.

Purposive sampling was used to identify the youths. The criteria for inclusion was: youth between 14 and 18 years old, nearing the end of their mental health treatment or having used mental health services within the previous two years. Youths experiencing an acute mental health crisis were excluded because, presumably, they were facing immediate circumstances that would make it difficult for them to participate and might have required more support than was possible within a research context. The youths were provided with an honorarium of \$30.00 (cash or gift certificate) per month for the duration of the study, as well as a \$15.00 transportation allowance per meeting or activity to cover travel costs. Ethics approval was obtained through the Research Ethics Board at Wilfrid Laurier University and the agency partner.

### **Data Collection and Analysis**

From March to November 2011, the youths participated in training in the basics of both quantitative and qualitative methods and assisted in the three research initiatives, one of which was the photo voice project. Drawing on their situated knowledge, the youth team generated a list of topics or questions they considered important to research based on their lived experiences as active mental health service users (Genat, 2009). Once the list was generated, each question was discussed for its overall importance to the individual members and to the collective as a whole. Each youth voted on their top three choices. The question that received the most votes was the topic chosen for further exploration by the team.<sup>4</sup> The topic that emerged as the team's first choice was: *What is 'normal mental health' in children and youth?* To answer their research question, the team opted to collect qualitative data, specifically, images and documents using a photo voice approach. The photo voice was completed in July 2011 and consisted of three sessions.

As a research method, Foster-Fisherman, Law, Lichty, and Aoun (2010) described photo voice as “a participatory method that puts cameras in the hands of individuals often excluded from decision-making processes in order to capture their voices and visions of their lives and their community” (p. 69). Photo voice has been used to study a range of issues such as: the ways youth become involved in their communities and neighbourhoods (Foster-Fisherman, et al., 2010); the experiences doctoral students have of their comprehensive exams (Koltz, Odegard, Provost, Smith, & Kleist, 2010); the impacts of service learning programs on students (Johnson, 2010); and improving the participation of adults with learning disabilities in research about their experiences (Ollerton & Horsfall, 2013).

In the first of the three sessions the youths were provided with instructions regarding the photo voice method and procedures, as well as a disposable camera. Participants were asked to use their cameras to take photographic images that represented answers to the research question: *What is normal mental health for*

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<sup>4</sup> For a full list of the topics generated by the youths refer to Liegghio, 2013. The list is telling of the prejudices and discriminations encountered by psychiatrized youth, including police encounters and the use of force and confinement.

*children and youth?* Once the photographs were developed, the second session consisted of individual meetings with the youths to organize their photo collages and prepare their written explanation of the images and the response to the research question. The third and final session consisted of the individual youths presenting their respective photo collages and written responses to one another in the larger group. Along with presenting their individual responses, the youths as a group also conducted an analysis of the responses identifying similarities and differences between the group members in their considerations of the answers to the research question. The large group discussion was audiotaped and later transcribed. The data analysis consisted of a thematic content analysis based on the principles of critical narrative discourse analysis of the transcript of the group discussion, the photographic images, and the individual written explanations of the photo collages.

### **The Young People**

Of the seven youth PAR collaborators, four were men and three were women. The youngest was 14 and the oldest was 17 years old. The average age was 17 years. All seven youths were born in Canada; five were Caucasian and two were racialized (Black-Caribbean and Filipino-Middle Eastern). Three youths came from low-income households, two from middle-income households, and two from high-income households. Four youths lived in two-parent households, two in single- (female)-parent households, and one was a ward of the state. Of the seven youths, one had no formal mental health diagnosis, two had two diagnoses, and four had three or more diagnoses. The main diagnoses included: attention-deficit/hyperactivity disorder; generalized anxiety or social anxiety disorder; depression; and at least one episode of paranoia, delusions, and/or psychosis. At the time of joining the project, all seven youths were actively using mental health services; four had experiences of psychiatric residential care and/or hospitalization. Three youths were involved in the criminal justice system, and five had police involvement related to the mental health issue. All experienced difficulties within the education system.

## **Findings**

### **Disabling Encounters with ‘Normal’ from the Perspectives of Psychiatrized Youth**

There were three main interrelated themes that emerged from the photo voice answering: *What is normal mental health for children and youth?* The first theme consisted of concepts about ‘normal’ as an ideal against which young people are compared and judged. The second theme is that the standard is a matter of perspective that depended on who was observing and making interpretations about the child; consequently, ‘normal’ was experienced as ambiguous and shifting. The third theme was resistance to disabling encounters with *normal*, whereby the youths offered a counter-narrative in which normal mental health was inclusive of emotional distress.

### **Theme One: *Normal* Is an “Ideal” Against Which Young People Are Compared**

Based on the discussion of their photo collages, the main theme to emerge was that ‘normal mental health’ was a standard against which young people were compared and against which they, as young people diagnosed with a mental health issue, were considered to fall short. For instance, Alicia (15 years old) photographed a subdivision of new estate homes, while Jamie (15 years old) had an image of a Jaguar, a luxury vehicle. Both described the ways the home and car represented *normal* as an ideal.

For Jamie, the Jaguar represented the ways some people are “put up” and others are “put down.” If the young person meets the standard or ideal, then they are valued; and if they do not, they are devalued and experience themselves as “put down.” The effects of this are that young people with mental health issues “worry about being judged as different” and “are scared of being put down.” As a result they are hesitant or avoid accessing mental health services because of worries about how they will be negatively judged as less than normal and subsequently treated negatively by others. Interestingly, when asked for clarification about the characteristics of ‘*normal*’, the youths were reluctant to describe specific qualities. (Actually they never defined the qualities.) For the youths, the characteristics of *normal* are not important to the ways they experienced themselves; instead, what was important were the processes of being compared and falling short to a preferred ideal. In other words, regardless of the characteristics, it was being constructed as abnormal that produced the negative identity and the disabling experiences of an abnormal self. This reluctance to define the characteristics of *normal* was interconnected with the second main theme.

### **Theme Two: ‘Normal Mental Health’ Is Ambiguous and Shifting**

Based on the situated knowledge of psychiatrized youth, what emerged was that ‘*normal*’ was ambiguous in that the meaning shifted depending on the person or professional observing and interpreting the child’s moods and behaviours.

Sarah (15 years old) had an image of a gold ring with a half heart so that half the heart was on the ring and the other half was cut away. For Sarah, the image of a half-heart ring represented the idea that some may see a “broken heart” (damaged and devalued) and others may see a “heart half-healed” (better and valued) and that ultimately, normal mental health was a matter of perspective and opinion. As an ongoing struggle in trying to understand themselves against their diagnoses, Jamie (15 years old), Stuart (16 years old), and Brandon (15 years old) constantly questioned whether or not the diagnoses they each had were “real” because of hearing different messages from their parents, psychiatrists, social workers, and/or educators. In many ways, the different and multiple constructions of their issues can be explained by the different mandates of the various professionals working with the youths. For instance, educators interpret mental health issues through an educational lens; consequently, young people can receive messages about the ways their “problems” are disruptive to their learning or to others, while parents interpret their

children through the lens of childrearing and family life. Youths can hear different messages not only about what the issues are, but also about what needs to change. By revealing its ambiguous nature, the youths created a space for challenging psychiatrization.

### **Theme Three: A Counter-Narrative that ‘Normal’ Includes Experiences of Distress**

The third theme to emerge was a counter-narrative that resisted and challenged notions that mental illness was different from normal mental health. Alicia (15 years old), Aidan (18 years old), and Jane (17 years old) each had images that conceived ‘normal’ as including experiences of mental and emotional distress. ‘Mental health’ and ‘mental illness’ were not conceived as a dichotomy, but rather as being ‘normal’ in that all people experienced both “health” and “distress.”

Alicia’s image of an open trail, winding off into a distance represented normal mental health in that “everyone is on a path in life,” that everyone’s path is long, winds, and turns. The winding part represented the “bumps in the road” that everyone has, whether or not they are said to have a mental health issue.

Aidan’s image was of a door in a residential treatment program, of which the window covering was located on the outside of the room for professionals to look in and observe the resident. The door was decorated with stickers and posters of different sizes of skulls and bones: The skull meant being “hard core” and “durable” that “the person has been through a lot,” “can take hits,” and has a “heart of bone.” The heart of bone represented normal mental health by symbolizing that *normal* meant “getting through tough times” and “moving on.” This framing of ‘normal’ had mental and emotional distress repositioned as valued, signifying that a person had lived and moved past “hard times.” The ‘mental illness’ was not necessarily understood as “the hard time,” but rather as indicators of the young person’s capacities and abilities to move past difficult situations or experiences.

Finally, for Jane (17 years old) the image of a large traffic stop sign represented “obstacles in life” and that everyone encounters obstacles as a ‘normal’ part of living. However, Jane also explained that the main difference between a young person with normal mental health and one with a mental health issue is that the “teenager who has mental health problems” was likely to think that they were “not capable” of overcoming those obstacles. Although a young person’s thoughts and moods can be an obstacle, the reactions other people had, (i.e., parents, teachers, and social workers), as well as the young person’s own reactions to having a mental health problem, can also be obstacles.

Thus, for psychiatrized young people, it was not necessarily the mental health issue that was disabling or impairing, but rather the perceptions of others enacted on the child or youth that rendered them abnormal, incompetent, and too young to know any better. While revealing disabling encounters with ‘normal’, the youths challenged and disrupted normative assumptions by repositioning themselves from ‘abnormal’ to ‘normal’. The binary is disrupted in that all people are considered to encounter difficulties and that a ‘mental health issue’ does not indicate an abnormal child. Rather,

mental health issues indicate a normal child reacting and adjusting to the conditions of their lives: They struggle, face their obstacles, and move past difficult times.

### **Psychiatrization in Childhood: Implications for Mad and Disability Studies**

Relying on the situated knowledge of the youths involved in the photo voice, there is one main implication important for Mad and Disability Studies. The implication is the immediate need to address the invisibility and under-representation of psychiatrized children and youth in Mad and Disability scholarship and activism. As their experiences indicate, psychiatrized children and youth “know” what it is to be constructed and constrained by a normal/abnormal binary, to be constructed as having a mental health issue and as being abnormal in childhood—a social position unique from that of adults. Through the photo voice, we learn that ‘normal mental health’ was a matter of perspective, an ambiguous and shifting standard or ideal against which young people are compared, and from which constructions of difference as negative and ‘abnormal’ were imposed. According to the youths regardless of what the characteristics of ‘*normal*’ were, it was being constructed as abnormal that produced the negative identity and the disabling experiences of an abnormal self.

As a feature of their psychiatrization, the youths were made to feel “less than” and treated as “incapable,” which was related both to their status as young/children and to the ways that psychological impairments are conceived as “incompetence.” For psychiatrized children and youth, their competence and capacity is considered diminished both by their mental and emotional distress and by notions that a young person does not have the wisdom to predict the consequences of their decisions (Brannen & O’Brien, 1995; Dalrymple, 2005; Ekmann-Ladd, 1996; Kellet et al., 2004; LeFrançois, 2008). In practice, the danger is that being “young” and “deemed to have a mental health issue” become the justification for denying psychiatrized children and youth their autonomy (Bell, 1993) and full participation in decisions about their mental health care (LeFrançois, 2008).

As a challenge to their own encounters with sanism and ableism, the very question the youths posed exposed for scrutiny the normal/abnormal binary as the social mechanism central to young people’s psychiatrization. By questioning what was normal mental health for children and youth, the youths problematized its meaning, exposed the contradictions inherent in the structure of the normal/abnormal binary, and revealed its use as a rationale for their discrimination. The youths poignantly described that although all people face “obstacles” or “bumps in the road,” the prejudices faced by young people diagnosed with a mental health issue can be a significant barrier and can exacerbate their experiences of emotional and mental distress. Suppressed by the binary are alternatives, such as the one revealed by these youths in their challenge to the dualism of the normal/abnormal binary in which they created the alternative possibility that ‘*normal*’ includes “distress” (Healy, 2005). By repositioning themselves from ‘abnormal’ to ‘normal’, the youths disrupted normative assumptions. The binary was disrupted by the construction that all people are considered to encounter difficulties and that a ‘mental health issue’

does not indicate an abnormal child, but rather a normal child reacting and adjusting to the conditions of their lives in ways that all people do—they struggle, face their obstacles, and move past difficult times. The constant questioning and disruption of notions of ‘*normal*’ by the young people makes an extremely useful intervention into the debates; their reframing of the norm is a political act that demonstrates the young people actively resisting the labels imposed upon them.

Many question the appropriateness of constructing emotional distress in young people as mental illness and disorder (Fisher & Spiro, 2010; Rabaia, Saleh, & Giacaman, 2014). Similar to the youths’ counter-narrative is an alternative interpretation in which distress is constructed, not as pathology, but as appropriate—as appropriate responses to the difficulties some young people face as they move through life. For example, while discussing concerns about the over-identification of depression in children, Horwitz and Wakefield (2009) questioned the legitimacy of conceiving sadness as a mental disturbance; instead, they suggested, the signs that signify a depression can also be understood as appropriate responses to the range of difficult situations some children may be facing in their lives. In other words, sadness in children can be normal expressions of the sad situations they may be facing.

In other instances, LeFrançois (2013b) and Langer & Martin (2004) have both highlighted the ways in which the thoughts, feelings, and behaviours of queer youth are constructed as a mental disorder, rather than constructed as appropriate responses to difficulties they may encounter as queer persons living in a heterosexist and homophobic society. Although careful not to dismiss emotional distress in young people as mere cultural constructions (Horwitz & Wakefield, 2009), the legitimacy of practices that interpret psychological differences and emotional distress as mental illness and disorder are questioned and challenged. The implication that follows is that psychiatrized young people could have very different subjectivities (experiences of self in relation to others) if their expressions of distress were constructed and treated as “appropriate” and even as ‘normal’ responses to the difficulties they face in life.

In their effort to disrupt the normal/abnormal binary, Mad and Disability scholars and activists have an important role to play in this challenge by bringing to light the equity issues inherent to psychiatrization in childhood—as issues related to the ways in which society is organized to be exclusionary to some children and youth because of their particular expressions of emotional, mental, and/or psychological distress. Since psychiatrization in childhood occurs at the intersections of childhood and adultism, distress and sanism, and (in)competence and ableism, adopting an intersectional approach is required for moving forward in both practice and research. Within an intersectional approach, adultism, sanism, and ableism are understood as intersecting and interlocking systems and structures of oppression, with each making possible the occurrences of the others, intertwined to produce the ‘abnormal child’ (Coppock, 2015; LeFrançois, 2013b; LeFrançois & Diamond, 2014).

In conclusion, moving forward scholars and activists in both fields need to continue with the challenge (cited in the opening) and actively engage children and youth in research and activism that centres their knowledge. However, inclusion and

participation does not necessarily mean that the theories we use to explain and understand children's lives are inclusive of that knowledge. Just because I started with Brandon's experience and I featured the photo voice of the youth group, it does not mean that the structural or systemic conditions of adultist, sanist, and ableist practices as interlocking and intersecting practices are addressed. In turn, this requires that we contend with both our own adultism and sanism that maintain (consciously and unconsciously; Perlin, 2000) psychiatrized children and youth as invisible and excluded from Mad and Disability scholarships and activisms. The aim is not necessarily for me, as an adult, to theorize from the position of the psychiatrized child and youth, but to work as an ally with psychiatrized children and youth to create and support spaces to have their knowledge known and to have actions and change organized around their own worldviews and theorizations.

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