Queering the Sociology of Diagnosis: Children and the Constituting of 'Mentally Ill' Subjects

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Abstract

A queer theory informed analysis of the findings of an ethnographic study detailing the experiences of children in relation to diagnosis within a psychiatric hospital is provided in this article. The perspective of the diagnosing psychiatrist in relation to symptoms and diagnoses is compared to the children's understandings, along with an analysis of the consequences of the normative approach inherent to bio-medical psychiatrization. The dehumanising process of psychiatric diagnosis, which strips people of their dignity, leads to what we have termed psychiatrised abjection. The act of diagnosis is shown not only to categorize, but also to 'other', to make abject and to make queer.

Keywords: sociology of diagnosis, queer theory, abjection, Mad Studies, children, psychiatry

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Queer theory interrogates and destabilizes normative practices and discourses that produce, reinforce and naturalize hierarchical social arrangements. This theoretical perspective emerged in the early 1990s out of feminist and LGBT studies and draws on a number of influential ideas proposed by post-structural theorists including Jacques Derrida (1976, 1988), Michel Foucault (1966, 1975, 1978) and Judith Butler (1990, 1993). Whilst queer theorists initially and primarily focus on interrogating gender, desire and sexuality, others such as Anzaldua (1991), Smith (2010), McRuer (2006), and Nyong'o (2005) have applied queer theory in their examinations of identities and practices related to race, disability, Indigeneity, and other sites of power. As such, the notion of 'queer' in queer theory does not only refer to bodies and subjectivities that deviate from normative heterosexuality, but may be seen as inclusive of all bodies that are constructed as abject, sick and inferior (Butler, 1993; LeFrançois, 2013). With this in mind, we extend the use of queer theory, in this article, to interrogate the construction of 'mental illness' diagnoses and 'mentally ill' subjects. We view this theoretical perspective as an anti-oppressive tool that can help foster a deeper understanding of how psychiatric discourse creates and perpetuates theory and practice which pathologizes, punishes and erases the human diversity that ultimately threatens the hegemonic order.

Although there is a history of feminist (Chesler, 1972; Smith & David, 1975; Burstow & Weitz, 1988; Millett, 1990; Ussher, 1992, 2005, 2011; Caplan, 1995; Burstow, 2003, 2005, 2006) and other interdisciplinary writing (Ingleby, 1980; Miller & Rose, 1986; St. Amand, 1988; Boyle, 1990; Cohen, 1990; Breggin, 1998; Rose, 1999; Newnes et al. 1999, 2002; Johnstone, 2000; Whitaker, 2002, 2010; Parker et al. 2004; Morrison, 2005; Crossley, 2006; Warme, 2006; Cohen & Timimi, 2008; Bentall, 2009; Metlz, 2009; amongst others) which has critiqued psychiatric diagnosis, including by those who were influential in the beginning of the anti-

psychiatry movement such as Szasz (1961, 1997), Laing (1960, 1967, 1971), and Cooper (1967), there has been no previous attempt to use a queer theory lens in deconstructing psychiatric diagnosis specifically nor has it been applied to the sociology of diagnosis generally. We believe that a queer theory lens offers us a unique post-structural form of analysis in its focus on questioning and destabilizing dominant discourses whilst exposing their normalizing and essentializing functions. This provides us with an approach to building upon and expanding on previous critical, radical and activist work by unwrapping and detailing the marginalizing functions of psychiatric discourse. Queer theorizing enables the uncovering of the intrinsic, complex and sometimes minute ways in which socio-politico-cultural processes function within psychiatric discourse to produce docile and abject bodies.

The importance of interrogating psychiatric discourse using queer theory is underscored by the various ways in which marginalized people are targeted by psychiatry. For example, queer theory provides useful concepts for examining how queer and trans bodies are targeted within both historical and current practice in psychiatry (Diamond, 2014; Diamond & Kirby, 2014; Withers, 2014). Also, in considering a broader understanding of 'queer' – to include all identities and bodies which are considered 'odd' within dominant discourses - we see widespread connections between the marginalization of oppressed people and psychiatry's approach of psychopathologizing difference. Many people who do not conform to various types of behavioural norms -- whether or not those norms relate directly to sexuality or gender -- are deemed sick by psychiatry and are considered odd and queer within dominant culture.

Recently, Jutel (2009) has reiterated the call for the establishment of the sociology of diagnosis. This field would include an analysis of the role diagnosis plays both within medicine and within the social sphere, the authority linked to diagnosis as well as the ways in which that authority may be critically analyzed and challenged. Diagnosis can be analysed as "both a process and a label" (Jutel, 2009, p. 279) in that it serves to evaluate functioning as well as to name or categorize deviance from 'normal' functioning. Using a queer theory informed critical analysis of psychiatric diagnosis, this article attends to the ramifications of both the form and process of the psychiatrization of children. Although our analysis focuses on psychiatrized children, much of it can be equally applied to psychiatrized adults.

There is a call, from within and without queer theory, to intersect with black studies and diaspora studies in order to directly question the ways in which queerness, race, colonialism and globalization impact on each other in complicated ways (Johnson & Henderson, 2005; Wesling, 2008; Tinsley, 2008; Eng, 2010). A queer diaspora and black queer studies approach is essential not only in ensuring that racialized bodies do not remain invisible within queer theorizing but also to ensure that deeply embedded structural racism and institutionalized white privilege are exposed as organizing principles. We contend that this is particularly important in queering psychiatry. For example, in some countries within the Global North such as the UK, racialized people are over-represented as patients within mental health services (Sewell, 2012). At the same time, in the Global South Euro-American psychiatry, with its diagnostic tools, bio-medical understandings and pharmaceutical treatments, is being imposed (Mills, 2014a) in order to replace what may be culturally relevant approaches to understanding and healing distressed members of their communities (Rabaia et al, 2014). Indigenous, cultural and/or spiritual approaches to healing are debased as barbaric and dangerous, whilst the violence inherent to neo-

colonial psychiatry remains obscured. Although the violence of psychiatry is obscured whilst debasing cultural-based remedies, we must stress that people viewed as mad have been mistreated and oppressed in many different historical and current cultural contexts that predate psychiatry. For example, in the contemporary context, activists in Ghana are resisting oppressive spiritual interventions being forced upon people, such as being deprived of food and being chained to trees as a means of 'curing' madness (MindFreedom Ghana, 2005). However, there are other forms of Indigenous and culturally relevant remedies that are not oppressive but are nonetheless also being dismissed as dangerous and barbaric, merely because they do not conform to bio-medical understandings (Mills, 2014b). Whilst black studies scholars have criticized queer theory for its implicit collusion with white privilege, so too have native studies scholars criticized both queer and queer of colour scholarship for neglecting to disrupt and interrogate the strictures and social violence of settler colonialism, including the ongoing genocide of Aboriginal peoples (Smith, 2010). As such, we believe that radical activist scholarship in relation to the sociology of diagnosis must include a theoretical and political union between queer theory, black studies, diaspora studies, native studies and Mad Studies. [1]

Research Context and Setting

In order to illustrate the importance of queer theory within the sociology of diagnosis, data from an ethnographic study of children's experiences in a psychiatric inpatient unit in the UK (LeFrançois, 2007), relating specifically to the symptoms and diagnoses given to the children, are considered in this article. This study consisted of immersing in the culture of the children on the inpatient unit for a period of four months. There were 12 children involved in the research, all White British and aged between 11 and 17 years. The inpatient unit is characterized as a four tier services (HAS, 1995). It is an unlocked ward with an interdisciplinary team of practitioners consisting of psychiatrists, psychologists, social workers, community psychiatric nurses, teachers and counselors within the day-patient unit as well as mental health nurses and support workers within the joint inpatient unit.

The data used in this article derive primarily from unstructured and semi-structured interviews with the children and a semi-structured interview with the consultant psychiatrist. As one of the aims of this study was to explore the experiences of mental distress from the children's perspective, information regarding their characterizations of their distress was documented. In addition, how the diagnosing psychiatrist talked about the children's distress was detailed in order to analyze the similarities and differences in standpoints.

Although this research study was initially analyzed and disseminated providing a qualitative descriptive analysis of the children's viewpoints by focusing on the children's voices, as has been the dominant trend within the sociology of childhood, this approach to highlighting children's standpoints has been insufficient in connecting with broader scholarship within

[1] Mad Studies is an umbrella term that is used to embrace all scholarship that may be classified as antipsychiatry or critical psychiatry, as well as and including the body of knowledge that has emerged from Mad-identified people, psychiatric survivors, and radical therapists (see, for example, Menzies et al. 2013). Although the project of Mad Studies aims to bring together a range of scholarship that provides a critique of psychiatry, it centers the knowledges and scholarship of those who have lived experience of psychiatric oppression, what Finkler (2014) refers to as a psychiatric survivor analysis or what Wolframe (2014) refers to as the maddening of text.

sociology and other related disciplines. As such, this article is based on a secondary analysis of some of the data of this study in order to connect the descriptive words and ideas of participants with post-structural feminist thought. This secondary analysis has involved a queer reading of the data, thus employing a methodology that links directly to its theoretical underpinnings (Browne & Nash, 2010).

The Power of Diagnostic Language

Queer theory challenges us to think outside of meta-narratives[2] to consider a post-structural approach to knowledge production. The very nature and function of language are queried using philosophical ideas developed by Derrida (1976) who postulates that language actually structures and organizes the world in a particular way to perform social actions and to reinforce hegemonic power relations. A result of this is that human experiences that deviate from the normative 'ideal' are either excluded or are represented only through disparaging representations. Derrida (1976) argues that language functions through a process of exclusion, based on oppositional relationships that are constructed through binaries such as normal/pathological or superior/inferior. The 'normal' or 'superior' subject always occupies the centre, whilst all subjects who deviate from this ideal are relegated to the status of 'less than', 'pathological', or 'inferior'. Whilst the 'normal' is left unquestioned, the meanings of its derivatives are under constant scrutiny and re-evaluation (Diamond, 2004; Wilchins, 2004).

Psychiatric discourse represents perhaps one of the most obvious examples of how power relations are structured through language. The Diagnostic and Statistical Manual (DSM) (APA, 2000) and the International Classification of Diseases (ICD) (WHO, 2007) provide hundreds of diagnostic categories that demonstrate the countless ways in which psy-discourses (Rose, 1999) pathologize difference, classifying human experience and behaviour into various categories of disorder. Although cloaked in the language of science, psychiatric diagnoses are highly subjective and value-laden in terms of both their construction and implementation and reflect what is (de)valued within dominant (read: white, middle class) culture (Caplan, 1995). This simplistic and reductive epistemology delimits our ability to represent and understand lived experience outside of this dichotomy, making it impossible to imagine alternative ways of understanding experience.

Although Jutel (2009) argues that diagnosis narratives combine the stories of both patient and doctor, this is less the case with psychiatrized children. Generally, the parents' stories of their children's functioning are sought by the diagnosing psychiatrist, who retells the story in psychiatric terms. As such, the child's narrative is often missed altogether or considered suspect due to age and maturity level (LeFrançois, 2007). Regardless of their lack of input in the process, all of the children in the present study accepted and reiterated the consultant psychiatrist's pronouncement of their mentally ill status. They were not granted the opportunity to understand their experiences outside of the psychiatric framework to perhaps find meaning or

[2] In post structural theory, a meta-narrative is a grand overarching story that orders history in a way that justifies the existence of social institutions and authorities (Diamond & Gillis, 2006).

Value in what they were going through[3]. Hence, the diagnosing psychiatrist – the inaugurating authority – can be said to play the essential role, as described by Austin (1962), Derrida (1982), and Butler (1990, 1997), of initial citation by an authority, which ultimately enables the repetition of that pronouncement in order to constitute the subject. Furthermore, the very act of judging and labelling their experience as abnormal may produce shame. As the children's self-understandings were limited within the confines of psychiatric discourse, there is no way of knowing how much of their distress was caused by the experience of sanism (Perlin, 2004, 2003; Poole et al. 2012) and the loss of control associated with being labelled and treated as mentally ill. According to Derrida (1988, 1982, 1976), language fails to capture and describe the infinite realm of possible human experience, as it is too limited to portray the complexities of the self, the body and desire. This is certainly true in regards to the language of psychiatric diagnoses, which reduce human experience to lists of symptoms. As a result, emerging experiences that do not fit within the existing psychiatric framework are rendered invisible. This understanding of how language works offers a lens to critically examine how the mental health/mental illness binary defines certain devalued aspects of human experience as sick/inferior and restricts and erases potentialities of human diversity and other ways of being in the world (Diamond & Gillis, 2006). As such, queer theorizing compels us to focus on the linguistic aspects of diagnosis, linking it with the way language is intimately connected to power and control, which expands on labelling theory (Becker, 1963; Goffman, 1963) by demonstrating the underlying functions of citation and repetition with regards to these labels.

Despite the history of hiding formal diagnoses from psychiatrized children in practice, all of the children in the study indicated being aware of their formal diagnosis. The children listed the following 'diagnoses': depression, eating disorders, self-harm, suicidal tendencies, personality disorder, family problems, school problems and 'impulsive washing disorder'. In all cases, bar one, the children's disclosures of their diagnosis to the researcher matched the formal diagnoses given to the researcher by the psychiatrist, with 'impulsive washing disorder' being named 'obsessive compulsive disorder' by the psychiatrist**.** Although 'school problems' and 'family problems' are not diagnoses found within the DSM or the ICD, the diagnosing psychiatrist named them as such (to both the children and the researcher) and the children repeated them to the researcher. With these diagnoses, the children's bodies continue to map the complex identity constructions that have been discursively detailed for them. The one exception relates to a child who indicated to the researcher that he suffered from depression, family issues and a personality disorder. The psychiatrist indicated that this child was discharged because on assessment he was found not to be depressed however, the psychiatrist offered the unsolicited prediction that he may develop borderline personality disorder over time despite his state of good "mental health" at the time of discharge. As such, the discursive mapping and re-mapping of bodies exists, evolves and overlaps between the present, future and past. None of the children involved in the study had been given a diagnosis of a psychotic disorder. One child was labelled with 'queried psychosis', but upon discharge was assessed as not having a psychotic disorder. Although 'queried psychosis' is not a diagnosis to be found in either the DSM or ICD, the application of this label by the diagnosing psychiatrist nonetheless resulted in treatment consistent with a psychotic disorder diagnosis. That is, the child was administered neuroleptic

[3] Psychiatrized people have developed non-medical understandings of 'madness,' such as those that have emerged within the Mad community, which find value and meaning in 'mad' experiences, as well as interpretations of 'problems in living,' which locate human suffering in the context of structural oppression

drugs, despite not wanting to take the drug, even refusing it on occasion, experiencing intense rebound symptoms and being threatened with the loss of privileges in order to ensure future compliance. Consider the child's own words in relation to the drug:

> *He* (psychiatrist) *sorts out my medication and stuff, which I've had a long ongoing battle with him. I'm against any form of medication 'cos…I don't like to think of it as brain chemicals all in the wrong. That makes me feel that it's out of my control and medication put forward to solve those problems, again is out of my control. I don't like, you know, how these things can alter the way I think and the way I am…It's an antipsychotic. It's supposed to change thought patterns, or alter, that's what I've been told…I don't like the idea that it changes who I am. They say they are fine but I don't want to lose something that is me…I think it's, I mean, I don't think that medication is the answer and I think people should be given a choice whether we want medication or not. I mean, it's your body and they shouldn't threaten you and things like that…I have refused several times…They* (practitioners) *put pressure on me. They put pressure on me from the start. It made me feel worse when I refused…When I stopped taking them my whole body felt like it was throbbing. It was uncomfortable…It was* _____ (case manager) *talking to me, and saying that if you don't take your medication it is not complying…it's non-compliance, and the people upstairs were considering my position…The high people.* _____ (psychiatrist). *They said they can chuck me out and then later, when I refused the chlozapine,* _____ (psychiatrist) *said that if I refuse medication, he wouldn't let me go home weekends. So I started to take them* [Liam, age 16].

In Liam's situation, the power of the language of diagnosis is evident, when uttered by a psychiatrist, even if it does not conform to official diagnostics. That is, this citationality, given the authority from which it is pronounced, allows for the constituting of mentally ill subjects even when it is inconsistent with authoritative written texts like the DSM and ICD. As such, the power of the language derived from psychiatric expertise remains unchecked and unaccountable even within the psychiatric profession's own standards. The consequences of this non-diagnostic diagnosis were grave in this instance, where the child was pressured to take neuroleptic drugs, suffered side-effects as well as rebound-effects and was fearful of the potential of losing his identity in the process. This particular child was discharged after over 1.5 years of treatment, when it was disclosed that his distress was related to his sexuality and fears in relation to coming-out as being gay. In the end, his distress was in no way related to having alternate experiences of reality, often pathologized as "psychotic," but instead related to the pressures in society relating to adolescent sexuality, homophobia and heterosexism. Upon discharge, the psychiatrist deemed him 'not mentally ill', however it is not likely that this subsequent pronouncement of 'healthiness' in anyway eliminated the experience of sanism for him, which is coupled with being an ex-patient or current patient. This exemplifies Sedgwick's (1994) claim that despite the removal of 'homosexuality' from the DSM, queer young people in particular remain in danger of experiencing the different layers of violence associated with psychiatric norms.

Important to note, in addition to the targeting of young queer bodies within psychiatry, the ongoing targeting and psychiatrization of trans bodies through the diagnosis of 'gender dysphoria' in the DSM, remains a blatant example of psychiatric violence through diagnosis

(Diamond & Kirby, 2014; Tosh, 2013). In order to obtain what is experienced by many as life-saving treatments (Withers, 2014), trans bodies and minds must first be read - and cited by a psychiatrist - as mentally ill. In relation to some intersexed children, the probing and touching of their bodies in unwanted and often painful ways may even occur in the process of imposing gender assignments that may neither be requested nor desired by the children themselves (Tosh, 2013).

Given the definition of child psychopathology as normal child development gone awry, the goal prescribed for the recovery of psychiatrized children is to develop the rational state of being that is defined by, and embodied by, white middle class men (Burman, 2008). Although the children in this study were White British, the psychiatric performance of 'good mental health' demanded of racialized and Indigenous children within psychiatry may be far more removed from their lived cultural reality. Arguably, the sanitizing effects of 'successful treatment' may be more readily achievable by psychiatrized middle-class white boys (LeFrançois, 2013), perhaps leaving psychiatrized racialized poor girls, for example, doomed to experience the neo-colonial violence of psychiatry for a much longer time, and sometimes even indefinitely. Given the widespread intergenerational trauma experienced by Aboriginal peoples, the authorized treatment for any resulting distress plays firmly in the hands of the current genocidal project, perhaps the most pernicious of the various hidden forms of psychiatric violence.

Abjection

When asked what they feared the most, North Americans rated 'mental illness' second only to leprosy (Reupert & Maybery, 2007). This readily brings to mind notions of fear, loathing, disgust and horror associated with the disfiguring disease afflicting people previously excluded from society and placed within leprosy colonies. Does the thought of 'mental illness' produce such similar sense of horror and abjection amongst those who have escaped psychiatrization?

Kristeva's (1982) concept of the abject and abjection may be instructive here, given that the abject may be understood as those who deviate radically from the norm. Abjection is the response to those deemed abject and is a state formed by dehumanizing practices. The abject is understood as "disgusting and irresistible", as "outraging and fascinating" (Holmes et al, 2006, p.308). Abjection not only plays a crucial role in constituting subjectivities, it also creates a space of opposition to the norm, a space where one eludes the strict demands of ordered life.

In the Global North, people who are othered or deemed deviant in some way generally are faced with reactions of abjection, such as in the case of those diagnosed with leprosy or 'mental illness'. Holmes et al (2006) explains that "what we usually find disgusting is a perceived threat of some sort to our bodily or self-integrity, and central to this feeling of disgust is the sense that our boundaries have been transgressed" (p.311). This makes psychiatrization frightening to those who self-identify as 'sane'. It may be the fear of being engulfed by the abject, and being deemed abject as well; fears embodied in the 'other' which ultimately leads to feelings of contempt toward the abject. Those who are deemed 'mentally ill' are seen as transgressing the dominant cultural definition (read: white, male, adult, middle-class, sane

definition) of rationality. In terms of specific diagnoses given to children, we can see how experiences which have been labelled conduct disorder or oppositional defiant disorder, for example, are seen as transgressing the norms of 'proper' (read: white middle class) conduct. We see how children who refuse to behave in ways that are strictly controlled - and comfortable for adults - are both psychiatrized and deemed abject. That is, those children who are perceived as a threat to the bodily and moral integrity of white adult male cultural norms are feared and othered in a manner that serves to reinstate control through psychiatrization.

Abjection is performed by individuals and groups in a way that excludes marginalized people in society. Social norms are secured via the existence of the abject. Abjection is a force that intends to annihilate but instead renders into an othered state that remains visible in its grotesqueness; a visible warning of the importance of social norms and the fate of those who deviate. This visibility may become more pronounced over time, from the side effects of psychiatric drugs such as involuntary movement of muscles, tardive dyskinesia, akathisia, dystonia and Parkinsonism (Nasrallah, 2003) and even shaking (and other withdrawal symptoms) in newborn babies who were exposed during pregnancy (Health Canada, 2011), amongst others. Given the association between psychiatric diagnosis and sanist practice in relation to exclusion from employment and social life, the effects of poverty also serve to make visible those made abject through psychiatrization. Children in the psychiatric system, however, are mostly tied to their parents' economic situation and, as such, are not as likely to be made visible through the 'mental illness'/poverty connection. However, the children in this study described a variety of side effects from drugging, such as lethargy, insomnia, fatigue, shaking, nausea, hyperactivity, feeling 'high', inability to react emotionally, inability to react verbally, inability to concentrate, feeling 'dopey', feeling unprovoked anger and agitation. These drug effects are quite visible, and yet they are generally perceived as being associated with 'illness' rather than the effects of 'treatment'.

Psychiatrized Abjection

Although Kristeva (1982) denies that the concept of abjection relates to what she refers to as "neurotics and psychotics" (p. 6-7), we understand it nonetheless as a process that is done to distressed (or distressing) people as a result of psychiatric discourse, with normativity playing an instrumental role within this disciplining process. It is a sociopolitical process that serves to exclude, to other, to make queer, and to make abject. As such, the concept of abjection may explain the political and structural foundations of experiences of social inclusion and exclusion.

Within psychiatry, the act of diagnosis – an act that points to deviations from the norm of 'mental health' – marginalizes people through psychiatrization via a normative process that renders abject those deemed outside the norm. As such, psychiatrized abjection may be understood as the process of rendering abject through psychiatric diagnosis; psychiatric abjection is the result of the crafting of subjectivities that takes place within psychiatrization and the subsequent objectification of psychiatrized bodies. Together child psychiatry and the act of diagnosis represent an attempt to take control of children's bodies and their individual thought patterns. The children in this study may be seen as abject in that they are held as objects of pity, fear and loathing within the dominant culture. Indeed, Holmes et al (2006) found that nurses in psychiatric hospitals often portray their patients as "perverse, dangerous, and monstrous" (p.

305). If abjection may be described as a force that "strips people of their human dignity and reproduces them as dehumanised waste, the dregs and refuse of social life" (Tylor, 2009, p.87), then psychiatrized abjection is a particular form of that process relating specifically to those children and adults who are seen to fall outside of the imaginary normative ideal of 'sane'. This concept of abjection may explain the political and structural foundations of experiences of inclusion and exclusion as well as the intersecting experiences of sanism and adultism in relation to psychiatrized children. However, "queer theory argues that there is beauty, power, and truth, even magic where dominant culture and its authorized language posit only ugliness, impotence, and falsehood" (Greene, 1996, p. 326). In this way, the abject body is not reified within queer theory but instead is lifted to the realm of desirable. This is achieved by not only recognizing the political limitations but by also acting upon the political possibilities of life on the margins, through the de-centering project of queer theory. However, given the social and political consequences of abjection in mainstream society, Tyler (2009, p.77) cautions that the use of Julia Kristeva's theory of abjection may reproduce "histories of violent disgust" toward those rendered .abject. Instead, subjectivities should be theorized based on a vigorous contestation of the marginalizing, dehumanizing and horrifying effects of abjection. In that vein, this article strives to challenge the cultural production of psychiatrized children as abject rather than to reproduce them as beings that naturally must be despised and viewed as monstrous. Rather, it is the act of diagnosing - a social and political act - that not only renders abject but may often produce unlivable consequences for people who fall prey to the normative binary practice of psychiatry. In this article, we expose the ways in which diagnosis within child psychiatry renders abject, with a view to challenging or subverting the disciplinary norms that frame the dominant biomedical representations of the sanity/insanity binary.

We must stress that psychiatrized children are not inherently abject but are made so via the actions of the diagnosing psychiatrist. However, children are also not vulnerable passive victims in this dynamic but instead are active agents within the process of diagnosis and the performance of 'mental illness'. They are also capable of engaging in individual and collective resistance against the forces of psychiatry (LeFrançois, 2010), as are psychiatrized adults. However, the process of abjection is formed by acts that intend to stop psychiatrized people from exerting their abilities to act as independent subjects. Resistance requires a refusal to accept their constitution as 'abject object' (Tyler, 2009). This refusal has been evident over the past several decades with psychiatrized adults from many different countries from the Global North and the Global South, engaging in collective resistance against psychiatry within the psychiatric survivor movement and the Mad movement. Indeed, a widespread global activist movement of resistance has formed but has yet to garner mainstream acceptance or understanding. As such, we suggest that there is a need to articulate against psychiatrized abjection in the field of the sociology of diagnosis.

Performance

Butler's (1997) notion of *gender performativity*, adapted from Derrida's (1982) and Austin's (1962) linguistic theorizing of performative utterances, offers a useful concept for understanding how diagnostic categories are reified through citation and repetitive actions. Her notion of gender performativity determines that even though gender constructs are naturalized and commonly accepted as truth that in fact there are no *real* genders. Butler (1990)

demonstrates that gender is constantly evolving and changing and that there is no stable reference point for defining what constitutes *real* gender. Whilst people are perpetually trying to live up to the ideals of normative gender, it is in fact their performance of gender itself that produces, reproduces and maintains gender constructs (Wilchins, 2004). The same analysis can be applied to the mental health/mental illness binary. There is no *real* state of mental health or mental illness. This is clear from an examination of the evolution of psychiatric diagnoses. An individual with a specific subject position in a specific cultural and historical context acting in one way will be named as mentally ill, whilst another person with a different subject position or cultural or historical context acting in the same way will not be. There are countless examples of how mental illness is constructed differently across cultural and historical contexts and applied in different ways depending on the individual's subject position (Watters, 2010). Yet, at any given time, individuals imagine what it means to be normal or mentally healthy, based on ideals that are constructed through naturalized truths emerging from modernist discourse. In actuality, these ideals are only *truth-effects* of modernist knowledge. This means that through the citation of an inaugurating authority and subsequent repetition of claims, these ideals have become solidified as 'truth', and individuals in the Global North have stopped questioning the validity of these claims, even when there is little evidence to support them (Sullivan, 2003). This production of white psychiatric knowledge paternalistically serves to negate Indigenous, cultural and/or spiritual understandings of trauma and distress and invalidates alternative healing practices in the Global South as well as within Aboriginal communities in the Global North.

Diagnoses generally are derived from the classification and grouping of characteristic symptoms of a particular disease, disorder, or illness. The two dominant classification systems in psychiatry are the DSM, which historically has been widely used in North America but has now gained recognition worldwide, and the ICD, which has its roots in Europe and is slowly being implemented in other countries around the world. These texts represent the authoritative knowledge, or the naturalizing truths developed by the powerful institution of psychiatry, from which diagnostic citations are legitimized and bolstered. Although most of the diagnoses in this study appear consistent with these dominant classification systems, when asked about symptoms, neither the children nor the consultant psychiatrist provided symptoms consistent with these formal biomedical approaches to understanding psychiatric disorders. That is, all of the children attributed their emotional, cognitive and behavioural experiences to being mentally ill after being diagnosed by the psychiatrist. Yet, both the psychiatrist and the children named numerous behaviours as 'symptoms' of disorder that were not otherwise cloaked in psychiatric discourse. The children described their experiences in feeling terms, such as being 'down', crying a lot, feeling 'stressed', being 'unhappy' and wanting 'to die' as well as concrete actions, such as cutting, over-dosing, not eating, over-exercising and washing their hands too much. The psychiatrist described many of the same experiences but also added judgmental descriptors such as being a 'drama queen', 'not in touch with reality', 'making stories up – fantasy and not reality stuff', 'disturbed behaviour', 'disturbing thought patterns', 'very strange young lady', 'very bizarre' or framing their 'mental illness' in relation to the practitioners' abilities to control them, for example: 'pushing boundaries', 'boss in groups about following the rules', 'difficult little boy to cope with', 'belligerent', 'pushing the limits', 'very resistant – wouldn't engage'. Additionally, the psychiatrist framed some of the children's symptoms in protectionist terms, such as "s/he doesn't feel safe" or "s/he is vulnerable". In some respects, the psychiatrist appeared to be discrediting the children's thoughts and behaviour by dismissing them as

'childish' or outside the social norm in some colloquial way rather than adhering to criteria and symptomatology noted within the diagnostic texts. Some of these descriptors may be associated with queerness, for example 'drama queen' and 'very strange young lady', where the children were ridiculed and pathologized as odd/queer. Here the children are given attributes that exist outside of the normative notion of the 'ideal child' whilst being exposed by psychiatric authority as odd. Within but a short phrase, they become deemed both queer and sick.

Although the characterization of these experiences was clearly outside of the official diagnostic criteria, the psychiatrist named them as symptoms. Given the power of the psychiatric profession and the power of language, the mere utterance of these characterizations from a psychiatrist lent them immediate authority, thus underscoring the power of citationality from an authority, whether touting the 'party line' as set out in the DSM/ICD or not. As these feelings, actions and judgments were continuously reified as 'symptoms,' they became part of the performance of mental illness that in turn proved their mentally ill status. The psychiatrist did not maintain a strict usage of biomedical discourse in his description of psychiatric symptoms, but his alignment with the institution of psychiatry rendered his words as powerful tools in proclaiming abnormality and crafting the abject. If the children had resisted the mental illness construct, the psychiatrist would have likely named this as a symptom of their illness, turning resistance into part of the performance, as was done whenever the children resisted certain treatments, such as psychiatric drugs or group work. Compliance, on the other hand, was viewed positively, moving the children one step closer to meeting the imaginary ideal of 'mental health", and one step closer to living a 'normal' life - or perhaps a sanitized white middle class life - outside of the institution.

This process can be understood using Austin's (1962) and Derrida's (1982) notion of citationality as well as Butler's (1997) concept of performatives, which together demonstrate how certain types of speech in the realm of psychiatry wield significant power to perform social acts. For example, when a psychiatrist declares that a person is a schizophrenic and does not have the ability to make decisions for herself, an involuntary mental patient is born; whereas if an individual who is incarcerated in a psychiatric hospital declares her psychiatrist as delusional and violent, there will be no significant consequence. Even though 'mental health' and 'mental illness' are not natural facts, these categories are made real through citation from an authority, repetition and performatives; and, the impact that these categories have on all of our lives is very real.

Discipline

In institutional contexts, people are under the direct gaze of authorities who are monitoring their behaviours and judging them as normal/abnormal. Diagnosis can be viewed as one form of discipline that is employed when people deviate from how psychiatrists imagine they should be and where their experiences and behaviours are often attributed to the severity of their 'mental illness'. Many physical forms of discipline are also used and justified through psychiatric ideology, such as drugs, electroshock, physical restraints and the limiting of rights and freedoms. These disciplinary measures are routinely said to be for the protection of the individual or others around them. Often, the only way to (re)gain one's rights and freedom is to conform to what authorities' judge as desirable behaviour. Once individuals have demonstrated

that they have internalized how they are supposed to be in the world, they might be released, often under the condition that they will continue to comply with treatment on the outside. As such, people who have been incarcerated in psychiatric hospitals tend to learn how to perform the various roles of 'mental patient', including which performance is required in order to be discharged (Johnstone, 2000).

The context of the present study was similar to other institutional settings. Within the institution, the children were diagnosed as mentally ill, their experiences were reduced to symptoms of their illness, and the psychiatrist would often frame symptoms through the use of language that pointed to discourses of 'safety', 'boundaries' and protectionism. The interplay of these various discourses justified intrusive interventions, such as forced drugging, forced feeding, heightened observation levels, adherence to a tightly knit and rigid routine, limited or complete lack of privacy, forced participation in group work, the limiting or denial of common privileges such as weekend leave, threatening involuntary detainment and other rights abuses. The only way the children could escape the institution was through conforming to the psychiatrist's expectations of how they should be behaving; that is, engaging in the 'right' performance. However, there appeared to be conflicting psychiatric expectations between children becoming 'normal' and 'healthy' and ensuring that they continue to play the patient role, reifying their 'mental illness'. This confusion may be best explained by the words of one of the children shortly after being discharged for 'noncompliance':

> *I don't know really. Maybe they want you to be mental all the time, you know, down, but you know, like when I was happy and that, more towards the end, they always had a go at me when I laughed and that. I said: 'You can't win in this place. If you're down it's not right and if you're happy it's not right'. I said: 'Obviously there is something wrong with this place'.* [Kimberly, age 14].

In this way, the children sometimes felt caught between what is an acceptable role to perform. Being incarcerated in a psychiatric hospital and having a diagnosis such as depression, as in the case of the child quoted above, implies that there is something 'unhealthy', 'abnormal', 'wrong' with the child. Working toward improving one's circumstances by performing wellness is then seen by the practitioners as the child behaving inappropriately and outside of the patient role, as defined by the diagnosis. Even if increased confidence and improved mood was part of the treatment goal, some children felt that its attainment was discouraged by the practitioners. This may be the case, as children moving beyond the patient role and no longer performing their diagnoses may reduce the practitioners' ability to exercise control over them and maintain the status differentials of 'sane adult practitioner'/ 'insane child patient'.

Although the children learned which performances were acceptable within the space of psychiatric institutionalization, the role characterized by psychiatry as 'normal' remained a point of tension as much as it was an envisioned goal. In evaluating their ongoing functioning, the manageability of the children – the extent to which they listened to practitioners, followed written and unwritten rules and complied with treatment – were equated with symptomatology, with those who were more easily controlled deemed as healthier than those who resisted the control of institutional and practitioner power. This links very clearly to Ingleby's (1974) suggestion that children's functioning is "a product of the political system – the totality of power

relations" (p. 298) rather than being biologically (or bio-chemically or genetically) determined. In the end, children's psychiatric labels appear to be more strongly related to the (white) adult tailored need to over-power and regulate behaviour rather than to actual lived experiences. Thus, the concept of performatives expands upon the well documented 'patient role' performed within psychiatric institutions (see, for example, Goffman, 1961; Johnstone, 2000), by uncovering the ways in which psychiatrized children (and adults) may engage in this performance based on their socially constructed subjectivities as 'mentally ill' as well as based on resistance and agency. That is, at times performance, and resistance to the imposed normative performances of 'mental illness', demonstrate both children's agency as well as the attempt by psychiatry to thwart agency. In effect, psychiatrized children may inadvertently perform their diagnosis as expected and constructed for them, or they may demonstrate agency by either resisting the performance through refusal to play along or by purposefully performing their diagnosis in order to meet some political ends within the relations of power in which they are embedded.

Authority is given to the psychiatric label based on the objective process of scientific classification (Frank, 1995). However, as has been revealed in a rare public display of abuse of power, when pushed, psychiatrists may admit that the naming of symptoms and diagnostic practice is actually subjective. For example, as relayed in the Zlomislic (2010) news article, a psychiatrist working at a child psychiatry inpatient facility in Canada, noted that the appeal board, which specializes in child psychiatry, may not come to the same conclusions as the diagnosing psychiatrist because "(h)ow they interpret the information is subject to their own attitudes and philosophies". Moreover, symptoms do not always match diagnostic categories, as in the case where "moderately eccentric interest in origami and the study of bugs" was used as evidence of psychopathology by the diagnosing psychiatrist. In addition, it appears as though appeals by children may be successful at demonstrating lack of need for detainment within this institution, where in the eleven cases that went to an appeal hearing, seven children were released. However, these issues and the information they are based on rarely make it into the public domain worldwide and hence child psychiatry largely remains unaccountable. The subjective nature of diagnosis and symptomatology (based on differing "attitudes and philosophies" within child psychiatry) points to the notion within queer theory that objectivity/subjectivity is a binary in which one cannot exist without the other; and, that the imposing of objective truths, through practices such as diagnosis, is presupposed by subjectivity.

Foucault (1978) argues that the policing that happens within prisons and psychiatric hospitals reaches far beyond the walls of institutions. He explains how control through fear of punishment has in some instances been substituted for control through fear of being abnormal. The fear of being labelled as abnormal and deemed abject compels people to self-monitor even when they are not under the gaze of psychiatrists or prison guards in order to meet their perceived standard of what is normal. Foucault (1978) views this as the creation of what he calls 'docile bodies' or conforming individuals with an internalized sense of social norms. The fear of being found out as 'crazy' and the self-regulation that accompanies this fear is widespread, particularly as psy-discourses (Rose, 1999) are being popularized far beyond the realm of those directly involved with the psy-disciplines, as tabloids, news reports, and a proliferation of tests encouraging the public to self-screen for mental illness are defining for people what their experiences should be in order to meet some imaginary standard of sanity (Voronka, 2008). Those who are labelled and institutionalized have become, through psychiatrized abjection, a

marker for others, reminding them of what could happen if they fail to perform 'normal' according to the ideological role prescribed for them within dominant white culture. Incorporating this Foucauldian notion of discipline, queer theorizing thus enables us to extend upon the concept of social control and institutionalization (Goffman, 1961, 1963) within the sociology of diagnosis.

Hence, in relation to psychiatric treatment, the act of diagnosis is a dominant normative practice that produces multiple subjectivities and points to the inherent ways in which, for instance, those children who do not conform to the developmental norms that represent the 'ideal child' are rendered as abnormal and subjected to intense scrutiny and control. That is, those who are unable to conform or refuse to conform to cultural norms, or who are caught in another state system that pathologizes nearly all children (for example, within foster care) are deviations, strange, abject or 'queer' (Butler, 1993). As such, a queer theory informed critical sociology of diagnosis is a subversive anti-oppressive project aimed to disrupt sanism (Perlin 2004, 2003; Poole et al. 2012) and normative psychiatric practice.

Consequences of Diagnosis

The aetiology of the distress experienced by the children was characterized by both the children and the diagnosing psychiatrist as environmental. That is, both the children and the diagnosing psychiatrist indicated that issues relating to family, school and/or social isolation were the initial causes of their distress. Regardless, the diagnosing psychiatrist prescribed medication for all of the children, with some taking a cocktail of several types of psychotropic drugs. It is difficult to comprehend why the distress known by the psychiatrist to be caused by environmental issues, would be treated primarily with a bio-chemical treatment rather than focusing on social solutions. There is a clear mismatch between the diagnosing psychiatrists' understanding of the environmental aetiology of the children's distress and the prescribed treatment. However, given that psychiatry is firmly rooted within the medical model, there is generally a focus on bio-chemical and genetic causes of distress. This notion that genetics and bio-chemical imbalances cause mental illness is a theory that has not been supported by scientific inquiry. It should be noted that psychiatrists' use of the medical model is sometimes complex, where there may be a realization of the inappropriateness of the model but it is nonetheless used and rarely criticized from within the profession[4]. This widespread medicalization of distressing feelings and behaviour has led to the use of pharmaceutical remedies (Jutel, 2009) as the preferred treatment within child psychiatry. As a result, the children experienced a wide range of side-effects associated with these drugs, which they described as including lethargy, sleepiness, inability to sleep, physical shaking, nausea, hyperactivity, feeling 'high', inability to react emotionally, inability to react verbally, inability to concentrate, feeling 'dopey', feeling unprovoked anger and agitation.

In addition to these consequences of drugging, we suggest that the ultimate and most devastating consequence of diagnosis is the state of psychiatrized abjection. Children are not

[4] There are some exceptions to this, including the work conducted by psychiatrists who are more openly critical of their profession such as Peter Breggin, Duncan Double, Joanna Moncrieff, Thomas Szasz, Philip Thomas, and Sami Timimi, to name a few.

vulnerable victims; they actively resist psychiatrization in multiple ways on a daily basis at individual levels and are capable of resisting at collective levels. However, they are nonetheless living within an abject space where they are feared and loathed, where their social status is lower than the lowest, where their participation in society is limited, where they are socially isolated and excluded and where they experience the limitless horrors associated with treatment such as forced drugging, forced feeding, restraint and electroshock. It is this lived experience of psychiatrized abjection that is important to document and link to the sociopolitical structures that produce and maintain it as well as to work toward the social and political solutions to psychiatrized abjection.

Queer Performativity of Madness

Rather than questioning whether 'queer' is about 'being' or 'doing', Burgwinkle (2006) asks: "Is 'race' or 'madness' implicated in 'queer' as a category already marked as *hors-norme*?" (p.85). We suggest not only that they are but that this requires fuller analysis from *within* the Mad community. To date, when 'madness' has been addressed by (sane-identified) queer theorists – most usually in passing - it has been disappointingly individualized, essentialized, and/or, othered as 'non-knowledge' or an 'absent space'; a performance that quietly cries in support of the *status quo ante bellum*, which even some queer theorists may have had trouble noticing or troubling. That is, although queer theorists focus on reading texts with the overt intent to question essentializing notions and to unwrap and expose normalizing assumptions, the pervasiveness of psychiatric discourse is demonstrated by the oversight of those who have failed to adequately recognize and subvert such sanism within their queer readings of madness.

Despite the long history of the pathologizing of (male) 'homosexuality', and the resulting defensive resistance to the pairing of queer and mad within queer politics, Rowe and Chavez (2011) acknowledge "the possibility for a subversive understanding of certain performative constitutions of madness" (p.2). Although Rowe & Chavez (2011) approach this deconstruction of the queer performativity of madness, or the discourse of critical madness (Schlichter, 2003), in a manner that recognizes the structural oppression and trauma associated with madness, it nonetheless appears to rest firmly outside of Mad politics with their unchecked acceptance of the health/illness binary and what they refer to as "legitimate struggles with mental illness" (Rowe & Chavez, 2011, p. 9). We are nonetheless encouraged by this burgeoning attempt by feminist and queer theorists to deconstruct the prevailing discourse on madness, and to acknowledge, to some extent at least, the agentic queerness of psychiatrized people.

Conclusions

Like Bendelow (2004), we are not denying the existence of the particular thoughts, feelings or actions that these children and those in their environment may have experienced as distressing. Instead, we argue that diagnoses, which inform subjectivities, falsely medicalize experiences, and fabricate 'abnormal' categories through a normative process, rendering children abject and queer. The diagnosing of feelings, thoughts and actions, reframed as clusters of symptoms, provides a script from which patients may perform their 'mental illness' and from which all those associated with the psychiatric regime serve as active spectators who scrutinize the performances and serve as agents of social control. The sociopolitical ramifications of being

diagnosed, and hence being made abject, may be experienced as devastating with the immediate rise of structural barriers, social isolation, exclusion from employment, lack of meaningful participation in civic society, and lack of choice in treatment. Although this article has focused on research with psychiatrized White British children, we feel the same process is at work within adult psychiatry, certainly in the Global North and, increasingly in the Global South (Mills, 2014a; 2014b).

We applaud the call for new scholarship in the sociology of diagnosis (Jutel, 2009), particularly in the area of psychiatric diagnosis, given the arguments being forcefully espoused by some sociologists in favor of bio-medical psychiatry and the medicalization of distressed and distressing thoughts, feelings and behaviours. For instance, Bendelow's (2012) assertion that "people want to be medicalised" is best understood by deconstructing the subjectivities and performances that have given rise to it, which queer theory primes us to do. Bio-medical psychiatry, or an integrative bio-psycho-social approach that is dismissive of social constructionism, does not adequately allow us to understand the embedded issues but merely accepts this performance as 'truth'. This trend, promulgated by Bendelow (2012), may be challenged effectively with a subversive queer reading. That is, queer theorizing may provide avenues within the sociology of diagnosis and Mad Studies to expose the power, privilege and violence associated with such neoliberal pro-psychiatry maneuvering. In effect, such a subversive queer reading allows us to reclaim anti-oppressive and anti-sanist stances in relation to biomedicalism and the neo-liberal machine that reinforces it.

To understand diagnosis through a queer theory lens is to intimately engage our analyses and critical practice with the political world, to denaturalize the process, to question the mentally ill/sane dichotomy, to open up the potential for multiple interpretations of experience. Through queer theory, we challenge the very structures that produce and assert diagnostic 'truths' in psychiatry. Through queer theory, we disrupt the dominant and privileged perspective of biomedical psychiatry which ultimately leads to abjection for those people who are psychiatrized through the diagnosis and treatment of 'mental illness'.

Our application of queer theory here is not meant to bring us to a complete understanding of human experience, but rather offers a lens to help us deconstruct and resist normative practices that produce and reinforce oppressive social relationships. The current psychiatric paradigm prevents us from analysing human experience in all its complexity, and it is our hope that in using queer theory as a tool we can begin to open up possibilities for "bringing forth differences, complexities and ambiguities from the fertile place of not-knowing" (Diamond & Gillis, 2006, p. 227).

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