

EDITORIAL

Psychiatrised Children and their Rights: Starting the Conversation

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The rights of children diagnosed with psychiatric disorders are a neglected area in the field of childhood studies and the sociology of childhood. Although children's rights scholars have demonstrated a commitment to documenting, supporting and researching the needs of marginalised children through the discourse of multiple childhood(s), psychiatrised children have received relatively little attention within the academic literature in this area. The aims of this special issue are to work toward redressing this absence as well as to document some of the work that is being done in this area by children's rights researchers, theorists and advocates around the world.

In the UN Convention on the Rights of the Child, 1989 (CRC), articles 12 (the right to consultation), 13 (the right to information), 16 (the right to privacy and correspondence), 19 (the right to be free of mental or physical violence within institutions), 22 (the rights of refugee children), 23 (the dissemination of treatment approaches internationally), 25 (the right to have treatment reviewed), 31 (the right to rest and leisure), 37 (the rights of detained children) and, 42 (the right to know about their rights), amongst others, are directly and indirectly relevant to children who are involved with mental health services. And yet, we know that children's participation rights are ignored or are applied in tokenistic fashion (LeFrançois, 2007), to varying degrees, within different countries within the Global North. Emphasis on the 'best interest principle' within children's services has become an institutional tool to control children and limit their direct involvement in decision making regarding their treatment and care (Coppock, 2002). The culture of care within child psychiatry with its biomedical focus, sanctions forced restrictions and the oppressive control of children (Coppock 1997; 2002), with the use of drugs, restraint, solitary confinement and electroshock which Baker (1995) has referred to as legalised clinical violence. In addition, in the UK, there is some evidence that children's right to privacy is seriously curtailed within psychiatric inpatient units (LeFrançois, 2007). Moreover, characteristic of total institutions (Goffman, 1961), tight-knit schedules designed to control children but camouflaged as treatment dramatically reduces or completely eliminates children's rights to rest and leisure time. In fact, some children

have described inpatient psychiatric treatment in the UK as a form of 'mental torture' (LeFrançois, 2008).

As guest editors, we aimed see these and other related issues addressed, so as to give a platform for the discussion of psychiatrised children within children's rights circles. We deliberately use the term 'psychiatrised children' rather than the 'mentally ill child' in order to politicise the assumptions relating to children who have been diagnosed within mental health services and to avoid the health/illness binary that is inherent to biomedical psychiatry. Furthermore, the adjective 'psychiatrised' (a term which has a long history of being used by adult psychiatric survivors and politicised service users) denotes that something has been done to the children rather than seeing their distress as natural and internal to the children themselves. This mimics the language used in critical race theory where 'racialised' bodies are seen as produced by white culture through racism (Razack, 1996). As in Fanon (1952) 'courageously' stating that "it is the racist who creates the inferiorized" (p.73), so too do we suggest that it is the sanist who constructs the psychiatrised, much as it is the adultist who constructs the notion of the (incompetent) child.

Although the concept of adultism (LeFrançois, 2013a) is not new to childhood studies scholars, the concept of sanism (Fabris, 2011; Perlin, 2003; Poole and others, 2012) may be, particularly given the lack of attention given to the oppressive experiences of psychiatrised children. Sanism may include individual experiences of discrimination, violence and stereotyping. It may also include systemic oppression such as the ways in which the institution of psychiatry limits or denies explanations of experiences outside of biomedicalism (Poole and others, 2012), the systematic subjugation of psychiatrised people (Perlin, 2003) and their exclusion from social life (Burstow, 2003). In addition, sanism points to a form of socially and culturally entrenched epistemic violence that on some level denies personhood (Liegghio, 2013) and certainly denies psychiatrised children as 'knowers'. As such, sanism helps us to understand the oppression that may be faced by children diagnosed with 'mental illness', and the very naming of sanism helps us to deconstruct assumptions regarding rationality, normalcy, madness, and the ways in which a range of human emotions, behaviours and thoughts are classified either narrowly or as part of a wide a spectrum of what it means to be human. Furthermore, the incompetence that may be attached to a child based on a negative mental health label and the incompetence that may be attached to a child based on age (as well as based on gender, racialisation and class) mutually constitute each other, allowing sanism to intersect with adultism and other

possible aspects of a child's disadvantaged and socially constructed identity to reinforce and reproduce notions of incompetence and inferiority.

With this in mind, we understand the psychiatrised child's alterity as the rational (white) adult man; that which has not been attained by the child and that which, for many children, cannot be attained. Although current work within the 'recovery movement' (see Morrow and Weisser, 2012; Poole, 2011 for a critique of 'recovery') suggests that people, including children, may be 'cured' of their 'mental illness', up until recently the child diagnosed as schizophrenic, for example, or classified with other psychotic disorders, has been socially constructed as 'incurably ill' and thus essentialised biologically as 'the schizophrenic child'. With the classic child development project of understanding children as in the process of developing rational adult male qualities, much in the same way that the colonial project depicts 'developing peoples' as 'progressing toward' white Western 'ideals' (Burman, 2008), psychiatrised children are seen within child psychopathology as those whose developmental course has gone awry. Although these discourses suggest that the un-developed, under-developed and/or wrongly developed are 'less-than', it bears mentioning that even the 'gifted' or hyper-rational child, who does not embody the 'average' (white) adult man's form of rationality, also may be psychiatrised through diagnoses such as 'Aspergers' and 'Autism Spectrum Disorder' or 'ADHD' and 'Obsessive Compulsive Disorder' (APA, 2013).

This leads us to pose a central question – if the standard (new) sociology of childhood accepts and attends to the notion of 'childhood' as a social construction, can the leap be made to understanding other aspects of children's identities as social constructions, including their 'mental health status' within childhood studies? Arguably, the theoretical conservatism that was broken down to understand 'childhood' as a social construction (James and Prout, 1997), should open the door to an evolving analysis of marginalised children's experiences of categorisation and inferiorisation, including those based on 'mental health status' through a deconstruction of the (seemingly benevolent) essentialising of children's rational, emotive and behavioural worlds. Perhaps we can learn from black feminist analyses (Andersen and Hill Collins, 2010; Crenshaw, 1991) in relation to how identities intersect, interlock and reinforce each other in ways in which inferior status is inscribed on, for our purposes here, the bodies of children and the subsequent oppression that is experienced by them.

With these notions in mind, the call for papers for this 2014 Special Issue of *Children and Society* generated several notable articles that make up this volume. Individually and collectively, they alert us to a range of important

issues in relation to sanism, psychiatrisation and the marginalization and oppression of children in the mental health system.

In their article, Yoke Rabaia, Rita Giacaman and Mahasin Saleh, demonstrate how the new emphasis on attending to Palestinian children's distress through trauma based psychosocial intervention obfuscates the source of their distress. They indicate that "(r)ather than considering social suffering an illness that needs to be 'cured', it is the collective and cumulative exposure to Israeli aggression and the international communities condoning of it that needs to be addressed. These are the root cause of their suffering" (p. 178, this volume). Indeed, with the call within article 23 of the CRC to import treatment options to the Global South, we see how biomedical psychiatry is being imposed in countries, such as Palestine, in a way that excludes cultural and historical understandings of the state violence that is causing distress in children (Rabaia and others, 2010, this volume). The distress experienced by these children may be codified in ways that individualises their distress and pathologises them rather than recognising the direct external source of their distress and finding political solutions such as 'treating' state violence (Burstow, 2003). These children are at risk of being subject to biomedical and psychosocial interventions which punish individual children whilst leaving oppressive socio-political arrangements intact (Rabaia and others, this volume; Rabaia and others, 2010). This imposition of treatment options, although sanctioned by the CRC, may be experienced as a form of psychiatric violence that negates culturally relevant healing practices within the Global South, mirroring detrimental colonialist actions (LeFrançois and Diamond, 2014; Mills, 2013). The same process may be at work within Aboriginal communities who are subject to white settler rule within countries in the Global North (LeFrançois, 2013b; Tam, 2013). Arguably, this is in conflict with children's rights to live within a culturally relevant context. And, as Rabaia and others explain, "(i)n mental health, what is understood in some cultures has no meaning in others. This is not an issue of finding the right word in translation, or semantics, it is about a way of being, of living, of reacting to stress and trauma..." (p. 179, this volume).

In addition, there is concern about the experiences of Muslim children living in the Global North who are subject to anti-terror / counter-insurgency laws and policies. As explained by Vicki Coppock and Mark McGovern in their article, "historical, theoretical and conceptual influences...shape and inform contemporary responses to young British Muslims who are constructed as 'outside of childhood' and thus a potential threat to the State" (p. 249, this volume). In this, they argue, "contemporary theorisations of the psychology of the 'would-be-terrorist' collide

powerfully with institutionalised discourses of childhood vulnerability” (p. 249, this volume). With specific reference to British counter-terrorist law and policy, these authors demonstrate how essentialised and racialised constructions of ‘childhood vulnerability’ are bolstered by ‘psychology of radicalisation’ discourse to facilitate pre-emptive, securitising State practices directed towards young British Muslims. They point to the development and application of positivistic ‘psy’ technologies in the screening and assessment tools now routinely used by practitioners to identify children and young people ‘at risk’ of ‘vulnerability to extremism’. Situating these practices within a powerful overarching protectionist discourse and the legislative framework of ‘children’s safeguarding’, Coppock and McGovern argue, provides “built-in resistance to questioning the legitimacy of enhanced state surveillance practices and interventions with young British Muslims” (p. 253, this volume). This article illustrates the contradictory relationship between the commitment of the British State to upholding and implementing children’s social and political rights (as a signatory to the CRC), whilst simultaneously pursuing policies and practices that constrain and undermine the social and political agency of British Muslim children and young people. Coppock and McGovern reveal how Muslim young people’s narratives of lived experience of social injustice or expressions of political dissent are positioned outside of ‘normal’ childhood and are therefore susceptible to reconstruction and pathologisation as indicative of potentially ‘dangerous minds’ in need of ‘treatment’ or ‘correction’. The authors conclude that these practices may serve to undermine, rather than ‘safeguard’ the mental health and wellbeing of many young British Muslims and caution non-Muslim practitioners to be wary of the potential for collusion in their oppression.

In line with the focus within childhood studies of listening to the views of children and young people, the very important issue of psychiatrised children’s agency is explored within both the article by Lauren Polvere, in the context of institutionalised youth, and the article by Geraldine Brady, in the context of the lived experience of ADHD diagnoses. Polvere interviewed youth who had been institutionalised in order to explore their agentic strategies in coping with oppressive practices within mental health services. She notes how the young people in her study demonstrated agency in their personal accounts of acts of resistance to oppressive practices. Such actions included complying with oppressive practices in order to avert further oppression and expedite discharge, as well as advocating for individual rights and collective rights through institutional reform. Similarly, the children in Brady’s study described taking responsibility for their well-being, engaging in decision-making in relation

to compliance (or non-compliance) and engaging in their own meaning-making in relation to their experiences of psychiatrisation. Crucially, Polvere notes that “the notion of agentic resistance presents an important challenge to dominant clinical perspectives, which construct oppositional and problematic behaviour as a symptom of psychopathology” (p. 190, this volume), whereas Brady notes that “(t)he adoption of a biomedical framework contributes to pathologising children’s behaviour, as difficulties in learning and behaviour become characterised as a disorder/condition and children are regarded as incompetent, impulsive, irrational, incapable of being responsible” (p. 226, this volume). In both studies, we see how children and young people challenge notions that link incompetence with a negative mental health label through a demonstration of agentic behaviour.

In their article, Cheryl van Daalen-Smith, Simon Adam, Peter Breggin and Brenda LeFrançois challenge conventional psychiatric practices in relation to the administering of electroshock to children within mental health services. Calling for a global ban on the use of electroshock on children, van Daalen-Smith et al address not only the lack of scientific evidence of the enduring effectiveness of the procedure, but also demonstrate how the science behind the procedure involves purposefully provoking brain damage in the growing brains of children who are made to undergo the procedure. The issue of informed consent is raised in relation to the paucity of full information given to children who are mostly ‘voluntary’ or informal patients, and the lack of legislative safeguards to ensure their rights in the context of electroshock and psychiatric treatment more generally. Although electroshock may be billed as a procedure of last resort to be used at the discretion of medical professionals when all other forms of treatment have failed, van Daalen-Smith et al argue that “(t)he failure of psychiatric drugs, the persistent lack of upstream strategies, or compelling arguments that there are no alternatives, ought not to mean that children and young people are subjected to a procedure whose sole intent is to incapacitate and damage the brain” (p. 213, this volume). Instead, they argue that the precautionary principle should be used in this instance, whereby any procedure, such as electroshock, that has a risk (or intent) of causing harm to children, and in the absence of scientific consensus that it is harmful, the burden of proof that it is not harmful should rest on those prescribing and administering the procedure. In this way, the precautionary principle should trump presumptions of prudence, and should be deemed both in the best interest of children and consistent with child protection rights under the CRC.

Both the article by China Mills and the article by Peter Breggin deconstruct the problems, and abuses, associated with psychotropic drug use with

children, the former focusing on the imposition of pharmaceutical treatments in the Global South using a post-colonial lens, and the latter focusing on the Global North from the perspective of a psychiatrist who is compelled to critique his own profession. Breggin details the proliferation of psychiatric diagnoses given to children in the USA and surveys the research literature demonstrating the harmful iatrogenic effect of psychostimulants (prescribed for ADHD) and anti-psychotic drugs (prescribed for “Bipolar amongst other diagnoses). He notes that “(n)o long-term benefits for children of any kind has ever been demonstrated for any stimulant drug – no improved behaviour, no improved socialization skills, no improved academic skills, and no improved learning...(d)espite six decades of research...” (p. 233, this volume) and that these same “decades of research confirm the lack of efficacy of anti-psychotic drugs” (p. 234, this volume). He concludes that it is never ‘in the best interest’ of children to be exposed to psychiatric drugs. Mills takes up these arguments from critical psychiatrists in relation to the over-medicating of children in the Global North with psychiatric drugs and the iatrogenic harm they produce (Breggin, 1991; Breggin, this volume; Moncrieff, Rapley and Dillon, 2011; Timimi and Radcliffe, 2005) and denounces the neo-colonial project of the Global Mental Health (GMH) movement in imposing Western biomedical pharmaceutically-focused treatments in low and middle income countries. She notes:

This points to a strange irony at work in GMH; for as psychiatry is being increasingly criticized in many countries in the Global North, with some calling for a paradigm change (Bracken and others, 2012) due to its controversial evidence base (Summerfield, 2008), there are simultaneous calls to ‘scale up’ the same psychiatry globally. This is a story often omitted from the evidence base of GMH and yet one that haunts its push to scale up psychiatric treatments to children globally” (p. 195, this volume).

Taking the psychiatrisation of children in the Global South as her entry point, Mills details how biomedicalism and psychopharmacology has enabled (or imposed) a particular way of being - known as the ‘mentally ill child’ - whereby the construction of an essentialised “category called ‘children’” (p. 193-194, this volume) and the universalised understanding of distress as ‘illness’ combine in often devastating ways for those children who have not escaped psychiatrisation.

Taken together, the articles featured in this special issue go some way towards redressing the absence of literature on the rights of psychiatrised children in the field of childhood studies and the sociology of childhood

noted at the beginning of this editorial. However, whilst our authors have addressed many of the issues relevant to psychiatrised children globally, it is our hope that the volume will spur further interest amongst children's rights and childhood studies scholars in attending to a wider range of problems linked to the oppression of children within the mental health system.

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