

Queering Child and Adolescent Mental Health Services: The Subversion of Heteronormativity in Practice

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This article explores the exercise of heterosexist-infused power relations within a Child and Adolescent Mental Health Services (CAMHS) inpatient unit in the UK. The ways in which heterosexism may wield its power within CAMHS in conjunction with the support of sexism, adultism, classism and sanism are discussed. That is, this article contributes to the understanding and subverting of heteronormativity in practice. With this focus in mind, other forms of intersecting oppressions are detailed to highlight the role they play in both controlling young people and teaching them about the workings of patriarchy and social norms. The aim of the article is to contribute to the disruption of the heteronormativity inherent in the arrangements within CAMHS and the dominant normative practice that produces multiple subjectivities in this setting. © 2011 The Author(s). Children & Society © 2011 National Children's Bureau and Blackwell Publishing Limited.

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Introduction

Living as psychiatrised children, that is, as children categorised with a psychiatric diagnosis, may be definitive in terms of their experiences of childhood. However, structurally their status as 'mentally ill' and 'children' may be compounded further by other lived socially disadvantaged subjectivities, such as those based on sexuality, gender, class and racialisation. These socially disadvantaged subjectivities, as they are lived and experienced within an adolescent mental health inpatient unit, may both impact on and determine the children's overall socio-political position in society, in terms of institutional responses to their 'condition' and the power dynamics that characterise their relationships with adult professionals and the state. Based on an ethnographic study conducted within Child and Adolescent Mental Health Services (CAMHS) in the UK (LeFrançois, 2007a), this article explores the exercise and impact of heterosexist-infused power relations along with an analysis of the impact of multiple and intersecting subjectivities such as those based on age, psychiatrisation, gender and class location. The issue of racialisation is addressed in relation to the pervasiveness of whiteness within this institutional setting. Given that all children in the setting were white British, there are no direct examples in the data of the ways in which racism may impact on heteronormative practice with racialised queer young people. Although 'the emergent field of Black queer studies' may go some way in deepening our understanding of the lived experiences of racialised queer young people as it acknowledges 'that whenever we are speaking of race, we

are always already speaking about gender, sexuality, and class' (McBride, 2007, p. 442–443), so too can we say that whenever we are speaking about sexuality, gender and class, we are always already speaking about race, including the enveloping realm of whiteness.

Largely influenced by the writings of Judith Butler and Michel Foucault, queer theory provides a perspective that both interrogates social arrangements that create and reinforce oppressive socially disadvantaged subjectivities and enables resistance to the heteronormative knowledge and practices that are rarely examined within society (Lee and others, 2008). In the title of this article, the term 'queering' refers to the troubling or disrupting of implicit normative approaches to working with psychiatrised young people. Heteronormativity, 'the power of heterosexuality when it operates as a norm' (Chambers, 2007), in this instance relates to the inherent ways in which those young people who do not conform to the dominant norms that represent the 'ideal child' are rendered as abnormal and subjected to intense scrutiny and control. Those who are unable to conform or refuse to conform to cultural norms are deviations, strange or 'queer' (Butler, 1993). This wider definition of queer opens a space for the forming of allies, recognising commonality amongst differentness and engaging in subversive action in order to disrupt the uncontested normative practices that serve to further subjugate all those who live in contrast to the dominant idealised culture. As such, anyone who is not male, white, middle or upper class, adult, able-bodied, heterosexual and, I would include, sane may identify as queer. Regardless of the attractiveness of the potential inclusive nature of this concept, for the purposes of clarity the term queer throughout this article refers to people who identify as lesbian, gay, bisexual, two-spirited,¹ transsexual, transgender, genderqueer, transwomen, transmen, intersex, queer, questioning, men who have sex with men or women who have sex with women, unless otherwise stated.

The systematic abuse and oppression of queer people is an ongoing social problem (Daley and others, 2007). Discrimination is justified by the heteronormative views that queer people are inferior to heterosexuals (Concannon, 2008) and in perceptions that their behaviour is 'sick, sinful, perverse, unnatural, dangerous, contagious for children, shameful' (Van der Veen and others, 1998, p. 492). Issues of social exclusion, stigma, bullying, victimisation and lack of social support contribute to 'mental health problems' in queer people (Concannon, 2008; Daley and others, 2007; Hansen, 2007; Warwick and others, 2000). Moreover, there is a disproportionately higher rate of distress (Daley and others, 2007) and suicide (Consolacion and others, 2004; Hansen, 2007; Mayo, 2006; Scourfield and others, 2008) amongst queer young people than heterosexual young people. Heterosexual young people may also be victimised by heteronormative practices, particularly if they are mistakenly assumed to be queer (Van der Veen and others, 1998) or are labelled such in an attempt to oppress.

However, it would be wrong to group the children together as being oppressed merely in relation to sexuality. We are reminded that this would be 'destructive and fragmented' (Lorde, 2004, p. 558). Analysing children's multiple subjectivities brings to light differences as well as similarities in oppressive experiences. As such, class location, racialisation, gender, age and psychiatrisation may intersect with sexuality in young people's experiences of heterosexism. Addressing such intersectionality with a critical lens requires 'attending to diversity within social categories to interrogate how the categories depend on one another for meaning', conceptualising 'social categories as connoting hierarchies of privilege and power that structure social and material life' and looking 'for commonalities cutting across categories often viewed as deeply different' (Cole, 2009, p. 171). Examining the role privilege, disadvantage and social injustice plays may enable an understanding of the ways

that multiple subjectivities position people within complex power relations within the kyriarchy (Shussler Fiorenza, 2001). Although the intersectionality literature emphasises the importance of hierarchies of race, class, gender and sexuality (Andersen and Hill Collins, 2010; Crenshaw, 1991; McBride, 2007), this article adds psychiatrisation and age – and hence the practice of sanism (Perlin, 2003; LeFrançois, 2011) and adultism – as important categories of analysis within CAMHS. The denigration of children through normative conceptualisations based on sanism and adultism are problematic within inpatient child psychiatry (LeFrançois, 2007a) and should be deconstructed and subverted in research as well as practice. The overall aim of an intersectionality framework is to avoid an additive approach to understanding the impact of multiple subjectivities whilst accounting for complex permutations of interacting and simultaneous experiences of oppression (Daley and others, 2007).

Chambers (2007) argues that Judith Butler has built a ‘politics of subversion’ that aims to corrupt, undermine or pervert the workings and hence the effects of heteronormativity. However, rather than subversion taking on the form of planned external collective action to secure definite ends, subversive acts are by their very nature ‘incalculable’ and internal to the system. That is, its effects are unpredictable yet ‘subversion must come from *within* culture, history and discourse if it is to be politically efficacious ... the agency involved in a subversive act or a subversive reading appears from inside the system that it attempts to overturn’ (Chambers, 2007, p. 660). This understanding of subversion demands a development of actions that are subtle or nuanced rather than anarchic and which may involve ‘patient, repeated, local action’ (Chambers, 2007, p. 661). In relation to young people and psychiatric ‘care’, subversive acts may take the form of interrupting heteronormative practice by naming it, challenging it, undermining the norms from which it derives and/or linking it to regulation and social control within the daily life on the inpatient unit.

Method

This research consisted of an ethnography study in which I spent four months within an adolescent inpatient unit. The overall aims of the research were to explore the relations of power within the inpatient unit, to document the ways in which children’s participation rights were accorded in practice and to explore children’s experiences of distress and treatment from their standpoint. The overall findings are detailed elsewhere (LeFrançois, 2007a). The example of heterosexist practice relayed in this article comes from the intersecting interactions between the practitioners, two girls and one boy, which were derived from a range of data collection techniques including participant observation, analysis of patient files, informal conversations as well as individual and group interviews with practitioners and young people. At the time those data were collected relating to this situation, there were eight young people (aged 12–17; four boys and four girls) living in the inpatient unit, with several mental health nurses and support workers working in the setting as well as one off-site psychiatrist.

The method of data analysis involved using a grounded theory approach, along with participatory analysis with the young people when possible, mostly during the theoretical sampling phase (Glaser 1992). Field notes, patient files, internal policy documents and interviews were transcribed verbatim. Themes in the data were identified using thematic analysis, a constant comparative method (Glaser & Strauss 1967) and theoretical sensitivity.

Heteronormativity in practice

During the time the study was conducted, two girls experienced difficulties with the practitioners due to the peer support the girls provided each other in the form of physical affection. Several times daily, and over a period of a few weeks, the girls were repeatedly forced to stop holding hands with each other by the practitioners and their presumed sexuality became the open topic of scorn within the inpatient unit. The overt 'lesbian behaviour' the girls were exhibiting – holding hands and cuddling – was described by the practitioners as offensive and inappropriate for the other young people to witness, especially for the youngest of the boys. One of the girls explained during an individual interview, as follows:

With us today, they said it is inappropriate ... because it was two girls holding hands or something ... They're prejudice against lesbians ... They said it wasn't a very nice thing to do in front of boys ... and that _____(*young person*) is only twelve and it is not very nice for him to see, for us to cuddle and hold hands ... They know we're not (*lesbians*) ... They just don't like it. They don't want us to support each other. (as cited in LeFrançois, 2007a)

Regardless of the sexual orientation of these specific girls, this public admonishing served the function of relaying to the young people who were inpatients at the time that same-sex relationships are not the norm and should be avoided. Moreover, the girls' behaviour was deemed 'not very nice', leaving for interpretation that same sex relationships are disgusting and/or immoral. Presumably, the girls' behaviour is perceived by the practitioners as leading to the corruption of the morals of young boys, given the particular reference to the 12-year-old boy. This display of scorn also serves the function of informing/reminding the young people that female sexuality exists for the pleasure of men, and as such, boys should not witness girls loving each other. This information reinforces male hegemony and instructs the young people in the workings of patriarchy. For example:

Included in and crucial to men's right to rule over women is control of women's sexuality. Indeed, patriarchy depends on compulsory heterosexuality to ensure that men maintain power over women. (Livingston, 1996, p. 253)

We are reminded that within patriarchal society – and child psychiatry is a paternalistic institution par excellence (LeFrançois, 2007a) that may offer an intense microcosm of the larger patriarchal society – women are considered inferior and any act of female bonding is ultimately considered a risk to the effective control exerted over them (Pharr, 2004). By extension, being a lesbian is perceived as the ultimate threat to that paternalistic control. Lesbian baiting – labelling women and girls as lesbian whether they are or not – is designed to exert control where men feel they may be in jeopardy of losing the inherent control they believe they are entitled to. That is:

If lesbians are established as threats to the status quo, as outcasts who must be punished, homophobia can wield its power over all women through lesbian baiting. Lesbian baiting is an attempt to control women by labelling us as lesbians because our behaviour is not acceptable, that is, when we are being independent, going our own way ... being self-assertive, bonding with and loving the company of women ... insisting upon our own authority ... Lesbian baiting occurs when women are called lesbians because we resist male dominance and control. And it has little or nothing to do with one's sexual identity (Pharr, 2004, p. 269).

This notion is confirmed by the young girls not only in their insistence that their hand holding was about supporting each other in what they perceived as a cold environment but also because they felt the scorn was in reaction to the practitioners not wanting them to support each other. The girls felt it was more relevant to seek support from each other than to request one-to-one time with practitioners (LeFrançois, 2007a). Also, they felt quite strongly that the practitioners knew they were not lesbians. Women may be called lesbians for doing such things 'that threatens the status quo, anything that steps out of role, anything that doesn't indicate submission and subordination' (Pharr, 2004, p. 272). For the girls, stepping out of the patient role by seeking support from each other and showing a lack of dependence on the practitioners for support is a threat to the paternalistic approach to treatment (LeFrançois, 2006, 2007a,b, 2008) as well as male hegemony amongst practitioners. In this way, the girls transcended expectations based on their gender, age and psychiatrised status. This was a large step outside the line of acceptable behaviour demanded within the inpatient unit and the response in the form of lesbian baiting can only be understood as heterosexist, sexist, adultist as well as sanist.

Moreover, one of the girls in question had marked in her patient file by a nurse that she was 'sexually age-inappropriate'. In this way, her sexual behaviour was being monitored and documented as part of her psychiatric condition – or developmental psychopathology. As Michel Foucault informs us:

From the end of the eighteenth century to the present, the concept of 'precocious little girls' and 'children wise beyond their years' were considered pervert, delinquents and madmen. They began to be under close supervision. By the mid-nineteenth century the law deferred to medicine to manage the perverts. (Foucault, 2003, p. 310)

Moreover, he explains that:

(S)ince sexuality was a medical and medicalized object, one had to try to detect it – as a lesion, a dysfunction, or a symptom – in the depths of the organism, or on the surface of the skin, or among all signs of behaviour. (Foucault, 2003, p. 312)

The monitoring of the girl's sexuality as indicative of developmental psychopathology plays into the stereotypes rampant within the paternalistic history of psychiatry of the 'sexually provocative' and 'uncontrollably lustful' 'mad woman' who needs to be cured of her lack of modesty. As such, issues of sanism and adultism intersect with both sexism and heterosexism creating a discourse that renders the action of two girls holding hands as 'sick', 'unchild-like', 'immoral' and 'abnormal'. Moreover, underlying the very choice to construct the girls' behaviour as meriting monitoring represents an investment in whiteness. Cultural and religious stereotypes, historically and currently enmeshed within psychiatry has led to preoccupations with reforming white women and girls, whilst remaining less concerned with their racialised peers whose embodied sexual 'deviance' may be dismissed as a condition of their 'inferiorly developing race'. Links also may be made between the ways in which racialised adults from 'developing' countries are infantilised, are seen as intellectually immature and primitive, as well as being viewed as in a process toward developing 'superior' white adult norms in the same way that white children are understood to be undergoing such development (see, for example, Burman, 2008). Hence, the 'abnormality' of the girls' action is deemed to have crossed the norms of sexuality, age, gender as well as 'mental health' and whiteness.

Although the practitioners tolerated the holding of hands between heterosexual young people, such same sex behaviour was barred, ridiculed and subjected to scorn. In addition to this differential treatment, heterosexism was also displayed with regards to the attempts made by the psychiatrist to stop one of these girls from self-harming, as relayed in the following field note taken during a community meeting held with all the young people, one nurse and one support worker:

_____ (*young person*) mentioned at one point during the meeting that once a practitioner (*the psychiatrist*) told her that she would 'never get a husband with my arms like that, all full of scars from cutting myself ... She said: "There won't be a Prince Charming for you"'. Staff at the meeting did not comment on this nor did they acknowledge verbally or non-verbally that it was said. (as cited in LeFrançois, 2007a)

Shaming the girl for her scars and pointing out her lack of options to find a husband who will be attracted to her not only reinforces the notion that female beauty and sexuality exists merely for the pleasure of men (Pharr, 2004), it is inherently heterosexist in its assumption that she is not only attracted to boys but that she has spent some of her adolescence contemplating her desire and preparing to find a 'Prince Charming' to marry. Connecting physical beauty with heterosexuality and disconnecting the scarred body resulting from self-harming with heterosexuality creates a space – or perhaps a void – that determines the specific positioning of girls who self-harm within mental health services, whether they identify as queer or not. Moreover, rendering self-harming girls into the category of 'other' on many different levels – from the standard norms of gender, sexuality, development, and mental 'health' – may have a devastating impact on their experiences of distress. Regardless, the queering of her scars may be read as a politicised call to consciousness, as the girl made her distress within the inpatient unit undeniably material, thereby disrupting the simplistic normative equating of 'mental health' with an unmarked and hence sanitised white female body. Regardless, left in the message from the psychiatrist is the warning for this young girl, and all other girls present, that their femininity and outward 'beauty' has not escaped the medical gaze and hence is being monitored along with their mental health functioning to determine their 'normality', with the young girl in question falling largely in the category of 'abnormally developing being' (LeFrançois, 2007a: 99). Clearly, not only is the stigmatisation of the 'mentally ill' and 'mentally ill woman' deeply entrenched within psychiatry and society but also these comments demonstrate deeply entrenched sanism in relation to the psychiatrisation process of young girls. The lack of response from the practitioners at this community meeting serves to reinforce the notion that paternalist psychiatric treatment reigns supreme even within an interdisciplinary team, that heterosexist approaches to practice are acceptable and that the voicing of opinion and concern of the young person, regarding the offensive statements of the psychiatrist, is largely irrelevant (LeFrançois, 2007a). Indeed:

It is at puberty that the full force of society's pressure to conform to heterosexuality and prepare for marriage is brought to bear. Children know what we have taught them, and we have given clear messages that those who deviate from standard expectations are to be made to get back in line. The best controlling tactic at puberty is to be treated as an outsider, to be ostracized at a time when it feels most vital to be accepted. Those who are different must be made to suffer loss. (Pharr, 2004, p. 268)

Although all young people in the inpatient unit may be considered to deviate from the standard because of their experiences of mental distress, the young girl in question is made to

feel ostracised even from her peers in the inpatient unit both because of her overt scarring and because of her 'lesbian behaviour'. As such, the institution of psychiatry may be better understood as a kyriarchy (Shussler Fiorenza, 2001) offering an intense microcosm of the larger kyriarchal society, with its shifting hierarchy of power and privilege. This teaches the other deviant young people to 'get back in line' in terms of their sexuality and teaches the girls in particular to 'get back in line' in terms of their 'mental health' before their own self-harming leads to such greater 'losses' in terms of their prospects for marriage and lifelong happiness with their 'Prince Charming'. Prince Charming is iconic, symbolising the bastion of white cultural and class-based privilege, which is conjured up in the inpatient unit in the form of shaming, as an investment in maintaining social norms and hierarchies. Similar to other forms of ritualised scarification, such as tattooing, cutting is viewed as spoiling the original white female form, as it comes under the scrutiny of the male medicalised gaze.

During the time the research was conducted, there were no derogatory comments made by any of the practitioners regarding sexual diversity amongst boys. However, unbeknownst to anyone at the time the comments were repeatedly being made towards the girls in relation to 'lesbian' behaviour, there was a boy on the unit who was struggling with openly admitting his sexuality. Several months later,² when I was interviewing the psychiatrist regarding this boy and his repeated self-harming, suicide attempts and frequent readmissions after discharge, the following comments were made:

Uhm, he had a lot of individual psychotherapy and uhm in fact eventually disclosed that he saw himself as being gay. Uhm, and that, you know, seemed to be the turning point really. And, uhm, so he was discharged again ... So I think that was probably all about uhm this, you know, the sexual problem he had. Coming out with it, saying it, seemed to, I don't know but, whether you know, seemed to have helped an awful lot ... But I think, it seemed to be around around the fact that he saw himself as being gay and yet they were terribly sort of liberal parents, you know. It was a surprise, really, that it was such a struggle for him. But, it took an awful long time (*for him to come out*). (as cited in LeFrançois, 2007a)

Locating the distress inside the boy – with reference to 'the sexual problem he had' rather than to the problem society has accepting sexualities (Cole, 2009) – ignores the environmental aetiology of the distress experienced by so many queer young people. Although the psychiatrist gave some recognition of the impact of his environment, this was limited to the reaction of his parents. However, in indicating that the boy's parents are liberal, demonstrates a lack of awareness that being 'terribly liberal' does not necessarily equate with being accepting of difference (LeFrançois, 2007a; Mayo, 2006). Although for queer young people coming out to family represents one of the greatest fears (Warwick and others, 2000), other aspects of their environment can provoke as much fear due to bullying, prejudice, harassment and heterosexist attitudes, such as within schools (Concannon, 2008; Daley and others, 2007; Hansen, 2007, 2007; Mayo, 2006; Warwick and others, 2000), neighbourhoods (Warwick and others, 2000), rural communities (Herdt, 1998; Mule and others, 2009), homeless street culture (Milburn and others, 2006), interactions with police (Milburn and others, 2006), legal institutions (Concannon, 2008), medical institutions (Mayo, 2006), primary health care settings (Mule and others, 2009), social service settings (Daley and others, 2007) and mental health services (Warwick and others, 2000), which may force queer people into invisibility. In any context of their lives, queer young people may find it impossible to discuss their sexuality if sexual diversity is shown to be not valued or accepted (Warwick and others, 2000). Moreover, hostile environments may lead to the hiding of sexuality, which is correlated with

high rates of suicide and distress (Hansen, 2007). There was no reflection made by the psychiatrist regarding the level of acceptance within the inpatient unit and the impact that may have had on the 'awful long time' it took him to disclose his sexuality. However, we are reminded that:

For most lgb youths, the lesson is learned vicariously as they observe – whether consciously or peripherally – the penalties that such violations draw for openly lgb peers. It is a common reflection of young adults who are lesbian or gay that they maintained total secrecy ... because they knew what would happen to someone who came out (D'Augelli, 1996, p. 131)

The exercise of power over the girls, in the form of lesbian baiting, may have had a direct impact on the boy's level of comfort openly discussing his sexuality either within the inpatient group or within one-to-one therapy sessions (LeFrançois, 2007a). The public scorn shown to the girls served a social control function in its attempt to create a culture of manageable young people who comply with the ascribed behavioural norms. Punishments for deviant behaviour are made public so as to intensify the effects on the young people in question – such as humiliation – and to warn other young people of their possible fate if they too are deemed deviant. As such, the negative impact of the intersecting sexist and heterosexist elements of the exercise of power over the girls may have had a devastating impact on the boy, given his ongoing self-harming and suicide attempts within the inpatient unit. This is an example of the way in which sexism can harm everyone, men included.

Although feelings of distress, suicide attempts and self-harming brought the boy to the inpatient unit (via his parents), the lack of safety of the environment may have actually led to *increased* distress for him for some time prior to making his disclosure. It is not uncommon for gay boys to internalise the negative stereotypes they are surrounded with and to believe when they are told they are 'sick, bad and wrong' for being gay (Herdt, 1998, p. 295). The boy was told these things indirectly through the scornful comments made to the 'lesbian' girls. However, unlike the girls who were confronted with lesbian baiting because of their display of independence and defiance of the unwritten rules around not engaging in peer support (LeFrançois, 2007a), the boy was congratulated for eventually confessing his sexual identity to a male support worker, thereby showing an adequate amount of dependence and subservience to the (male) practitioners, the adults and ultimately the paternalistic institution of psychiatry.

The overall acceptance of the boy's private disclosure contrasts markedly with the scorn shown to the girls' public display of physical affection. In addition to his display of deference to institutional authority, this acceptance may be due to class location and the public/private nature of the display of forbidden sexualities. The two girls were working class whereas the boy was described in very positive terms by the psychiatrist as belonging to a privileged class location. It is conceivable that the boy was protected by his class location, with his private disclosure reinforcing class-based behavioural expectations. Indeed, the issue of class-based behavioural norms is intertwined with the emphasis in white culture of admiring upper-class imperialist ideals. This notion of whiteness is reflected with his queerness coming under the *private* gaze of medical experts before he is handed back to the fold of life that has been laid out for him via his 'liberal' or, perhaps more accurately termed 'inherently socially successful' parents. This process is an example of symbolic purification and the institutionally bartered citizenship (Foster, 2007) that is necessary in order to maintain the status associated with white class-based privilege. This is an example of the way in which racism,

in the form of white normativity, can harm everyone, white people included.³ However, I was unable to engage in an in-depth analysis of class-based power relations as the practitioners refused to discuss the issue of class, indicating that it is an offensive topic. Indeed, '(a)lthough issues relating to sexism, sexuality and racism were considered acceptable topics for discussion and analysis, it appears as though classism remains a taboo subject in this milieu' in the UK (LeFrançois, 2007a, p. 170; LeFrançois, 2007b). Why classism was unspeakable in this setting, compared with other lived socially disadvantaged subjectivities, is not known. However, it may be that classism represented a source of vulnerability amongst the practitioners – some of whom may have been working class – from their mostly privileged position of white, sane, able-bodied, adult, heterosexual and either male or female-embracing-the-paternalistic-male-model-of-practice⁴ (that is inherent to psychiatry). Drawing attention to class location may have been perceived by some of them as potentially weakening their authority and subjugating some of them from the idealised norm, thus noticeably rendering them into an 'othered' and perhaps 'unliveable' (Butler, 1993) position along with the child 'patients'.

The girls' continued acts of defiance, even after repeated admonishments and public ridicule, may be seen as their own form of subversion against the relations of power inherent within the psychiatric regime that limits self-expression and enforces a strict normative culture that renders those under its gaze as 'abnormal'. Their acts of resistance involved continuing to engage in what was labelled as inappropriate lesbian behaviour, naming the response of the practitioners as 'prejudice against lesbians' and linking the heteronormative talk to social control issues. Although both girls self-identified as heterosexual,⁵ they may readily identify as queer nonetheless, using the broader definition of 'queer', given their embodied multiple subjectivities as young working class mad girls who, within the system, patiently yet repeatedly targeted for subversion the offensive heteronormative practice that was directed at them. However, Butler's (1994, 1999) description of subversion as incalculable in its effects may illustrate this performance as a cautionary tale. That is, questions arise as to whether the girls' acts of subversion served to weaken heteronormative practice or whether it served to buttress the dominant position of heterosexuality (Lee and others, 2008). As Chambers (2007, p. 668) points out, to 'deviate from a norm is not necessarily to subvert it; indeed, norms depend for their survival on a certain percentage of deviant cases'. The girls' defiance may be seen as a site of resistance to the regulatory practices within the inpatient unit – a site of resistance that nonetheless reified heteronormativity given that one of the impacts of their actions was to teach the other inpatients to get in line if they want to experience life as liveable within the inpatient unit. The two straight girls 'played lesbian' or parodied the label and behaviours associated with it as a form of resistance that may or may not have served to subvert the heteronormative practice that gave rise to it.

Conclusion: implications for practice

Queer theory and the politics of subversion offer not strategies *per se* but an ungrounded plethora of possibilities (Chambers, 2007) for those working within and those living within CAMHS inpatient units to make visible and erode heteronormative practice. Although the effects of such action may not be predictable, it offers possibilities and opens an immediate space not only for queer 'patients' and queer practitioners to act but also opens a wider space for allies, such as all those 'patients' and practitioners that may self-identify as 'queer' by virtue of their own specific exclusion(s) from the idealised norm of male, white, middle or upper class, adult, able-bodied, heterosexual and sane. This may include spontaneous acts of:

explicitly naming the unspeakable (Butler, 1999); resisting normative and regulatory practices; deconstructing the workings and effects of heteronormativity (Chambers, 2007); pointing to the systems of power that produce the practice; revealing the 'institutional, cultural and legal norms that reify and entrench the normativity of heterosexuality' (Chambers, 2007, p. 665); exposing the ways in which heterosexual identities are rewarded and privileged; and finding ways to reshape practice – or rearrange the world – with the exclusion of norms and hierarchies (Butler, 2004). All these approaches involve demonstrating the existence of norms, which in and of itself may be subversive given that norms function best when they are hidden (Chambers, 2007). As such, the politics of the subversion of heteronormativity is a call to action, which may include an analysis of the intersection of multiple subjectivities in order to combat the normative structures that produce and maintain the binaries inherent within social injustices and privileges.

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Notes

1 The term two-spirited, derived from an Ojibwa term, is used amongst some indigenous people to identify those who are said to embody both a masculine and a feminine spirit. Traditionally, in many indigenous cultures, two-spirited people were revered, respected and sometimes feared. Over the past 20 years, this term has become (re)used as an identifier for many Aboriginal/First Nations queer people.

2 The boy's disclosure took place after I finished my fieldwork. I was informed about it because the consultant psychiatrist was only able to meet with me for an interview some months after the fieldwork had been completed. As such, I was precluded from speaking directly to the boy at that time.

3 Although the British imperialist project has been most devastating to indigenous and racialised people, particularly from the global south and 'America', arguably within British culture it has also had the impact of positioning white people 'from the colonies' as inferior as well as (re)producing complex power relations between white people from different class locations within the 'mother country'.

4 By embracing an approach to practice that is paternalistic, women practitioners immerse themselves uncritically into the workings of the patriarchal institution and both (re)enforce and (re)produce sexism in practice. Identification with and adherence to this male model of practice places these women practitioners into a more privileged position within the institution compared with practitioners who critique or transgress this approach.

5 It is not known whether any of the practitioners were queer-identified. However, there were no open challenges to the heteronormative practice made by any of the practitioners at the time the research was conducted. It is not known if there were any challenges made behind the doors of the staff room or within practitioner meetings. Certainly, none were made during my presence.

References

Andersen M, Hill Collins P (eds.). 2010. *Race, Class and Gender: An Anthology*, 7th edn. Wadsworth Sociology Reader, Wadsworth Publishing Company: Belmont, CA.

- Burman, E. 2008. *Deconstructing Developmental Psychology*, 2nd edn. London: Routledge.
- Butler J. 1993. *Bodies that Matter*. Routledge: New York.
- Butler J. 1994. Gender as performance: an interview with Judith Butler. *Radical Philosophy*, 67: 32–39.
- Butler J. 1999. *Gender Trouble*. Routledge: New York.
- Butler J. 2004. *Precarious Life: The Powers of Mourning and Violence*. Verso: New York.
- Chambers SA. 2007. 'An incalculable effect': subversions of heteronormativity. *Political Studies*, 55: 656–679.
- Cole ER. 2009. Intersectionality and research in psychology. *American Psychologist*, 64: 170–180.
- Concannon L. 2008. Citizenship, sexual identity and social exclusion: exploring issues in British and American social policy. *International Journal of Sociology and Social Policy*, 28: 326–339.
- Consolacion TB, Russell ST, Sue S. 2004. Sex, race/ethnicity, and romantic attractions: multiple minority status adolescents and mental health. *Cultural Diversity and Ethnic Minority Psychology*, 10: 200–214.
- Crenshaw KW. 1991. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43: 1241–1299.
- Daley A, Solomon S, Newman PA, Mishna F. 2007. Traversing the margins: intersectionalities in the bullying of lesbian, gay, bisexual and transgender youth. *Journal of Gay & Lesbian Social Services*, 19: 9–29.
- D'Augelli AR. 1996. Enhancing the development of lesbian, gay, and bisexual youths. In *Preventing Heterosexism and Homophobia*. Rothblum ED, Bond LA (eds.). Sage Publications: London; 124–150.
- Foster C. 2007. *Blackness and Modernity: The Colour of Humanity and the Search for Freedom*. McGill/Queen's University Press: Montreal.
- Foucault M. 2003. Sexuality. In *Social Theory: Essential Readings*, 2nd edn. Bailey G, Gayle N (eds.). Oxford University Press: Oxford; 307–315.
- Glaser BG. 1992. *Basics of Grounded Theory Analysis*. California: Sociology Press.
- Glaser BG, Strauss A. 1967. *The Discovery of Grounded Theory*. Chicago: Aldine.
- Hansen AL. 2007. School-based support for glbt students: a review of three levels of research. *Psychology in the Schools*, 44: 839–848.
- Herd G. 1998. Gay and lesbian youth, emergent identities, and cultural scenes at home and abroad. In *Social Perspectives in Lesbian and Gay Studies*. Nardi PM, Schneider BE (eds.). Routledge: London; 279–302.
- Lee H, Learmonth M, Harding N. 2008. Queer(y)ing public administration. *Public Administration*, 86: 149–167.
- LeFrançois BA. 2006. 'They will find us and infect our bodies': The views of adolescent inpatients taking psychiatric medication. *Radical Psychology: A Journal of Psychology, Politics and, Radicalism*, 5: 1.
- LeFrançois BA. 2007a. Psychiatric Childhood(s): Child-Centred Perspectives of Mental Health Inpatient Treatment and Care, Unpublished PhD Thesis, Canterbury: University of Kent.
- LeFrançois BA. 2007b. Children's participation rights: Voicing opinions in inpatient care. *Child and Adolescent Mental Health*, 12(2): 94–97.
- LeFrançois, BA. 2008. 'It's like mental torture': Participation and mental health services. *The International Journal of Children's Rights*, 16: 233–248.
- LeFrançois BA. 2011. Supporting positive relationships in families where fathers suffer with mental distress. *Critical Social Work*, 12: 1.
- Livingston JA. 1996. Individual action and political strategies: creating a future free of heterosexism. In *Preventing Heterosexism and Homophobia*. Rothblum ED, Bond LA (eds.). Sage Publications: London; 253–265.
- Lorde A. 2004. Age, race, class, and sex: women redefining difference. In *Oppression, Privilege, & Resistance: Theoretical Perspectives on Racism, Sexism, and Heterosexism*. Heldke L, O'Connor P (eds.). McGraw-Hill: London; 553–560.
- Mayo C. 2006. Pushing the limits of liberalism: queerness, children, and the future. *Educational Theory*, 56: 469–487.

- McBride DA. 2007. Toward the new Black Studies: or beyond the old race man. *Journal of Black Studies*, 37: 428–444.
- Milburn NG, Ayala G, Rice E, Batterham P, Rotheram-Borus MJ. 2006. Discrimination and exiting homelessness among homeless adolescents. *Cultural Diversity and Ethnic Minority Psychology*, 12: 658–672.
- Mule NJ, Ross LE, Deeprrose B, Jackson BE, Daley A, Travers A, Moore D. 2009. Promoting lgbt health and wellbeing through inclusive policy development. *International Journal for Equity in Health*, 8: 18.
- Perlin ML. 2003. “You have discussed lepers and crooks”: sanism in clinical teaching. *Clinical Law Review*, 9: 683–729.
- Pharr S. 2004. Homophobia: a weapon of sexism. In *Oppression, Privilege, & Resistance: Theoretical Perspectives on Racism, Sexism, and Heterosexism*. Heldke L, O'Connor P (eds.). McGraw-Hill: London; 259–274.
- Schussler Fiorenza E. 2001. *Wisdom Ways: Introducing Feminist Biblical Interpretation*. Orbis Books: New York.
- Scourfield J, Roen K, McDermott L. 2008. Lesbian, gay, bisexual and transgender young people's experiences of distress: resilience, ambivalence and self-destructive behaviour. *Health and Social Care in the Community*, 16: 329–336.
- Van der Veen E, Hendriks A, Mattijssen A. 1998. Lesbian and gay rights in Europe: homosexuality and the law. In *Social Perspectives in Lesbian and Gay Studies*. Nardi PM, Schneider BE (eds.). Routledge: London; 491–505.
- Warwick I, Oliver C, Aggleton P. 2000. Sexuality and mental health promotion: lesbian and gay young people. In *Young People and Mental Health*. Aggleton P, Hurry J, Warwick I (eds.). Wiley: Chichester; 131–146.

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