AN ETHNOGRAPHY OF ONTARIO'S YOUNG PEOPLE'S MENTAL HEALTH SERVICES

LOCATIONS OF THERAPEUTIC BENEFIT: AN ETHNOGRAPHY OF CHILD AND YOUTH MENTAL HEALTH SERVICES IN ONTARIO, CANADA

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Abstract

This dissertation focuses on young people's and staff's discourses about, and participation in, day treatment mental health programs in Ontario. These experiences and perspectives are situated within broader structural contexts of power, policy and societal expectations. In doing so, I adapt and update Scheper-Hughes and Lock's (1987) *Three Bodies* model as an overarching structure for the thesis. I differ from their distinct division between the *three bodies* as my grounded theory approach to fieldwork data highlights the relational aspects of therapeutic practices, and in turn I draw attention to the interaction between and within Scheper-Hughes and Lock's *individual-social-politic* bodies.

I completed fieldwork at two services, one for 13-18 and one for 5-12 year olds. These institutional settings are primarily concerned with (re)creating mental health and educational well-being. As such both they and my research are at the intersection of multiple academic disciplines, which means that my dissertation draws heavily on a variety of anthropological, sociological and childhood studies literatures and methodologies, as well as on influences from psychiatry and psychology, in addition to a broad range of post-structuralist / post-modern theorizing.

In addition to this *academic* approach, my work has applicability, which was necessitated in part by the fieldwork sites' demand that they see benefits from research. My applied approach was also necessitated by my position that anthropological research can fruitfully combine both applied and academic approaches to research, known as *praxis*.

Key issues addressed within my thesis are: the need for multiple qualitative methodologies, both to address questions around working with young people and questions arising from fieldwork sites primarily informed by quantitative research; the usefulness of combining aspects from the theoretical work of Bourdieu and Foucault in understanding how mental health therapies act to reenculturate young people; the importance of the role that the young people play in their own therapeutic recovery which I explore through my concept of *confined agency*; that (perhaps surprisingly) *rites de passage* and *liminality* can be useful conceptual frameworks to approach the sociality of individual bodies in the daily material activities at the fieldwork sites; and the negotiation by young people and staff of the ongoing negative impacts of stigma associated with mental illness. Within my ethnographic theorizing is the importance of relational interaction between *individual-social-politic* level bodies.

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1. Introduction to the dissertation

1.1 An ethnography of young people's mental health services

This dissertation is based on anthropological fieldwork at day treatment services for children and youth with severe mental health difficulties in Ontario. These sites invoke and engender multiple academic disciplines – anthropology and sociology of health and illness, mental health (psychiatry and psychology) as well as policy and educational research. Because these fieldwork sites are in essence 'at home,' rather than in distant foreign countries, and some participants are within social categories that are temporal and in flux (children and adolescents) I have faced questions concerning the anthropological (as opposed to sociological or medical) nature of the research, as well as questions concerning methodological rigour (i.e.: can accurate research be done with young people?). In this thesis I demonstrate that anthropological fieldwork, which includes young people as participants in addition to adults, can fruitfully access understandings of institutional experiences of childhood and adolescence.

The primary site, *Cornerstone Youth Service*, is in southern Ontario, Canada, and is part of Hamilton Health Sciences (HHS) *Integrated Child and Youth Mental Health Portfolio*. This site offers day treatment services using the Therapeutic Community Model to adolescents aged 13-18, who present a range of internalised psychiatric diagnoses with about 80% co-morbidity. Diagnoses include, but are not limited to, mood disorders, anxiety disorders (including specific disorders such as Post Traumatic Stress Disorder, School Refusal, and Obsessive Compulsive Disorder), Tourette Syndrome, Asperger

Syndrome, schizophrenia, eating disorders, and drug and alcohol abuse. Most client-students at *Cornerstone* have impaired self-image, and all have histories of substantial non-school attendance. Usually between 55-60% of clients are female (I address this gendered pattern in chapter seven). The client-students served by *Cornerstone* lack both the social and coping skills required to deal with their mental health problems (Stride-Darnley and Buchanan, 2005). First contact with *Cornerstone* can come through a variety of routes such as school counsellors, family doctors, self-referral, or paediatric specialists and intake includes full psychiatric assessments. During fieldwork, intake was, however, becoming a centralised process. *Cornerstone's* funding is predominantly through Health monies, with funding for education programming being derived through Section-23 of the Ontario Education Act (1994), and is under the auspices of Hamilton-Wentworth District School Board's Care, Treatment and Corrections Programs. Onsite staff consist of six Child and Youth Workers, a psychometrist, a social worker, two teachers, and a Child Psychiatrist (the clinical director).

Cornerstone was physically independent from all other HHS Hospitals. It rented two floors of a downtown building, which made it a relatively anonymous for a psychiatry facility with only the *Cornerstone* sign located on a quiet side road at the entrance to the car park. During the fieldwork period, the Hospital was able to rent the remaining two floors and so this anonymity and relative independence has begun to change. At *Cornerstone*, the young people tend to fall within a broad spectrum of diagnoses that can be termed internalizing disorders – psychiatric diagnoses where the ill person situates the problem as being within the self and turns in on themselves often withdrawing socially. In general, these client-students are *highly* anxious and depressed, have experienced social and familial trauma, and some have experienced abuse in the home and /or detrimental levels of bullying in school. Nearly all of these teens have withdrawn themselves from their schooling, most have been 'drop outs' for between twelve to thirty-six months, and predictably they are behind their age-peers educationally. The number of client-students present varies on a day-to-day basis, but usually between twenty-five and thirty client-students are officially attending. In my time at *Cornerstone* I met fifty-six, another fourteen were discussed at Staff meetings, another eight were on the waiting list, and six were re-directed to other services. The length of client-student attendance varies case by case, but often client-students attend full time for one or two semesters and then half time for one semester – this is however a highly individualized process with some client-student progressing rapidly and moving on within one semester, while others attend for four semesters. The teens are more likely to be female than male, and most are from poorer parts of Hamilton and are, or appear to be, of European backgrounds. At point of entry, their ages ranged from thirteen to seventeen, although most were in the fourteen to sixteen year range.

Predictably, these teens are *highly* socially awkward and are initially extremely nervous about unstructured social situations such as the pool room before programming starts at nine-thirty. This is perhaps as a result of their illness and their lack of attendance at school (i.e. lack of experience), but also this is likely because their prior experiences of peer relationships were extremely poor. During the intake process, most client-students disclosed they felt as though they had few, if any, friends, and that they have great difficulties making them. During their time at *Cornerstone* these teens learn to overcome their depression and anxieties, and in turn gain social skills and progress educationally. At times these processes are highly stressful, at times they can be fun and exciting. Most client-students develop strong friendships with a small number of other client-students. Some develop romantic relationships that are typical of high-school aged young people. These friendships continue outside of *Cornerstone's* parameters and location, and according to both staff and client-student they are often the first true friendships of the client-students' lives. *Cornerstone's* client-students participate in a range of therapeutic activities that are grounded in psychiatric approaches to mental health and mental illness.

The service's medical director is a pediatric psychiatrist who has been with *Cornerstone* since its inception in the mid-1990s. There were two female and four male Child and Youth Workers (CYWs) who act as front-line clinical staff, but this changed during my fieldwork to one staff member taking a more administrative interim role. This female-male staff ratio was apparently unusual for child and youth mental health services, which from staff, other fieldwork experiences and audience comments at conferences, I understood to be a profession dominated by women (aside from clinical directors). The CYWs usually have a case-load of five or six full time equivalents, depending on their client-students' diagnoses and stage of recovery. CYWs act as client-students' mentors and their 'go to' person if they have problems. CYWs also run a range of therapeutic programs, ones that explicitly follow cognitive behavioural therapy guidelines, as well as ones that aim to build confidence and social adeptness in client-students. *Cornerstone* CYWs' experience is extensive with the least experienced receiving their '15 Year

Service' pin and '20 Year Service' pin from Hamilton Health Sciences (HHS) during my fieldwork time. Their qualifications range from College level diplomas (all that was available when they started out) to BAs and MAs in psychology, and these staff members are dismissive of and resistant to the Provincial and HHS move to recognize 'paper' qualifications above and beyond experience.

Cornerstone also has an English / Humanities class and a Math / Science class, where client-students can return to work on credits for their high school diploma – often very successfully. The two class teachers have extensive experience working in alternative and mental health educational settings, and prepare individualized curricula for each client-student. The Staff's recognition of the importance high school credits play for client-students means that wherever possible they have aligned aspects of therapeutic programs with high-school credit descriptions so that programming counts twice – therapeutically and educationally. A clear example of this is the mixed media arts credit. Therapeutic and educational decisions are informed by whole staff discussions of the data collected as part of the intake process, extensive psychometric testing (undertaken by an onsite psychometrist who is at *Cornerstone* half-time), as well as the client-student's Ontario Student Record (OSR). However, there is often considerable delay in the *Cornerstone* teachers access to the OSR – in one case, it arrived the week before a client-student had been at *Cornerstone* for a whole semester! These discussions help staff and teachers to direct an incoming client-student towards programming that would be most beneficial to them and away from programming and classes they are nervous of. The latter are introduced once the client-student has become settled into the daily routines of *Cornerstone* and has made some therapeutic and educational progress.

The second fieldwork site, *Northern Ontario Service* (*NOS*), is situated in a city of more than 100,000 in Northern Ontario, Canada. This site's services are funded in part through Provincial Ministries of Children and Youth, and Education, with some connections with local hospital and medical community services. The children accessing services are between 5 and 12, but during my fieldwork most were between 7 and 12 years old. Usually, 80% of the children are male – although during my research this was as high as 92%. Eleven of twelve client-students are, or appear to be, of European backgrounds, and eight were from poorer neighbourhoods in the city. *NOS* is designed as short term segregation incorporating assessment and treatment services for a range of presenting behaviours, including but not limited to significant levels of impaired learning, impaired self-control, and impaired social performance when compared with their peers at their 'home schools.' During their assessment process with *NOS* it would not be atypical for client-students to be diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiance Disorder (ODD) and at times Obsessive Compulsive Disorder (OCD) in conjunction with severe learning impairments. Although these services are physically located within two 'regular' elementary schools they are separate from the main school's activities and are not bound by the school's regulations. Onsite staff consisted of two Child and Youth Workers and one Special Education Teacher, with visits from Registered Nurses, a Psychometrist and other Mental Health professionals working with the *NOS*.

The social impacts of the behaviours that are identified as symptoms of these illnesses are myriad. The young people who become client-students in their 'home schools' are exceptionally difficult children to teach – often referrals to *NOS* come directly from their class teachers (Staff Interview March 2006). Like the *Cornerstone* client-students, those attending *NOS* also have exceptionally poor peer relationships, few if any friends, and unlike *Cornerstone* client-students, *NOS's* young people regularly got into trouble in their home school. First contact with *NOS* generally occurs because the children's behavioural difficulties are so severe that the children cannot function in their home schools. In the past, client-students went through the intake process and then waited to enter *NOS* as a cohort, with six to eight client-students starting at each *NOS* site each September. The cohort was then assessed and received treatment, and then returned to their regular school within the year. However, recently the client-students have begun attending *NOS* whenever a space becomes available, and current client-students remain attending *NOS* until they are ready to return to their home school. This has meant that client-students are at different stages of therapeutic recovery and CYWs are adapting cognitive behavioural therapies originally designed for a cohort approach.

Whereas most client-students at *Cornerstone* have internalizing mental illnesses, at *NOS* the young people tend to be diagnosed with externalizing disorders – those where the individual lashes out against their peers, adults or social convention. Much of the daily routines and therapeutic activities are concerned with order and self-control, and educational activities are largely focused on maintaining or catching up attainment in relation to age-peer expectations. *NOS* days generally follow the pattern of a shortened school day – starting later and finishing earlier than other grades. Each morning client-students are greeted by CYWs and escorted to the classrooms where lessons are differentiated for each client-student and focus on math or language. Recess is sometimes taken with the other members of the school, but often it is not. Put simply, this removes the possibility of confrontation between the client-students and the other students at each school. Explicitly therapeutic activities tend to be after lunch, are completed in groups around large tables, and led by one CYW supported by the second, although in some instances there is some one-to-one counseling. As will become apparent in the remainder of this thesis, any situation can become a therapeutic moment, and *NOS* CYWs take every opportunity to remind and repeat therapeutic lessons.

1.2 The need for an anthropology of young people's mental health services

Anthropology has, over the last three decades, increasingly become focused on marginalised and vulnerable populations situated within broad global socio-economic structures (Baer, 1996; Estroff and Henderson, 2005; Farmer, 2003 and 2000; Goodman and Leatherman, 2001; Inhorn, 2007; Singer, 1990 and 1989; Singer and Baer, 1995; Singer and Clair, 2003). For many, this trend grows out of an anthropological 'tradition' that focused on marginal populations within colonial endeavours (Garro, 1993; Inhorn and Sargent, 2006; McElroy and Townsend 2004; Rasbrigde 1996; Warry, 1991; Weiss, 2001), which is one of the primary characteristics that differentiates cultural anthropology from the discipline of sociology and other social sciences. The focus of this dissertation has become, even if unintentionally, about a marginalised area of health care within Canada – that of mental health and illness, and in particular urban child and youth mental health and illness. In the chapters, that follow I provide evidence to suggest that it might be particularly apt to conceptualise my research as marginal. Furthermore, because the central topic is at the intersection of multiple disciplinary margins, the research arena has not been researched 'holistically' and is therefore in need of anthropologically grounded research. In this introduction, I summarise the need for a holistic approach to young people's interaction with mental health services to propose that mental health and illness are marginalized within dialogues about Canadian health; children and adolescents are marginal within Canadian society, and research about this arena within social science generally, and anthropology in particular, is rare.

While estimates of Canadian rates of mental illness prevalence range from 12.5% (Statistics Canada, 1986) to 20% (Health Canada, 2002; Shah, 2003: 232), a recent report that summarised key Health indicators of Canadians only included two indicators that directly related to mental health or mental illness (Health Canada, 2004a). The first listed is the "Potential years of life lost due to suicide" (Health Canada, 2004a: 81), which highlights the impact of suicide, but suicide can be understood to be a symptom, rather than a particular diagnosis of mental illness. The second, "Prevalence of depression" is the last of 70 indicators mentioned in the document (Health Canada, 2004a: 82). Neither were 'featured' indicators in the report, rather they were merely numbers 54 and 70 on a list of 70 indicators; in annex three (of four), effectively making mental health and mental illness invisible within the document. Furthermore, people who experience mental illness are often socially stigmatised and are hence socially marginal (Kirby, 2006; Link and Phelan, 2001; Mechanic, 1999). Canadian research and practice is also relatively marginal as much of the research literature that focuses on mental health and illness, psychiatric diagnoses and therapeutic regimes stems from the United States (Stroul, 1996). Such research has similarities to service provision in Canada, but significant differences with regards to access and funding (Moniz and Gorbin, 2007).

Within Canadian and western societies, those in the life stages of Childhood and Adolescence, that is children and adolescents, are marginal. While some might consider them as merely young humans, children and adolescents are treated socially as humans in potential, or not fully human, and have specific locations and parameters of and for activity (Alanen, 2000; Lee, 1999 and 2001).[1] Indeed, Hirschfeld notes that traditionally anthropologists have considered "children as culturally incompetent creatures, who are, at their most interesting, simply 'appendages to adult society'" (Hirschfeld, 2002: 613, citing, Bloch 1998; see also Caputo, 1995; James and Prout, 1997; Schwartz, 1981; Toren, 1993). Within research literature on mental health and illness, qualitative approaches to issues relating to children and adolescents are greatly surpassed by work that focuses on adults (Brodoff, 2005; Hughes, 1996; Lubostsky-Levin and Petrila, 1996; Sayre, 2000; Schneider et al, 2004; Young, 1993), with some notable exceptions (Freidman, 1996). Finally, within cultural and medical anthropology and other social science research on mental health or mental illness in North America, mental health and mental illness is often the focus of research only when it pertains to homelessness (Clatts and Rees-Davis, 1999; Hopper, 1988; Susser, 1996), and adult homelessness in particular (Desjarlais, 1997; Hopper, 1988; Wright, 2005), or prison populations (Vandevelde et al, 2004).

Anthropological literatures tend to focus on 'big impact' diseases such as cancer (Inhorn, 2006; Miczo, 2003; Sontag, 1978), tuberculosis (Farmer, 2000 and 1999; Ito, 1999; Weiss, 1997) or HIV/AIDs, along with sexually transmitted diseases (Farmer, 2003 and 1997; Pigg, 2002; Singer and Clair, 2003), the interaction of these 'big' diseases (Singer and Clair, 2003), the medicalisation of birthing (Bourgeault, 2000; Jordan, 1997; Van Hollen, 2003), as well as recent medical and cultural challenges to meanings of the body (Hogle, 1999; Taylor, 2005). It should be noted, however, that there is a strong history of anthropological research that focuses on psychiatric issues, particularly in a cross cultural setting (Cohen et al, 2002; Gaines, 1992; Hughes, 1996; Kleinman, 1980; Kleinman and Good, 1985; Littlewood and Dein, 2000), and within social science literatures that focus on various cultural groups within multicultural settings (Doi, 1990; Dreier, 2000; Hunt, 2005; Romanucci-Ross, 1997; Yates and Day-Sclater, 2000). Even sociological research on health and illness, which traditionally has claimed the 'modern' and urban spaces of first world countries, in opposition to traditional anthropology field-sites of the 'primitive' and rural spaces of third world countries, rarely focuses on child and youth mental health services (Estroff, 1981; Henderson et al, 2005; Moran and Wright, 2006). Rarely is any of this research based on urban and institutional Canadian settings. [2]

In a recent reprint of *The Social Medicine Reader* – based primarily "on the syllabus of a year long, required interdisciplinary course, Medicine and Society, which has been taught to first year students at the University of North Carolina at Chapel Hill School of Medicine since 1978" (Henderson et al, 2005: ix), one chapter in more than eighty is solely based on mental health issues, and it elaborates on the perspective of a having a sister with schizophrenia (Brodoff, 2005; for further details see Henderson et al 2005; King et al 2005; Oberlander et al 2005). For a reader based on an innovative and interdisciplinary Medicine course, we could expect more space and time be allocated to mental health and illness, especially when the National Institute of Health suggests that prevalence rates for mental health illnesses in the United States are between 20% and 21% for adult and child/youth populations respectively (DHHS, 2001: 7; DHHS, 1999: 46, 124). In the US, the direct economic costs of mental illness were estimated in 1991 to be $55 billion (NIMI, 1991: 29). By 1999 it was noted that the indirect costs were estimated at $79 billion while service provision cost $69 billion, just 7% of health spending (DHHS, 1999: 411, 412). In Canada, the prevalence is in the range of 12.5% to 20% (Cochrane et al, 1997; Kutcher et al, 1996; Schissel, 2002), and "[t]he economic cost of mental illness in Canada was estimated to be at least $7.331 billion in 1993" (Health Canada, 2002: 15), while roughly $1.6 billion is lost productivity annually due to long-term mental disability (Davis, 2006: 10, citing Health Canada, 1997a). This is not an issue found solely in North America. Worldwide the impact of mental illness is vast, with mental disorders contributing considerably to disability. Currently mental illnesses are "the leading cause of disability among women and by 2020 are expected to become the main cause of years lost to disability" (Muntaner and Geiger-Brown, 2006: 278 citing Murray and Lopez 1996).

Yet, as suggested above, we see mental health/illness marginalised within Canadian Public Health discourse, within Federal Health indicators, and within Health

Budgets. The Kirby Commission (2006) on mental illness in Canada notes that the social stigma associated with mental illnesses contributes to the societal marginality of those individuals with mental illness. Kirby (2006) presents the numerous benefits of helping individuals with mental illnesses become productive members of society as justification for Health monies spent on treatment services. Such rhetoric around economic productivity is examined in detail throughout my thesis. The marginalisation of mental health issues, young people, and young people with mental health issues, makes my research focus closer to 'traditional' anthropological endeavours.

1.3 Three Bodies Metaphor – adapting a theoretical framework

In 1987, Scheper-Hughes and Lock wrote their now seminal piece in *Medical Anthropology Quarterly*. Their *prolegomenon* called for the incorporation of a 'mindful' approach to medical anthropological research through their *Three Bodies* model – individual body, social body, and body politic (Scheper-Hughes and Lock, 1987). The subsequent work of both these authors (Lock, 2001, 1993; Scheper-Hughes, 1991, 1990; Lock and Scheper Hughes, 1996) examined how bodies, health and medicine are researched and understood, and has had a considerable influence in anthropology and social science thinking about how biomedicine views healthy and natural body states. This thesis, in part, attempts to bring up-to-date the three bodies metaphor and framework, through an investigation of the individual and social experiences of attendance, participation and recovery at two Ontarian day treatment services for young people with mental health difficulties and diagnoses.[3]

I explore how various cultural and social categories (such as childhood, adolescence, professional, clinician, or researcher) interweave in the everyday occurrences at these services (such as evidence-based therapy, intake, discharge, staff meetings). I also explore how various normative discourses (policy, biomedicine, health and educational progress) are negotiated, adhered to, and resisted by both adults and young people at these services. Through fieldwork and analysis of the data collected in various qualitative and participant observation methodologies it has become apparent to me that the stigmatised roles associated with mental illness, which the young people perform, negotiate, and disown, are a key aspect of success and healing at these services. Integrally linked to the health and illness of the young people is their success (or lack thereof) within education and school. The interaction between educational and medical components adds further complexity to the ethnographic analysis.

I have adapted the *Three Bodies* model in order to elucidate understandings of the ethnographic contexts. Scheper-Hughes and Lock focus on the potential for emotion to mediate between the *three bodies*, and I take this as a launch pad for further inquiry. There is a distinct lack of focus on the mediation between these bodies within the anthropology literature on health and specifically mental health. That is to say, I add to and adapt the model to consider how interaction between, as well as within, each *body* influences the daily practices at the two mental health services. The *individual body* draws on the Cartesian separation of body and mind along with the location of disease within individuals, which has come to be known as *medicalisation* within anthropology of health literatures: "the illness dimensions of human distress is being medicalized and individualized rather than politicized and collectivized" (Lock & Scheper-Hughes, 1996: 48). I closely follow this *individual body* approach. My interpretation of the *social body* is slightly different from Scheper-Hughes and Lock's. They examine how bodies are used in societal metaphors, how social and natural worlds have human shapes, and how healthy bodies come to symbolize healthy states (Scheper-Hughes and Lock, 1987: 19, 20). However, I take the 'social' to mean just that – how are bodies understood and used in interactions and dialogues? How are they represented to friends and colleagues, other clients and the 'outside' world? And, how does the outside world view these bodies and their 'sick' minds? Finally, I consider Scheper-Hughes and Lock's conceptualization of the *body politic*:

> Sickness is not just an isolated event or an unfortunate brush with nature. … The individual body should be seen as the most immediate, the most proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle (Lock & Scheper-Hughes, 1996: 70).

For Scheper-Hughes and Lock, this third *body* is highly influential in any individual's illness experience, and I will argue that this is also the case for those attending mental health services. For me the *body politic* is very much akin to Singer and Baer's (1995) Critical Medical Anthropology's (CMA) political-economic contexts and causes of illness.

In addition to using an adapted three bodies model, this thesis is influenced by a wide range of theoretical posits, and as implied above (inter)disciplinary considerations. This is because I am reluctant to "shoe-horn" data to fit a particular theoretical approach, or to actively undertake methodologies that might generate data that fits theory in a formulaic manner. As such, I have used my fieldwork to reflect on the currency of some classic anthropological writing concerned with habitus, agency, stigma and therapeutic processes as *rites de passage*. I hope that the potential strength of this thesis is that I am attempting to draw out dialogues (in a Bahktinian or Vygotskian sense) between each *bodily* layer (Bahktin, 1981; Wells 2000). Therefore each section and its chapters is an attempt to view the same issue using a different theoretical lens. The effect might be considered eclectically kaleidoscopic, which could distract and distort, but the aim is for individual chapters to build a holistic total.

1.4 Outline of thesis

What follows, then, is a thesis that attempts to mirror the structure of Lock and Scheper-Hughes *Three Bodies* metaphor, but in reverse. Following a methodologies chapter, which examines the specifics of my methods and how working as an applied anthropologist was key to my successful negotiation of entry into the field, I present one chapter which considers a broad *body politic*. The first *body politic* segment focuses on situating my research within recent anthropological and other academic literatures that explore mental health / mental illness. The second portion in the chapter addresses the social construction of Childhood and Adolescence as life stages, and young people (or children and adolescents) within them. The final *Body Politic* segment attempts to contextualize the fieldwork sites by addressing the history of mental health services in Canada (with particular attention to provisions for children and adolescents), presenting the biomedical context and discourses in play for these services, and discussing the implications of these institutions' attempts to meet both medical / therapeutic and educational goals.

The second and third sections of this thesis are closely aligned, and address the interweaving of social and individual bodies in the ethnographic data. At a *social body* level, ethnographic details of interactions between services, workers, and client-students come into focus. Chapter four explores the ethnography scene primarily utilizing aspects of Bourdieu's theoretical insights – specifically *habitus* and *hexis corporeal.* Chapter five examines societal notions of young people's agency. Both of these chapters have been submitted for publication. The former is undergoing corrections and will shortly be resubmitted to *Medical Anthropology Quarterly* for peer review. The latter is forthcoming in *Childhood, Youth and Social Work in Transformation: Implications for Policy and Practice,* edited by Lynn Nybell, Jeff Shook and Janet L. Finn, published with Columbia University Press.[4] At a more *individual body* level, chapter six utilizes a rites of passage framework to explore how power is negotiated within the therapeutic milieu of the services, while chapter seven examines how stigmatized roles are performed, negotiated, and at times disowned in the contexts of individuals' self-presentation and performance.

My concluding chapter re-visits the *three bodies* metaphor, and discusses the ethical and methodological practicalities of doing research with young people. I reflect on the fieldwork processes and experiences, and address the applied context of my research to suggest that systems changes and improvements to interventions can be made though this kind of research, but systemic (*body politic*) scale change is not possible.

1.5 Three notes on language use

a) In order to ensure anonymity for each individual child, youth, or member of staff all names given in this thesis are pseudonyms. In addition, the ethnographic vignettes are based on collated data from fieldwork notes, interviews and conversations. The ethnographic illustrations, then, while giving some specific details are based in generalities. However, the institutional name for one site has been given at the request of staff and administrators. All participants were made aware of this format as part of the free and informed consent / assent processes.

b) Throughout this thesis I will use the term client-student to describe the younger research participants, except in direct quotations where original language shall be used. This is because from the outset of my fieldwork there was one area of tension – that of language use. While it has been noted that "[m]edical vocabulary replaces social terminology" (Estroff and Henderson, 2005: 10), this hegemony is challenged at the fieldwork sites. Both adults and the young people themselves raised concerns and contradictions over what descriptors would best identify the younger. During the initial analysis and writing for the Role of the Arts project (Stride-Darnley and Buchanan 2005), my 'in' to the fieldsites, it became clear that there is considerable difference between how staff (adults) and clients (young people) see clients. *Cornerstone* staff, in the main, have to conform and adhere to hospital rhetoric and language, but are also aware of the young people's concerns – hence the use of the term 'clients' to describe the conglomeration of young people, rather than ‘patients,’ while at the same time the young people always described themselves as students. The question then becomes what label is most appropriate – children, young people, youth, teenagers, adolescents, pupils, students, clients, or patients? This tension over nomenclature is also noted within the mental health literature. Davis, in particular, notes the difficulty in choosing terminology that appeases all of the various ‘stakeholders’ perspectives (2006: xv). I decided to use client-student to acknowledge both perspectives, which also serves to highlight the tension; a tension that reflects social and institutional pressures on both the staff and young people.

c) All interviews were transcribed *verbatim* and presented as such. I have chosen to present the transcriptions in this way rather than as a representation of the interviews for two reasons. Presenting the ‘raw’ material means that I have removed a level of interpretation from my analysis – the readers of this thesis see the original data set and can evaluate my analysis on its merits. Secondly, by not “cleaning” the text, and presenting the literal speech, I am reminding the readers that research participants are humans, who take time to think about their responses and follow their own train of thought, which, to my mind, is a clear benefit of semi-structured interview schedules. I use the following notation:

I = interviewer

R = respondent

Brief pause = pause for count of less than three

Longer pause = pause for count of three to six

Long pause= pause for count to six or more word underlined = volume increase for that word, or part of the word.

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[1] The right to vote is a clear marker of 'human-ness' within Canadian society. Only those who have reached the age of majority (19 in Ontario, 18 in Quebec) are considered full members of society and have the right to vote; thus children and adolescents are not considered as socially fully human. Even the fact that this age varies between provinces and nations denotes the socio-construction of being fully human.

[2] Estroff (1981) offers a wonderfully insightful and lucid account of ethnographic fieldwork with people with schizophrenia in Madison, Wisconsin. But like much anthropology from that time, in focusing on the impacts of deinstitutionalisation on adults with mental illnesses in an urban setting, Estroff excludes children and adolescents completely.

[3] See Marcus (1999) for a summary of the debates on why multiple fieldwork sites are potentially beneficial to ethnography. I comment further on this issue in the methodologies chapter.

[4] As it includes material that is already published or submitted for peer review, this is considered to be a "sandwich" thesis. There is a regrettable but unavoidable degree of repetition that comes with this thesis format, although I have endevoured to keep repetition to a minimum.

2. Dissertation Methodologies

2.1 Introduction

In this chapter, I describe the methodologies that I implemented to collect the data that is analysed in this thesis. Following in the anthropological tradition of fieldwork, I undertook extensive participant observation with the two services at the centre of my research. This was supplemented by individual interviews with staff, small group and individual interviews with client-students, and review of client-student case histories. This final methodology was as much a necessity of ethical daily practice as a useful source of data. There is need to be sensitive to case histories when working with people with mental illnesses, including being aware of words or topics that might trigger a decrease in mental health. Fieldwork was made possible because of my participation as a qualitative researcher on a project that investigated the Role of the Arts programming at *Cornerstone* (Stride-Darnley and Buchanan, 2005). Once I address some ethical considerations of doing fieldwork with young people in institutional settings, I briefly tackle the importance of the applied side of my research in enabling access to fieldwork sites in order for 'pure' anthropology questions to be addressed. Following this brief discussion, I then turn to the specific methodologies that I utilised during my fieldwork and what analytical techniques I used to interrogate the data. Before my concluding reflections on my methodologies, I outline the implications of attempting multisited ethnography.

2.2 Ethical considerations

While my fieldwork underwent Research Ethics Board (REB) reviews before the research commenced, for me ethical practice can be embedded as an ongoing part of research, rather than being seen as a procedural barrier. There are clearly many ethical considerations in connection to research with young people, and I spent considerable time taking into account the sensitivity of such issues to try to address such concerns in my methodological approach, which is reflected in my applications to the various REBs (TCPS, 2005; see also Fluehr-Lobban 1998; King et al, 1998; Marshall, 1991). As a result my REB applications were approved upon their first submission (the various consent and assent protocols can be found in Appendix 10.1 and 10.2). As a potentially interesting aside the Hamilton Health Science REB application allocates more space to ethical issues relating to potential conflict of interest (i.e. payments of investigator by a pharmaceutical company) and on the dangers of experimental medical practices, than on how best to guarantee ongoing free and informed consent. I interpret this imbalance as a reflection of the medicalised nature of that particular REB and the pressures it faces as a provider of health services and medical research. Such allocation of space does not countermand the tenets of the Tri-Council Policy Statement on Ethics (TCPS, 2005), but it does draw into question the relative importance assigned to potential physical harm that quantitative science research may cause as opposed to the relative limitation of potential harms associated with qualitative social science research.[1] In terms of the discussions of the introductory chapter, I suggest that the focus on physical suffering within REB procedures can be considered to highlight the relative marginality of mental despair (as opposed to the centrality of physical suffering) within discourse around ethical research practice, even when such research aims to include the perspectives and voices of young people who are characterized as vulnerable within public discourse and the TCPS.

2.3 Accessing fieldwork sites

My initial contact with *Cornerstone* resulted from a telephone message left with my Ph.D. supervisor during the oral stage of my Ph.D. comprehensive exams. The caller was wondering if Dr Warry knew of any anthropology students who were available to work in the Winter of 2005, and who were experienced in qualitative methodologies and working with young people. Like much anthropology fieldwork this contact was highly fortuitous. I had been attempting to begin fieldwork with Boards of Education in the "golden horseshoe" area in Southern Ontario. At that time my proposed research focused on the social aspects and experiences of Attention Deficit Hyperactivity Disorder and Attention Deficit Disorder in mainstream schools. I had had a series of verbal and written refusals (even before I submitted ethics applications) and the gatekeepers who were, in the main, educational psychologists, tended to belittle the need for this kind of research as well as the potential value and rigour of qualitative methods and / or anthropologically informed participant observation.

I followed up on the message and arranged a meeting with a research team for early January. This group had begun a project investigating the role of the arts programming at *Cornerstone* (Stride-Darnley and Buchanan, 2005). From the outset there was a tentative 'courtship' between myself and the senior project staff as I was looking to impress upon the research team that my skills as a qualitative researcher would prove valuable to the project and the service, while also to hoping that *Cornerstone* might be a suitable site for my Ph.D. fieldwork. My contributions to this project were integral to the subsequent Ph.D. fieldwork taking place.[2] I demonstrated that multiple qualitative methods could be usefully implemented to develop an evidence base of the practices at the service. The Role of the Arts project constituted the beginning of the applied contributions that developed as part of my research, and highlights the importance of cooperation with and for service providers when working with Canadian medical institutions. By this I mean that in my experience, anthropological research 'at home' with relatively powerful institutions requires relatively high level of control by, and feedback to, research participants.[3] During the Arts project I met with Cornerstone's entire staff to propose my Ph.D. fieldwork project, and subsequently submitted a REB application. I began extensive fieldwork in late April 2005. The Role of the Arts project, then, was the beginning of my conversation with practitioners about the advantages of multiple qualitative context-orientated research practices for small services in relation to the more usual practice of standardized generic measurement tools (Stride-Darnley, In press, No date(a), No date(b), 2006b; Stride-Darnley and Buchanan 2005). Without completing The Arts project, my Ph.D. fieldwork would not have been possible. Through contacts and support of The Arts research team I was introduced to *Cornerstone* staff, with the purpose of proposing my fieldwork ideas. In addition, I was formally 'introduced' to other service providers by members of The Arts research team, which eventually led to working with *NOS*.

The third chapter addresses, in detail, various approaches to health and illness, and examines recent changes in how academic disciplines approach childhood and adolescence as life stages. This latter issue, of how to understand young people and their attributes, exemplifies one of the reasons for the relatively broad range of methodological approaches in my thesis. Indeed, my reference to the Arts project as an example of a successful research endeavour in this thesis reflects, in part, my response to the complex questions related to young people's assumed incapacities and lack of competencies. Briefly summarized, this is related to adultist assumptions about young people's relative lack of agency, which I examine in considerable detail in chapter five. My use of multiple qualitative methods, then, is firstly designed to address questions surrounding the viability of collecting data from participants who are minors both legally and in terms of their role in therapeutic settings where the authoritative knowledge is owned by adult health care professionals. Indeed, one of my overarching questions was to examine the interplay of young people's role in therapy, policy and service provision. Secondly, my methodologies are designed to address questions concerning the rigour of qualitative approaches within an arena dominated by discourses about rationality and objectivity, two characteristics promised by quantitative methods within the biomedical realm. It is to these methodologies that I now turn.

2.4 Methodologies

The qualitative methodologies were implemented after extensive consultation with staff members, and were designed to suit the particular ethical (i.e. client-students' vulnerability) and site-specific contexts (i.e. subject matter and language issues) of the services. This research is typical of applied medical anthropology, particularly the *praxis* approach as advocated by Warry (1992), which calls for research to directly address the concerns of communities (see also Ervin, 2000; Fisher, 1989; Meiwald, 1997; Pelto and Pelto, 1997; and Scheper-Hughes, 1990; Singer, 1994). As mentioned above, I used four methodologies – participant observation, staff interviews, client-student interviews, and case history reviews – and each are, in a sense, like using a different lens with which to view a research landscape; lenses that enable research questions to be viewed from many angles, and at different magnifications.[4] These methods were repeated on a shorter time frame at or with *NOS*.

2.4.1 Participant observation

Participant Observation has a proven record in generating qualitative evidence (Bernard, 2006; Bryman, 2001; Ervin, 2000), and implicitly demands that the researcher become a member of the participant community. In my fieldwork, this methodology enabled me to gain insights on each service's culture that would not otherwise be accessible via quantitative methods (Ervin, 2000; Spradley, 1980). For ethical and methodological reasons I made field notes at regular intervals but not within sight of participants. Participant-observation generated fieldwork notes that were used to focus the direction of subsequent semi-structured interview protocols (Prus, 2005; Spradley, 1980; Trotter, 1991).

As part of my attendance at *Cornerstone* I met weekly with the lead Child and Youth Worker (CYW) *Esme.* This is akin to the other staff members weekly supervision. *Esme* suggested that at first I sit in on a variety of programmes over a week so that we could develop a schedule that fit with my needs and client-student numbers and staffing ratios (so that I not draw too heavily on the resources). In each program, and as new client-students arrived, I would be introduced by a CYW as a researcher learning about what happens at *Cornerstone*. In each program, I would follow the lead of the CYW in charge and as long as it did not decrease client-student access to resources, I would participate in the activities alongside the client-students (reading or writing in one of the two classrooms, doing ceramic work in Ceramics, eating the prepared lunch at lunch time). My behaviour was initially somewhere between that of a client-student and that of a staff member as I acclimatised to the setting. I demonstrated adult knowledge, but in terms of *Cornerstone's* routines and practices I was very much like any newer client-student. By the end of my fieldwork at *Cornerstone*, both staff and client-students came to see me much like any of the other adults present. I discuss this in more detail in later chapters, but here will give two very brief examples of my participant observer positionality.

Within three months of beginning daily fieldwork, I would regularly be left alone with client-students despite this being contrary to the rules laid out by the Hospital's Volunteer Services and Risk Management. Most usually, this would occur during the Ceramics Program where the moulds and green-ware are stored in a different room to the class itself. One 'flashpoint' around my role was witnessed in June 2005 when I reminded *Douglas* (a CYW) about this rule as he was leaving the room with some client-students and one of the client-students who stayed behind said "it's ok because you're a staff member" and another responded "or nearly anyway" (Fieldwork notes, June 2005). I mentioned the situation to *Esme* in our next weekly supervision meeting, and the issue was raised at the following staff meeting. *Esme* reminded the other staff members that this was a Risk Management issue, rather than a comment on my abilities to interact with the kids in a suitably supportive way, which they all agreed was "great." *Esme* framed her concern in terms of the potential for client-student accidental injury and ensuing liability. *Cornerstone* just would not be covered. From time to time, however, and at least once a month, similar situations would arise. A second example of my shifting role at *Cornerstone* can be seen in my attendance and participation at weekly staff meetings, where initially I only provided input whenever asked and did not offer unsolicited information. But gradually, and definitely by August 2005, I began to participate in the conversations, dialogue and discussions at staff meetings. For me, these two examples suggest that relatively soon after beginning formal fieldwork I came to be viewed both by client-students and staff members as similar to, but not exactly the same as, other adults at *Cornerstone*. At *NOS* I completed a much shorter period of participant observation. The client-students treated me very much like any other adult visitor to the classroom, and extra person who from whom they could get specific attention. The adults, especially CYWs wanted to ensure that I could access the information I needed for the project. Each morning they would take time to explain processes, routines as well as the purpose of activities to be completed in a given day. In my evaluation, my presence at *NOS* was less "normalized" than my presence at *Cornerstone*.

2.4.2 Individual staff semi-structured interviews

Individual interviews were chosen as they assure professional anonymity, thus putting participants at ease, as evidenced by the high (97%) participation rate. These interviews accessed perspectives of *all* types of professionals working at the service – from business associate to medical director. Thus, data is generated from a broad range of experiences at the services. Each interview lasted from between thirty minutes to two hours and were taped recorded for accuracy. Each interview was based on the same schedule of questions and was transcribed verbatim, including the length of pauses and laughter. This ensures accuracy and that text data was comparable. This semi-structured interview format has the advantage of the protocol having a set of 'core questions,' which leads to collecting comparable data. Semi-structured protocols also encourage 'tangents' to be followed, as details can also be teased out through follow-up questions, enabling detailed data from specific perspectives to be collected (Spradley, 1979). Additionally, the pace of conversation is relaxed as it is largely regulated by the participants. Thus, this data constitutes an in-depth perspective that includes a variety of details specific to program processes and experiences. The data from these interviews was useful as it was made up of directly comparable words, phrases and examples of situations raised by staff in response to the questions, which were in turn written with the overarching research objective in mind.

2.4.3 Semi-structured interviews with young people

While focus groups often consist of individuals who "are of roughly equal status" (Ervin, 2000: 156), they can at times include people with highly heterogeneous status

(Stewart and Shamdasani, 1990) especially when selected from the same work location. In response to my concern that young participants would be silenced within a focus group setting that included them alongside a range of staff members, at *Cornerstone* I implemented what I call Small Group Semi-Structured Client-Student Interviews. I developed this homogeneous small-group interview approach for three reasons: first, all participants were similar thus addressing ethical concerns around participation and confidentiality; second, the low participant numbers in each interview (up to 3 participants) encouraged supportive conversational responses to questions, which is essential in light of the participant populations characteristics;[5] third, heterogeneous focus groups can be dominated by senior participants (i.e. doctors, management, parents) decreasing chances of getting client-students' perspectives. This concern is negated in small group interview contexts where all participants were client-students. Each interview lasted for between one hour and one hour and thirty minutes. The semi-structured format was chosen for similar reasons as noted above for the staff interviews, and similar questions to those used for staff interviews in order to generate data that is directly comparable to staff-based data. I began the client-student interviews with questions that participants knew the answer to – what they are doing now, when or how they became involved in program – which acted to boost confidence, and thus ease participants into the interview while also generating data from their perspective. In a conversational style, each client-student was asked the questions and asked to responded or discuss each other's replies.

At *NOS,* where the client-students are much younger, and at the direction of *NOS* administrative staff I completed individual rather than group interviews. These conversational interviews took place while the two of us played a game that the client-student chose – usually *UNO* or *Connect 4.* These individual interviews followed a similar protocol to the *Cornerstone* client-students and the staff interviews, but were interspersed with comments about the game we were playing, and in one case particular fascination with the tape recorder. Client-student interviews were transcribed verbatim and generated qualitative data which included comparable words, phrases and examples, as well as in-depth perspectives and details specific to program activities and processes. Methodologically, this approach offers the advantage of accessing perspectives and experiences from the service's target population, the people that *Cornerstone* and *NOS* exist to assist.

2.4.4 Service and participant sampling

My fieldwork sites were very much "convenience" samples, as was the process of interviewee sampling (Bernard, 1994; Bryman, 2001). During my time at *Cornerstone* I completed interviews with fourteen adults (7 ♀, 7 ♂) including a psychiatrist, administrators, an administrative assistant, teachers, Child and Youth Workers (CYWs), and CYW trainees on their practicum. This number and range includes 93% of adults at *Cornerstone* (one member of staff declined to be interviewed). I completed small group interviews with eighteen client-students (10 ♀, 8 ♂). During this fieldwork, there were a total of fifty-six client-students (33 ♀, 23 ♂), with another dozen or so discussed at staff meetings and being redirected to alternative services. None of the client-students that I approached and requested to be interview participants to attend and listen to the initial information that made up the informed consent process. None of these client-students subsequently declined to participate in the interviews and all gave their informed consent. In relation to the overall number of client-students at *Cornerstone* this is a participation rate of 32% (30.3% ♀, 34.8 ♂). The low numbers of client-student interviewees reflects logistical and ethical issues because they have to miss programming for the interviews, the impact of which both staff and I wanted to minimize. In terms of all of the client-students at *Cornerstone* seventy percent were from poorer backgrounds, as noted by their home residence, and all but three (95%) of the attending client-students during this time were second or third generation Canadians of a European background. At *NOS* I interviewed fourteen adults (7♀, 7 ♂) including administrators, psychologist, psychometrist, CYWs, teachers, and nurses, and twelve children (1♀, 11 ♂), which was a 100% participation rate. Just over eighty percent of whom were from the city's poorer neighbourhoods and all but one child (92%) were second or third generation Canadians of a European background.

2.4.5 Data analysis

All text-rich data are coded. In terms of interview transcripts this meant that they are read repeatedly, until I had an intimate knowledge of them. Next, 'coding' began (Miles and Huberman, 1994). Key emergent themes are given a symbol or highlighted which can be accomplished by using the highlight function in Word. Gradually, each transcript is coded in turn using a coding sheet (a list of emergent themes), and once themes are saturated (i.e. no new ones are generated from the evidence), all transcripts are re-coded to ensure that all of the newly generated themes are included for each data set.[6] This process is then repeated so that specific/consistent words or phrases can be given a secondary code (Strauss 1987). Formally, this process of text-rich data analysis is described as open coding and axial coding (Glasser and Strauss 1999; Strauss 1987).

This iterative process is an example of *Grounded Theory*, which proposes that the strongest theoretical posits are generated inductively from evidence (Glasser and Strauss, 1999; Meiwald, 1997; Warry, 1992). My *grounded theory* influenced approach is supplemented by recent developments in *discourse* and *content analysis* which advocate the analysis of texts from policies, newspapers, articles, as well as interview and other research-based text-rich data (Blommaert and Bulcaen, 2000; Chimombo and Roseberry, 1998; Fairclough, 2001; Hoey, 2001; Taylor 2001; Wood and Kroger 2000). It has been cogently argued that 'best practice' is to analyse discourse (texts) both paradigmatically, or thematically, and syntagmatically, or phrase and word use (Fairclough, 2001). The *grounded approach* used is in opposition to having set themes prior to approaching the data or assessing the data with specific theory. Such grounded qualitative analysis of interview and survey data has recent successes within youth mental health research practices (Crouch and Wright, 2004; Smith et al, 1999).

2.5 Implications of doing a multi-sited ethnography

I completed research with two services, one focusing on youth mental health and one focusing on child mental health (with this service being based at two locations within one city). Thus, my research is in a way multisited. I use the phrase "in a way" because the anthropological literature based on multisited research tends to focus on transnational fieldwork, where phenomena occur across national boarders such as issues of identity and representation or asylum seeking and immigration (Berg, 2008; Pink, 2005; Scarangella, 2005). While my fieldwork was restricted within the Province of Ontario (so is not transnational), I completed research at more than one service and also the services practices are not confined to one physical institutional location. In addition to providing mental health programming in two Elementary schools, *NOS* also has a central headquarters where meetings, assessments and administrative tasks take place. *Cornerstone* client-students are often off-site as programming includes activities in community facilities and public spaces (e.g. YMCA, Supermarkets or Provincial Parks). Indeed, Cornerstone owns a fifteen-person minivan to facilitate these activities.

Multisited research offers particular advantages and disadvantages. Marcus (1995, 1999) offers a detailed exploration of debates on why multiple fieldwork sites are potentially beneficial to ethnography. In terms of the relevance of Marcus's posits to my research, I am adapting traditional single-site / single-culture fieldwork, and attempting to examine the various relationships between power-discourse-policy and adults and young people through grounded ethnographic research that takes place at multiple sites (Marcus, 1995: 100). Fieldwork at *NOS* was primarily intended to gauge the differences between various mental health services, and cross-cultural comparison is a framework common to some forms of cultural anthropology. [7] My inclusion of young people is a tangential continuation of anthropology's ethnographic focus on "the subaltern" (1995: 101-102) or in terms of my introduction, marginal populations. But again I differ from Marcus' position, as I am neither solely "studying 'up'" (1995: 101) nor doing strictly comparable fieldwork (1995: 102). Rather, I am investigating how the same sets of *body politics* frames and impacts of different populations – children and teens; for me the cultures at the centre of my ethnography are institutional cultures rather than geographically or ethnically bounded. To adapt Marcus's descriptive constructions of multisited research (1995: 105-111) I am *following the discourse*. For my thesis the benefits of attempting multisited ethnography includes the introduction of a comparative dimension, and facilitated the examination of the range of service provided within Ontario.[8] I am following Fischer (1999) who notes that multisited ethnography can be used to "strategically accessing [sic.] different points in geographically spread complex processes" (458).

One clear disadvantage of my multisited work lies in this geographic spread. Undertaking fieldwork with multiple services effectively dilutes time with each, as well as time to consider the data both as it is being collated and once I exited the field. By this I mean that the addition of REB procedures, consultations and report writing, as well as the fieldwork itself, reduced the time I could spend with *Cornerstone*, the initial or primary site and also on the data collected from that site. My comparison is also of a very small portion of the overall number of services in Ontario (less than 1% of those funded through the Ministry of Child and Youth Services [Ontario, 2006]). Furthermore, it will become apparent throughout this thesis that the majority of ethnographic details come from data collected during fieldwork at *Cornerstone*. This likely reflects the longer period I spent completing participant observation with this service – nineteen months – while at *NOS*, fieldwork totaled just over six weeks completed over a period of three months.

Overall, I believe the additional fieldwork sites facilitate the potential for "thickness" in my ethnographic analysis (to paraphrase Geertz, 1978).

2.6 Conclusions

On reflection, I have included far less direct examples from the young people themselves than I had anticipated at the outset of my Ph.D. fieldwork. After all, including voices and perspectives from a social group that is rarely heard in the academe was an explicit aim of my research, and one innovation both service providers and the funding body liked.[9] By including fewer young people's perspectives than adult ones I am perhaps falling into the pattern of privileging adults, a characteristic typical of biomedical and social science research. However, when all is said and done, professional adult's perspectives have more weight in the everyday practices of child and youth mental health services irregardless of the disruptive impact of young people or any forms of agency they demonstrate (See chapters four and five for more details on this assertion). Furthermore, there are areas of service provision that demonstrate the importance of including adult voices; by this I mean that there are aspects of the services' daily and weekly activities that are exclusive to adults. Three examples of this are: staff arriving earlier and leaving later than client-students; weekly staff meetings are not attended by client-students; and administrative issues with external bodies are not the concern of client-students but rather solely the concern of adults. While young people are undoubtedly the focus of services, adults retain a certain priority within the daily function of such sites, and these are areas that can be examined and analyzed through fieldwork and participant observation. I assert that these areas are in need of analysis as they are not assessed through the standardized measurement tools used at many child and youth mental health services in Ontario, such as the Child and Adolescent Functional Assessment Scale (CAFAS) or the Brief Child and Family Phone Interview (BCFPI), which are explained in detail in endnote 3 for this chapter.

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[1] Jenkins (1998: 124) highlights the privileging of physical violence over symbolic or structural violence within anthropology. I suggest that in the same way Research Ethics Boards appear to privilege their concerns of physical risks over emotional or mental risks to research participants.

[2] The Arts project clearly demonstrated the applicability and rigour of my methodologies to service providers more used to quantitative and statistical scale research. The Role of the Arts project demonstrated to *Cornerstone* staff that while quantitative methods are suitable for generating evidence of who utilizes arts programs, the qualitative methods can generate evidence as to why this is the case from both the perspectives of client-students and staff, and also that qualitative research methods can be particularly useful to specialized mental health services in assessing their therapeutic programs. This position challenges the predominance and use of standardized and generic measurement tools (such as the Brief Child and Family Phone Interview [BCFPI] and Child and Adolescent Functional Assessment Scale [CAFAS]), as the primary and preferred basis of research by and on child and youth mental health services in Ontario (Cunningham et al, 2004; Hodges 2000). A difficulty with using BCFPI and CAFAS to generate evidence-based knowledge about services is that the sample size required for statistical analysis is not always possible for small-scale services. In addition, such tools are not designed to meet the specific research needs of individual services, while rigorously applied qualitative methods that are adapted to the local setting can be highly productive and valuable for mental health services (Kleinman 1988a; Young 1982).

[3] See Peirano (1998) for a review of the complexities faced by anthropologists doing research "at home"

[4] This is akin to triangulation, which was, and is a technique used by ordnance surveyors to accurately ascertain the geographic positioning of hills and mountains. The use of multiple 'lenses' enables our research 'hill' to be triangulated, or viewed from many angles.

[5] Focus groups are usually large in number (8 to 12 participants) and are led by a facilitator who asks questions with the hope of generating discussion between the various

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members and the content of the discussions becomes data (Bernard, 1994; Bryman 2001; Morgan, 1988).

[6] This process is often completing using NVivo or similar qualitative analysis tools which allow for subtle coding and automated linking between examples of codes.

[7] The multisited approach gave me the opportunity to apply for funding / scholarships that I would not have needed if I were “just” doing fieldwork at *Cornerstone*, which is in the same city as McMaster University. This is particularly necessary as I was not eligible to apply for prestigious Ph.D. scholarships from either the British or Canadian funding agencies (as I was a British citizen at a Canadian institution). Thus, the multisited research approach enabled me to build my CV.

[8] Although *NOS* were very clear that they did not want my work with them to be directly comparable, as they feared that their geographic isolation contributed to difficulties with service provision.

[9] This was an aim and position that was highly influence by Roberts (2000) as well as many others cited in section 3.3 that follows.

3. Contextualising *Body Politics*: academic literatures, social categories, and fieldwork sites

3.0 Introducing three interweaving contexts

This chapter addresses three interweaving aspects of the overarching *body politic* that frames both my fieldwork endeavour and research sites, and thereby the thesis as a whole. It is divided into three broad topics. Initially, I review anthropological and other social science research on health and illness. Next, I examine changes in the research literature on Childhood and Adolescence as social categories. In the final section, I contextualise the various medical and educational discourses and practices at the fieldwork sites by historicising them.

In the first section, I explore how biomedical practices have come to be understood as a form of bio-power that reflects, reproduces, and normalizes social and systemic hierarchies. I suggest that psychiatric and psychology approaches to mental illness are part of these forms of bio-power. In this first section, I summarize how the anthropology of health and illness has endeavored to rectify and alleviate social suffering, by actively participating in dialogues over health service efficacy and mechanisms for improvement. I address how my research is an attempt to merge both applied and academic anthropological approaches. In the second section, I consider changes in the academic conceptualization of key social categories at play for the fieldwork sites – this being the social construction of Childhood and Adolescence and the young people within these life stages. I address how such groups are often categorized in essentialized ways, and how this othering process impacts on both service and research practices. In the third section, I attempt to contextualize the mental health services at the centre of my fieldwork by considering several facets of present-day practices. I situate the history of mental health services delivery within Canada by locating these practices within specific biomedical discourses around mental illness, and the importance of educational components in service delivery.

3.1 Situating the thesis within Anthropology and Academic Literatures

> By 'theory' I mean a range of types of thought-frames – narratives, maps, categories, perspectives, positionalities – that operate as the conditions for allowing us to see and talk about social and cultural phenomena at all. Most theorising of the late twentieth century is quite eclectic drawing on a variety of master theoretical narratives but rarely signing up of any one of them in full. Yet these master narratives, claiming to describe / explain / represent how the social / cultural world is put together and why things are the way they are and not otherwise, remain the (sometimes hidden) condition for the ongoing *bricolage* of contemporary theory-work (Ortner, 1999: 66).

This dissertation is about many interconnecting issues, experiences and perspectives, but at its core are young people's mental illness and mental health. Thus, of critical importance are two research literatures. First, anthropological approaches to health, illness and medicine, and secondly approaches to young people. Anthropology of health and illness encompasses a wide variety of research topics, focussing most frequently on health issues in cross-cultural settings, with health and body inequalities 'at home' becoming a more acceptable focus in recent years (Hogle, 1999; Jaklin and Warry, 2004; Lupton, 2003; Macdonald, 2006; Sargent, 2006; Van Hollen, 2003; Wynn and Trussell, 2006). Part of this research endeavour has been to move away from medical anthropology towards an anthropology of health and illness thereby acknowledging western *bio*medicine's sociocultural construction, its hegemonic role within society, and how it reflects global economic systems (Singer & Baer, 1995: 33; Taylor, 2005: 743). My dissertation adds to this shifting semantic vein, as I actively highlight *illness* narratives and experiences, rather than focusing on *disease* models. I am, then, attempting to participate in the discipline's reframing away from Medical Anthropology to an Anthropology of Health and Illness, and mental health and illness specifically. Like the 'Theory' quote above from Ortner, I suggest that there is a multiplicity of theory that leads to a complex *bricolage* of perspectives and understandings. In terms of my dissertation's introductory discussions, this chapter begins to outline and grapple with the academic *body politic*.

I interpret the 'anthropology of' endeavour to be influenced by at least two strands of anthropological dialogue. On the one hand, reflexive, and interpretative post-modern theorising (Abu-Lughod, 2002; Marcus, 1986; D'Andrade et al, 1995; Ortner, 1999, Rodman, 2000, 2004; Rosaldo, 1989), and on the other, by *critical* and sometimes leftist theoretical approaches to social phenomena (Baer, 1996, Lock and Nichter, 2002; Singer, 1990). For me, the recent process of shifting towards an 'anthropology of' is indicative of ongoing attempts to react and respond to anthropology's interpretive turn that began in the mid-1980's, the dilemmas surrounding "knowledge," "truths," "facts" and "authority" that arose with it, and the clearly privileged positions of academic researchers working on / with vulnerable people (Abu- Lughod, 1999; Appaduri, 1996; Clifford and Marcus, 1986; Ortner, 1999; Sewell, 1999). The need to remedy these interpretive and postmodern dilemmas is particularly important as my field of research includes an arena that deals primarily with increasingly evidence-based facts (Daly, 2005; Pope, 2003; Rock, 2005), presents knowledge as being cumulative, and considers itself to have authority over bodies and diseases – this arena being 'modern' biomedicine. The 'constant shifting' has been and may continue to be problematic for both anthropologists and anthropology's 'reputation(s)' (whatever standing that may be) because it is juxtaposed with and challenges the objective, reductive rationalism that justifies and legitimates broad power differentials within society.

I suggest that the growth in medical anthropology, and critical medical anthropology within it, might be seen as a key reaction to the dilemmas associated with the interpretive turn, and the desire to better understand and thereby influence biomedical policy and practice. Furthermore, this interpretive/critical division might also be considered similar to the separation between recent social science approaches to bodies, knowledge and ways of knowing, and the approaches of biomedicine. I would go so far as to suggest that there is a series of parallel dualisms that reflect these two distinct approaches. I acknowledge Kleinman's call for theoretical models that can cope with "complex ethnographic findings, which make a shambles of established dichotomies" (Kleinman, 1978: 664), but the cleavages summarised below do bring some clarity to the issue, while perhaps oversimplifying it:

Body – Mind
Biomedical Science – Social Science
Critical Anthropology of Health and Illness – Interpretive Anthropology
Disease – Illness
Health – Wellbeing
Psychiatric Disorder – Mental / Emotional Wellbeing
Normal – Abnormal / pathological

In order to have productive dialogue across and between these sets of dualisms there is a necessity to remedy the cleavage between them, and the two disparate anthropological tendencies – postmodern and critical.[1] This is especially the case when the interpretative dilemmas might be countermanded and disparaged as academic 'follies' when 'real life' health difficulties are explored and exposed. I, like the Critical Medical Anthropology canon, am not attempting to "break objectivism's monopoly on truth" (Rosaldo, 1989: 102) or even, for that matter, biomedicine's monopoly on truth. Rather, I am attempting to challenge, question and be critical of what is accepted as naturalised, essentialised, and normal. *Critical* approaches are attempting to add to the facts, authority, and knowledge of western biomedicine by conveying the sociality of medical practices, highlighting the multitude of illness narratives and the patterned variations in disease impacts. Kleinman for example was an early proponent of criticizing the taken for granted "biomedical categories of biomedicine (e.g. 'disease,' 'diagnosis,' 'preventative measures,' 'medical system'), as if these were universal, culture-free and therefore unproblematic" (Kleinman, 1978: 662). By building on the insights and approaches of Critical Medical Anthropology and Critical Interpretative Medical Anthropology, by questioning the "taken for granted" and naturalised experiences of disease and bodily processes as portrayed by the biomedical models prominent in western society (Butler, 2001; Lock, 1993; Scheper-Hughes, 1991), we can come to an understanding that is indicative of socio-cultural aspects of health and illness (Estroff and Henderson, 2005; Farquar and Lock, 2007; Helman, 2001; Jordan, 1997; Martin, 1991; Rapp, 2007).

The balance of this chapter focuses on two distinct academic literatures. First, I address anthropological understandings of health, bodies, biomedicine, and mental wellbeing. Second, I discuss the social constructions of Young People, Childhood and Adolescence, and essentialised categories applied to people within these life stages. By offering a summary of these two literatures, I can contextualise key aspects of the overarching *body politics* for the ethnographic field sites, where social constructions and understandings interweave with issues of power, control, and participation.

3.2 Anthropology on bodies, minds and social locations

> Once the purview of laboratory scientists and clinicians, in white coats, the domains of disease and health, birth and death, bodily suffering and debilitation are now inhabited also by scholars

> from the social sciences and humanities (Estroff and Henderson, 2005: 4).

In the introduction to this chapter I use the term *bio*medicine. This nomenclature reduces the privileged position that western *bio*medicine has in comparison to *ethno* medicines, *folk* medicines, and *alternative* medicines. By questioning the hegemonic position of biomedicine, social scientists and anthropologists are able to highlight the cultural specificity of western medicine, situating it within both a specific recent history (less than 200 years) and a cultural value system that includes taboos and rituals which occur during practice and knowledge production (Hahn, 1995: 131-132). The key to *bio*medical understandings of disease is the mechanisation of bodily processes, which makes disease symptomatic of mal-functioning mechanical bodies. Underpinning this position is a dualism based on Descartes' separation of minds and bodies, souls and physical beings. The link between *bio*medicine and *Cartesian dualism* is well documented and too numerous to fully cite here.[2] Cassell suggests that "Medicine's traditional concern primarily for the body and for physical disease is well known, as are the widespread effects of the mind-body dichotomy on medical theory and practice" (Cassell, 2005: 9). One advocate of Clinical Critical Medical Anthropological (*CCMA*), Kleinman, suggests that this dualism places pervasive barriers between doctor and patient, which needs to be rectified and can be by applying a CCMA approach:

> We can advance this dialectical interaction between social structure and physiology – the symbolic reticulum between person and society – in the practical moment of the clinical

> transaction so as to compel the attention of clinicians to a much-needed reformulation of clinical models, one that can liberate practitioners from the inadequate and dehumanising Cartesian mind/body and individual/society dichotomies and can offer a theoretical basis for the myriad of research findings supporting biopsychosocial interactions, a model congenial for many practitioners (Kleinman, 1985: 69).

Yet such Cartesian dualism is prevalent today in *bio*medical training, even in progressive teaching hospitals such as McMaster University. A result of this orientation in conjunction with a 'drive for knowledge,' is that *bio*medicine is able to have better medical practices and procedures, better emergency care, better health outcomes, and in turn produce longer lives, when compared to fifty or a hundred years ago. These *bio*medical advances are to be praised, and recognised as considerable achievements. However, I consider there to be (at least) three un-stated aspects implicit within such modernist rhetoric about biomedicine: *bio*medicine has tended to overlook the roles that power and control can play in creating differential health outcomes; psychiatric or mindful (to use Scheper-Hughes and Lock's word) aspects of wellbeing often go unaddressed within *bio*medical disease models; and, finally *bio*medicine rarely asks how, where and if alternatives and unheard voices can interact with biomedical models. I shall discuss anthropological approaches to these three aspects in turn.

3.2.1 *Bio*medicine and Power, bodies and minds

Over the last thirty years anthropology orientated its research to include biomedicine as well as 'traditional' anthropological foci of ethno and folk medicines. Influenced considerably by Foucaultian notions of power as well as political economic perspectives, this newer focus has come to question how biomedicine might be a tool of control and support for a capitalist system and resulting unequal social/world hierarchies. Indeed, lead proponents of the Critical Medical Anthropology (CMA) approach have argued that "[b]iomedicine … can be understood as a vital hegemonic force in the capitalist world-system" (Singer & Baer, 1995: 27). Foucault's work on technologies of power such as social apparati (criminal law) and material structures (panopticon prisons) can and have been applied to biomedical models and systems of disease and health care (Foucault, 1980: 146-147; see also McCallum, 1997: 63-64). For the discussion here, Foucault's concept of bio-power is particularly apt, and can be defined as knowledges, technologies, and discourses used to normalize people and to naturalize hierarchically valued attributes (Dryfus and Rabinow, 1982: 195; see also Dean, 1996). Foucault argues that *the* site of bio-power is the clinic, where "a reorganization in depth, not only of medical discourse, but of the very possibility of a discourse about disease" (Foucault, 1975: xix) takes place. Through bio-power's reorganization of discourse and knowledge (*bio*medicine's empirical knowledge and its application), a social hierarchy is normalized and individuals "come to accept the state of affairs as natural" (Goodnow, 1990: 280). In Foucaultian terms the object of bio-power are bodies, which "possesses [sic.] an a priori individual unity disarmingly reminiscent of its arch-rival, the transcendental subject. As objects of the disciplines of medicine, psychology, sexology and other discourses of power, bodies are inherently individual units" (Turner, 1994: 37-38). Individuals' bodies conglomerate in groups or classes through the "unifying power of habitus" (Bourdieu, 1998: 2; see also Bourdieu, 1977: 81), and the reality of these bodies (both individual and class) is determined historically and politically, in terms of power's operation and resistance to it (Turner 1994: 40).

Turner recognises the potential for resistance within Foucault's bio-power framework, which contradicts those researchers who have argued that Foucault "leaves no scope for resistance or action" (Jones, 2001: 172). While I argue that bio-power is hegemonic in appearance, I follow Turner (1994) and Gordon (1980) who consider the application of bio-power to leave some (albeit limited) space for counter-hegemonic activity. Foucault's bio-power "does not mean that one is trapped and condemned to defeat no matter what" (Gordon, 1980: 141-142). There is capacity for counter-hegemonic discourse as witnessed not least in CMA's very existence, which can perhaps be considered as a "necessary precondition for new ways of thinking and acting in everyday / everynight life" (Alanen, 1994: 40-41). Moreover, *Critical* approaches argue that data that is collected and analysed should have the potential to impact *bio*medical / health policy and practice (more on this in *Anthropology and Application* below).

CMA further builds on Foucaultian orientated perspectives and argues *bio*medical discourse and structures work as sources and tools of power within world systems:

> Critical medical anthropology understands biomedicine not solely as a socially constructed system embedded in a wider

> cultural pattern, nor only as a mechanistic and depersonalizing structure with important social control functions in contemporary society, but more broadly in terms of its relationship with the truly global capitalist world economic system (Singer & Baer, 1995: 33).

CMA approaches, therefore, question biomedical processes and the power they wield. Such critical perspectives examine how "the broader social order is reproduced in the biomedical division of labour … [and how] the legitimization of this social order is also reproduced in the biomedical setting" (Hahn and Kleinman, 1983: 318). CMA therefore also argues that individual bodies interact within culturally delineated hierarchies, and that biomedicine helps to make these hierarchies acceptable as merely common sense (Baer, 2001: 34). Thus, during biomedical processes those bodies, which do not fit within or accept biomedical frameworks become pathological (Baer, 2001). This process of pathologising bodies is ultimately a dualistic othering process.[3] CMA has also questioned biomedicine's internalisation of approaches to infection, morbidity, and mortality and the differential outcomes of disease and illness (Becker, 2004; Crooks, 2001; Leatherman, 2001; Thomas, 2001). Biomedicine thereby reflects a classist, racist, and sexist social system that benefits from ill-health (in Baer's terms health outcomes reflect socially delineated hierarchies). A main conclusion of *Critical* approaches is that social and economic inequalities also influence bodily health, and therefore health inequalities reflect social inequalities. A brief example comparing US and Canadian health care systems is useful in illustrating this point.

Bodenheimer and Gumach note that "aside from the United States, Canada has one of the most expensive health care systems in the world" (2005: 210). Yet Canada has lower health care costs, which result not from lower per population service utilization but rather from considerably higher per patient costs in the United States. These higher per patient costs result from administrative costs, greater intensity of in-hospital services (i.e. fees are higher for hospitalized cesarean section as opposed to mid-wife led home births) and finally physician fees and pharmaceutical prices, all of which are manifestly higher in the US (Bodenheimer and Gumbach, 2005: 210). Put simply, the US health care system costs more, and fewer patients (in relation to total population) have access to and make use of health care services. At the same time, it is clear that universal (i.e. Canadian) access to health care improves overall health status: "A comparative study of the United States and Canada found a strong association between income inequality and mortality in the former, but none in Canada, at either the provincial or the metropolitan level" (Ross et al, 2000: 902). While this is a blunt comparison (just in terms of income level and mortality) it does suggest that biomedicine, as a form of bio-power is more hegemonic in the US. This is because those individuals and classes least likely to have access to health care insurance, and thereby services, are more likely to be from poorer and racialised backgrounds (Armelagos and Goodman, 2001; Baer 2001; Rylko-Bauer and Farmer, 2002; Schnittker and McLeod, 2005; Susser 1996). Although not perfect, the Canadian health care system goes considerably further that the US system to narrow the gap between rich and poor (Moniz and Gorin, 2007: 12).[4]

The process in which the *bio*medical systems, such as those described briefly in the above Canada-U.S. comparison, treat the body, rather than the 'whole' patient while potentially blaming individuals when their bodies malfunction, has been termed medicalisation (Chrisman and Johnson, 1996; Good, 1994; Good and Delvecchio-Good, 2000; Helman, 2001). Medicalisation as a conceptual tool has been applied to a wide range of health and other contexts (Bennett and Cook, 1996; Browner, 1999; Finn and Nybell, 2001; Foucault, 1997; Franklin, 1995; Helman, 2001; Hughes, 1996; Illich, 1977; Kleinman, 1995; Lupton, 1997; Oliver, 1990; Rafalovich, 2001; Taussig, 1980, Weiss, 2001; Weitz, 2007; Young, 1981). Conrad comments:

> Medicalisation consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it. *This is a sociocultural process* that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession (Conrad, 1992: 211, emphasis added)

With the process of (bio)medicalisation there is an accompanying internalisation of disease within individuals' bodies, and in such processes we see causal factors transferring away from broad socio-cultural political-economic causes and towards individuals' behaviours and genetics (Dufour, 1997; Inhorn, 2004; Lock, 1993; Sunday et al, 2001). I must add a caveat at this point: Public Health, which is a part of *bio*medical health care systems, explicitly draws on wider contextualisation to explain ill-health, as it often utilises a social determinants of health approach (Levy and Sidel, 2006; Marmot and Wilkinson, 2006; Rachlis, 2004; Raphael, 2004; Shah, 2003). Such a nonmedical determinants of health approach has been part of the Canadian Public Health promotion since the 1970s, and its value and impact has been debated (Morse, 2004; Singh Bolaria and Dickinson, 2001: 205-207). [5] Schneider describes the difference between biomedicine and Public Health in the following way: "Medicine focuses on healing patients who are ill. Public Health focuses on preventing illness" (2006: 6). Public Health, as a more contextual section of *bio*medical health care systems, therefore tries to implement programs and practices that assist in generating improved health outcomes at the 'class' level – often by targeting specific underserved groups, especially those facing considerable inequalities. Furthermore, such Public Health programs do not have to be directly tied to health care. Low et al (2005), for example, argue that

> One of the best ways to reduce health disparities and income inequalities while improving the health of the nation is to focus policies on optimising both early childhood development and education, linking early child care, family support, and developmental enrichment with K-12 education in a seamless continuum (Low et al, 2005: 106).

In that Public Health endeavours have tried to highlight broader social or nonmedical determinants of health and illness, and highlighted the parallels between the lack of equity in social, economic and even educational outcomes and patterns of poor health outcomes, Public Health might be considered to be the institutional practice of CMA theorising. That being said, Public Health as a discipline and a practice does not, to my knowledge, overtly draw on CMA research. Furthermore, despite its broader-based approach to health and illness, Public Health endeavours can be criticised as being bio-power tools, because they are not "value free," but politically driven "technocratic procedures" (Rees-Jones, 2001: 164). It should be noted that Public Health policy is inherently tied to politics - Sears argues that Public Health is like "[s]ocial policy [which] is not neutral; it is linked to the production and reproduction of a particular set of capitalist social relations" (Sears, 1995: 184). Moreover, not only are Public Health programs justified in terms of reducing future health care costs (Schneider, 2006: 7), they are also justified as they help create people who add to a "collective economy through *gainful employment*"(Low et al, 2005: 135, emphasis added) – 'docile bodies', to use Goodson and Dowbiggin's (1990) phrase, indeed.

In summary, I have argued that biomedicine helps form docile and productive bodies (Dryfus and Rabinow, 1982; see also Jones, 2001). Through the process of medicalisation, biomedicine acts to disenfranchise people and their bodies from power, and at the same time separates disease causes and outcomes from illness experience (notwithstanding Public Health and social determinants of health approaches). It might be useful to consider a process akin to Conrad's medicalisation of the body as applied to 'minds,' which could be termed 'psychiatrisation'. I suggest that while Conrad (1992) does address medicalisation as it pertains to the psychiatric as well as the physical fields, the colonising processes of biomedicine over behaviours would be more transparent through the explicit use of *psychiatrisation* as the term highlights processes of medicalisation within specifically psychiatric realms. Fabrega (1993) too, while explicitly calling for psychiatry to become an arena addressed by medical anthropology, uses the term medicalisation. Indeed, although not using the term *psychiatrisation*, Tyler offers a thought-provoking account of psychiatrists' active attempts from the 1930's onwards to "secure a new area of activity" (1997: 86) by expanding their authority over diagnostic and assessments of young children to include "behavioural problems" in addition to "mental deficits" (Tyler, 1997: 86-87; see also Diller, 1998). Gaines (2007; 1992) notes the close alignment of western psychiatry, or bio-psychiatry, to and with biomedical contexts of power, normalcy and naturalisation. While Hahn and Kleinman have argued that biomedicine as a sociocultural system has "distinct elements that interact in a manner which separates them from other systems within society" (1983: 306), I agree with Gaines who describes biomedicine and psychiatry as having false neutrality and argues that they are "pre-eminently cultural constructions" (Gaines, 1992: 6). Tausig et al (1999), as sociologists (rather than as anthropologists), describe the processes of colonization of behaviours by psychiatry and they too rely on the term medicalisation. I suggest that there is a qualitative difference between the development of improved medical processes in relation to physical illnesses, and the development of psychiatric processes that relate specifically to behaviours that were once considered "immoral, sinful, or criminal" and are "now increasingly defined as illness" (Tausig et al, 1999: 139). Further, using medicalisation hides the fact that psychiatrisation is a socioculturally constructed response and form of social control. I will argue that the biomedical psychiatric practices undertaken at my fieldwork sites are deeply intertwined and interconnected with other systems within society, and that I have witnessed a "confluence of political systems, the law, moral codes, ideology, and beliefs about illness and health" (Romanucci-Ross, 1997: 324). It is to how anthropology approaches bio- and ethno-psychiatry to which I now turn.

3.2.2 Anthropology, psychiatry, psychiatric disorders, and power

> All human societies have notions of what constitutes normal behaviour patterns expected – indeed, demanded – of group members, as contrasted to abnormal behaviour – behaviour that is not only different but often also socially disvalued … But the clear specification of when a pattern of norm-violating behaviour passes from being mere forgetfulness or outright criminality to that of pathology is one of the most vexing issues in psychiatry and social deviance (Hughes, 1996: 137).

Anthropological approaches to behavioural abnormalities and deviance have a fairly long history (Honigmann, 1956; Hughes, 1985; Sapir, 1949; Scheper-Hughes, 1979; Wegrocki, 1953), and have come under a variety of disciplinary titles – including psychological anthropology, transcultural psychology, transcultural psychiatry, and cross-cultural psychiatry (Bock, 1980, 1979; Carr and Vitaliano, 1985, Sapir, 1985, 1924, 1913; Spiro, 1990). These approaches tended to focus on psychiatric-type issues for non-western peoples. Indeed, Hughes argues that much of this work was assessing if western psychiatric frameworks fit with local behaviours, and is critical of the universal application of what I call bio-psychiatry over local non-Cartesian medical systems

(Hughes, 1996: 132-136). This critical stance is shared by a strong proponent of cross-cultural and comparative methodology, Kleinman (1987), who discusses how behavioural abnormalities become psychiatric illnesses in various settings. In addition, Kleinman expresses concern that anthropology exerts little influence on psychiatry, and that anthropology perspectives should be of more than "informal, heuristic interest" (1987: 447) to psychiatry (see also Littlewood, 1990; or Young, 2002).[6] Early debates were concerned with 'culture-bound syndromes' and the authoritative claims of the various editions of the American Psychiatric Association's (APA) Diagnostic and Statistical Manuals (DSM) versions I through to IV-tr (1952, 1968, 1980, 1987, 1994, 2000). More recently, the focus has been to highlight power disparities within doctor-patient interactions, where again bio-psychiatry has come under criticism (Gaines, 1998). Such criticism is linked to *labelling theory* (Marks, 1999). Broader social science literatures, which share vantage points with anthropology (Estroff and Henderson, 2005: 4), also offer interesting insights into issues of access to service, which mirror CMA's political-economic theorising. All of these broad topics within the anthropology of mental illness are linked, even if tangentially, to academics' and activists' critical reading of Foucault's critique of institutional psychiatry (Foucault 1997, see also Armstrong, 1997: 16-17). I will briefly discuss these three pertinent topics within the literature by addressing each in turn.

Cross-cultural psychiatry has questioned the appropriateness of culture-bound syndromes, which are defined as "a constellation of symptoms which has been categorised as a disease," (Hill and Fortenberry, 1992: 73; see also Helman, 1985 and

2001) that are specific to single cultures (Carr and Vitaliano 1985). These culture-bound syndromes were outlined in early versions of the DSM to describe the clusters of pathologically abnormal behaviours that occurred in non western settings, and presumably fell outside of the universal bio-psychiatry diagnostic categories (APA 1952, 1968). These behavioural abnormalities were considered strange, exotic and rare by western psychiatry (Hughes, 1985: 7-9). Cross-cultural psychiatry proposes that bio-psychiatric culture-bound categories are false or ethnocentric, and attempts to undermine psychiatry's (and implicitly *bio*medicine's) universal individual and normal mind (and body). Much of the anthropological work exploring culture-bound syndromes critiques the psychiatrisation of everyday social actions and "[s]ocial anthropologists have objected that their [psychiatry's] error was to use a medical grid which inevitably objectified social action as disease entity" (Littlewood and Dein 2000: 22; see also Helman, 1985). These 'folk' or 'ethno' psychiatric syndromes or disorders do "not fit easily into the Western diagnostic formulations" (Hughes, 1996: 141), and therefore became know as culture-bound syndromes. As Young saliently argues, Western mental disorders are closely aligned with physical diagnostic models:

> the official nosology of the American Psychiatric Association … is modeled after the classification of infectious diseases, in that each named mental disorder is identified with a unique set of diagnostic features and is assumed to have a distinct etiology (Young, 2002: 223).

I suggest this official mirroring of psychiatric with physical is an attempt to imbue psychiatric diagnoses and diagnostic processes with biomedical power associated with identifying physical (bodily) mal-functioning. Yet there are considerable problems when this nosology is applied in cross-cultural contexts, where notions of normal and abnormal are not necessarily the same as in the case of the West, and the culture-bound syndromes (Hahn, 1995: 55-56), as diagnostic categories, might be considered "residue[s] of colonial reading of local practices" (Littlewood and Dein 2000: 26; see Doi, 1990 for a discussion of Japanese mostly negative reaction to Western psychiatry). Here I will briefly outline five anthropological critiques of culture-bound syndromes and by implication bio-psychiatry.

Firstly, mental 'pathology' associated with western psychiatric approaches has been identified as "just one possible grid and one that carries with it particular assumptions about normality and abnormality, which explicitly ignore considerations of power and of context of observation" (Littlewood and Dein 2000: 23). Secondly, while genetic and environmental factors might trigger mental health difficulties (Hughes, 1996: 131), Stolzman notes that "[s]ocial scientists have been critical of both the biological determinism and the ideological conservatism implicit in this [genetics as sole cause] viewpoint" (Stolzman, 1994: 449, my insertion; see also Bury, 2005: 16). Within these first two conjectures we see critiques of the cultural assumptions inherent in Western psychiatry – egocentric and reductionist approaches to behaviours, which overlook the possibility that even if 'abnormal' behaviours exist they are abnormal in very specific cultural contexts. A third critique of culture-bound syndromes and, by implication western psychiatry, is outlined in Young's (2002) examination of recent evolutionary accounts for psychiatric disorders. These accounts are designed primarily to provide the "origins and significance of mental disorders" (Young, 2002: 222). Yet, Young argues, they also implicitly justify the present-day diagnostic criteria, as "they vindicate the correctness of the categorical perspective" (Young, 2002: 223) and "vindicate rather than challenge conventional wisdom" (2002: 233). The consequence of which has been "the naturalization or medicalisation of morals" (Young, 2002: 236). In summary, Young argues that through evolutionary psychiatry arguments both the origins and justifications for present-day disorders are inherently intertwined and, I would further argue, that evolutionary psychiatry discourse becomes a tool of bio-power, as I defined above. A forth critique of the concept of culture-bound syndromes is that culture-bound has also been applied to behaviours specific to western individuals. For example Hill and Fortenberry (1992) somewhat mockingly use the culture-bound frame to explore how American Adolescence, as a life stage, might be described as undergoing a medicalized 'epidemic'. Such 'reapplication' of a culture-bound frame further undermines psychiatry's authoritative voice,[7] and has led Schweder to argue that cross-cultural psychiatry is heretical as it undermines the APA's authority, for example (Schweder, 1990: 22). More generally, there is a fifth critique of bio-psychiatry. There have been strong critiques of any and all DSM-based diagnostic nosologies as there has been little or no clinical replicable or scientific laboratory testing approach to their reliability since introduction of DSM-III (Kirk and Kutchins 1992). When the diagnostic criteria have been tested, reliability problems are blamed on "practitioner mistakes, not the instrument itself" (Kirk and Kutchins 1992: 217). The resolution of questions surrounding reliability and validity of diagnostic criteria and assessment continues today along two lines: some disorders that have fragmented and expanded with each edition of the DSM (i.e. ADD-ADHD, AD/HD, ADD(H)/ADD(I)); and psychiatric research still seeks a clinically reliable test for behavioural disorder diagnoses that does not rely on observation by parents, teachers or other involved adults (Brewis 2002a, 2002b).

I am not explicitly attempting to undermine psychiatry's universal applicability, or the ways in which it can and does reduce suffering and mental distress in Western settings. I am, however, attempting to situate psychiatry and its diagnostic categories within a broader context, in order to highlight their cultural construction within biomedical practices. In this way, I am critiquing bio-psychiatry. In the next section I broaden the scope further to consider how *power* acts within psychiatry and psychology practice. To do so I discuss anthropological perspectives that focus on the "relationship between individual and sociocultural phenomenon" (Bock, 1980: 1) such as doctors and patients (see also Scheper-Hughes and Lock, 1986).

3.2.3 Anthropological approaches to doctors, patients and psychiatric power

As early as 1966 it was noted that the process of mental health diagnosis involved a *relational sociality*. For example, Zuzman argued that mental health diagnoses occur when dialogues and interactions between two or more people transpires (Zuzman, 1966: 636). It may seem patently obvious to acknowledge the relational aspect of diagnostic processes (as it involved doctors *and* patients), but it was not until the interactional models put forward by Kleinman (1978; 1980) that the power differential between the two parties became a focus of anthropological research. Kleinman's influence is clear in two key anthropological texts on psychiatric doctor and patient relationships that highlight the role power plays in these contexts – Young (1993) and Hughes (1996) in particular bring power to the foreground of their analysis. Kleinman's *Explanatory Model* acknowledges that both physicians and patients have ways of accounting for a given disease or illness (Kleinman, 1980, 1988a), and that physicians have a cultural language of biomedicine, which is grounded in rationality and empiricism that assumes universal application (Good, 1994). Of particular importance is that Kleinman recognises the power that accompanies physicians because of their position; their doctor status (this is much like the power associated with authoritative knowledge in birthing settings [i.e. Jordan 1997]). A result of the physician's power is that the biomedical explanatory model often overwhelms the patients' own explanatory model, which can include cultural, sacred and secular causes and treatments (cf. Kleinman, 1988b: 156) which, if overlooked, can reduce the efficacy of the biomedical treatment response (Helman 2001: 103-106)

Kleinman's explanatory model has been adapted fruitfully for a contextualised understanding of mental health practices, and has been utilized in both research on mental health (Hutchby and Moran-Ellis, 1998; Estroff et al, 1991; Lester and Tritter, 2005; Sayre, 2000; van Dongan, 2005) and more general medical practice (Farmer, 2003, 1999; Helman, 2001; Monks, 2000; Schnittker and McLeod, 2005). Kleinman advocated more culturally sensitive way to undertake psychiatric interviews, and "wanted to encourage the use of open-ended questions, negotiation, and listening, not the usual mode of clinical interrogation" (Kleinman, 1995: 9). This is because patients' "[c]ultural models may implicate sacred or secular causes and treatments; they also tend to relate personal distress to social circumstances" (Kleinman, 1988b: 156). In addition to incorporating patients' "perceptions and knowledge about their health" explanatory models also "focus on the interactions and the negotiations between health professionals and clients in order to uncover the power relationships" (van Dongen, 2005: 194). The explanatory model approach is useful as it explicitly acknowledges the "unequal footing" (Monks, 2000: 21), or power differential, inherent to the relationship between patients and doctors. This power differential is predicated on the doctors' authority, by right of their status and training, and patients' dependence upon their authority (Doi, 1990: 447), which can be linked to Foucault's inscription of power/knowledge onto bodies (Fox, 1994: 26, 163). Doi who examines psychiatric practices in Japan argues that specifics of Japanese culture (a polytheistic and animistic ethos) make it culturally "immune from Western secular rationalism" (Doi, 1990: 451), thereby causing western psychiatry to fall short, both in contributing to people's explanatory models, and to their willingness to participate in bio-psychiatry orientated treatments. These failings, in this setting, means that doctors who utilize a western psychiatric model do not have automatic authority.

Part of the doctor (as authoritative) – patient (as dependant) role includes the patient's submission to doctor's expectations. The patient's "sick role" within the doctor-patient interaction "requires sick persons to be motivated to get well, rather than languish in a state of illness, and to pursue this end by seeking help from a competent physician and following a prescribed therapeutic path" (Heritage and Maynard, 2006: 352). I address the submission to an appropriate sick role in greater depth as part of chapter six.

In taking on the sick or dependant role, patients have to accept or internalise the diagnosis (Sayre, 2000). In Disabilities Studies literature, patient submission to a physician's diagnosis, and the often-negative social effects this can cause, has been described by labelling theory (Marks, 1999).

This concept has been transferred to mental health arenas where labelling theory has been used to "fundamentally challenge the medical conception of mental disorder that informs modern psychiatry as well as public attitudes on the subject" (Stolzman, 1994: 451). Mitchell (2003) goes further than labelling theory, when reflecting on the diagnostic process and categories of the APA's DSMs themselves. Mitchell is critical of the DSMs' deficit model as the precursor to therapy (2003: 291), and argues that the authoritative descriptors themselves are negatives – child 'A' is compared to peers, and is significantly less able, less proficient – which means that the ideological foundation of pediatric psychiatric diagnoses is also negative. The work of Cocks (2006) parallels these criticisms of labelling theory and deficit models. Although writing about ethics of research with young people, Cocks problematises how people with disabilities are most frequently seen as "rigidly compartmentalized: either striving to prove they are not incompetent, or who are labeled incompetent, regardless of their actions" (Cocks, 2006: 257). For Cocks, people with disabilities have to fight against their labels. Implicit in Marks', Mitchell's and Cocks' positions is that social reactions to mental illness diagnosis will always be negative if the ideological foundations are themselves negatives, and there is broad acknowledgment within the mental health arena of the stigmatizing impact a mental health diagnosis can have (Olsted, 2002; Schmitz et al, 2003; Sharfstein, 2006).

Some research suggests that the negative impacts of stigmatization are more debilitating than the mental illness it is associated with (Cummings and Cummings, 1995; Link et al, 1997; Sayre, 2000). An example which more closely relates to the fieldwork context is that of Browne et al (2004), which acknowledges the negative implications that labelling young people with psychiatric type difficulties in schools can have (see also Jacobsen, 2003). Yet the impact on patients and their response to psychiatric diagnosis is not homogenous. Some patients associate positively with their diagnostic label, as a 'proper' label can become central to identity performance and lead to recognition (of suffering and existence) by others (Sayre, 2000). This can occur even to the extent that those patients performing most closely with their label are more accepted and receive better treatment options (Hermas, 2003; Schmitz et al, 2003). These social responses to psychiatric labelling will be explored in more detail in chapter eight.

Kleinman's explanatory model perspectives have, over time, morphed into calls for the necessity of physicians and services to demonstrate cultural competency (Matsumoto and Juang, 2004: 374-376; see also Glass et al 2006) or be patient centred (Heritage and Maynard, 2006: 354), especially in the United States. Advocates for a cultural competency approach are particularly vocal in multi-cultural contexts where there is considerable need for medical doctors (especially paediatric psychiatrists) to gain cultural competency so that they might better navigate the diagnostic process when patients and their families present culturally specific symptoms alongside structural obstacles to service access (DHHS, 2001; Harwood, 1998; Stroul and Friedman, 1996).

Yet, like much biomedical practice, there is also concern that this has become an overly formulaic approach. Ideally it would mean physicians are

> appropriately cognizant of and responsive to cultural issues [and] should not be thought of as reaching a 'competency,' as much as engaging in an ongoing process of honing and applying skills for self-awareness and for respectful recognition of the unique perspective each patient brings to the clinical encounter (Hunt, 2005: 136).

Kleinman has also voiced concern over the misapplication of the explanatory model approach,

> I [Kleinman] am extremely uncomfortable when it is misapplied as an identification of medical meanings as 'beliefs': things that can be elicited, often outside the vital context of experiences … I meant the explanatory models technique to be a device that would privilege meanings, especially the voices of patients and families, and that would design respect for difference (Kleinman 1995: 8).

So while the explanatory model has been useful in examining and acknowledging the authoritative power of biomedical physicians and diagnostic categories (at an academic level), it has not always been possible to apply it so that patients' and families' cultural perspectives are incorporated in diagnostic and treatment decisions (Kleinman, 1988b: 156). Clearly, the power differential between physicians and patients still exists even when an explanatory or cultural competency model is put into practice, and this power differential can and does impact on diagnosis and treatment outcomes.

3.2.4 Anthropological Contextualisation of Mental Health Service Use

I now briefly turn to the anthropological and social science literature on social determinants of service access and utilization (the practical implication of power differentials). As part of a cross-continental comparison of mental health systems in four countries, Arnett notes that in Canada, "[m]ental illnesses affect people of all ages, educational levels, walks of life, cultures and socioeconomic levels" (Arnett, 2006: 142). Yet, there is growing evidence that even in countries where mental health services are in place, individual's access and treatment outcomes are framed by socio-cultural factors, which mirrors CMA's political-economic theorising. Put simply, there are patterns of unequal seeking, use of, and success in, mental health services for both adults and young people (DHHS, 2001; Government of Canada, 2006: 43). These patterns tend to follow lines of social stratification, such as gender, class, race / ethnicity and to a lesser extent age, although most research on the relationship between social status and mental health / mental illness tend to focus on socioeconomic factors (Backett-Milburn et al, 2003; Eaton and Muntaner, 1999; Muntaner et al, 2000). Such research suggests that social inequalities exacerbate difficulties in access to and success in mental health treatment that arise because of the complexity of the system, especially in countries where mental health services are not entirely covered by national health insurance, or indeed employer health insurance (Olson, 2006a: 237-238). I will first discuss why access to mental health services in Canada is similar to the US situation, thus making the improvement of social status a significant aspect of improving mental health. I then turn to a brief review of the literature on the relationships between social status and treatment of mental illness.

It is well known to Canadians that many millions of people living in the United States have no access to medical insurance of any kind; this fact is a source of pride, as our universal coverage automatically grants our system superiority – all here have access to health services. Yet there are striking similarities between the situation for both Canadians and Americans in need of mental health services, which might surprise those proud of the Canadian Medicare system (Health Canada, 2006). Despite the *Canada Health Act of 1984*, which legislates comprehensive insurance coverage for publicly administered accessible and portable health services, mandates for mental health services are considered a provincial matter, which in turn leads to a variety of often fragmented mental health systems (Olson, 2006a: 241; see also Mhatre and Deber, 1998). There is one key impact on mental health services that results from the provincial, or de-centralized, control of Health spending – that being the availability of different types of mental health services covered by Medicare (Health Canada, 1997b). Put simply, provincial policy directs funding to specific mental health services (adult or child /youth, in patient, residential, outpatient, community) and directs funds to address specific disorders and diagnosis, and these policy decisions vary between provinces, which in turn means mental health services vary between provinces.

It should be acknowledged that mental health services are regularly under-funded (Arnett, 2006: 162; Government of Canada 2006; Newman, 1998: 4). For example, Ontario directed just 8.8% of its health monies towards funding mental health services in

1998/1999 which is disproportionately low "[r]elative to prevalence estimates of 20 percent of the population experiencing mental disorders, the 8.8 percent of total health care budget in Ontario appears to be disproportionately low" (Arnett, 2006: 162). Also, as stated above, provincial policy dictates the availability of certain types of mental health services. This has the consequence of considerable variety in what mental health services are covered across Canada rather than mental health services being comprehensive and portable across all provinces. For example, during fieldwork, practitioners often spoke highly of the services offered in British Columbia, and of their perception that these services were better funded than mental health services in Ontario. Arnett notes that the decisions over which services to fund have considerable impact on who actually accesses mental health services: "[e]ighty percent of psychological services in Canada, for example, are not funded by any government program and are thus not equally available to Canadians at all financial levels" (Arnett, 2006: 157).

The result of these two issues, under-funding and directed funding, is that an estimated 4.5 million of 6.4 million Canadians with mental disorders have ongoing unmet needs for mental health services (Olson, 2006c: 310). A more conservative Government of Canada estimate, based on the 2002 Mental Health and Well-being Survey (CCHS 1.2), suggests that the prevalence of unmet needs is closer to 21% rather than Arnett's 70% (Government of Canada, 2006: 52). Yet in an earlier section on *Primary and Speciality Care* the data from the same source is presented, and suggests that unmet need are closer to Arnett's higher assessment and interpretation. The data suggests 62.9% of people with criteria meeting a mood or anxiety disorder did not consult a health care professional (Government of Canada, 2006: 49, citing Statistics Canada 2002). The document goes on to state that "[u]nder-diagnosis, misdiagnosis, and under-treatment of mental illness can result in poor outcomes" (Government of Canada, 2006: 49). Yet here, like the internalisation and individualisation associated with the biomedical model generally, the problems and blame lay with the ill person. The language of this government publication is that only 37.1% "consulted a professional" (Government of Canada, 2006: 49). I argue that the document's (and therefore the Canadian government's) rhetoric, is that low consultation numbers indicate individual's choice, and is not in anyway a reflection of the lack of service availability. In fact, variation in Medicare cover for mental health / mental illness services is not mentioned at all in the publication.

Unmet needs then, in Canada, are considerable and are often reflected in long wait times for publicly administered mental health services. Olson explicitly states that the private sector services are used to by-pass the often minimum two month wait list for many mental health services by those "who can afford supplemental private insurance or pay out-of-pocket for outpatient psychotherapy by nonphysician mental health specialists" (Olson 2006a: 288) – although in terms of the wait lists at *Cornerstone* and *NOS* two months is a very optimistic estimate. The result is a Canadian mental health system that lacks equity (Olson 2006a: 228), and suffers from detrimentally excessive fragmentation and insufficient integration (Romanov, 2002: 178). Both Arnett and Olson suggest that such inequality results from the dominance of biomedical medical-physician services within the Canadian health system as a whole (Arnett, 2006: 171-172; Olson, 2006a: 288). Consequently, on the one hand, issues traditionally associated with the social determinants of health in the US also appear to affect the determinants of mental health and mental illness in Canada; and on the other hand, such social determinants are largely disregarded by a Canadian system dominated by bio-psychiatric approaches to mental illness. I now briefly discuss, in turn, how class, race/ethnicity, gender, and age interact with mental illness. I also give one example of how multiple aspects of social status and individual identity intersect in Ontario's mental health system for mental illness sufferers.

Stolzman presents evidence to suggest that lower-class people in the United States have fewer resources to resist a mental illness diagnoses than upper-class people (1994: 453, 457). As early as the late 1950's there was evidence that there were patterns in treated diagnostic categories. Hollingshead and Redlich "discovered that members of the lower classes were more likely to be diagnosed as suffering from relatively severe disorders (psychoses), whereas members of the higher classes were more frequently diagnosed as having milder disorder (neuroses)" (Stolzman, 1994: 446, citing Hollingshead and Redlich, 1958). In the case of the United States, there is evidence that the disparities of access to therapy and successful outcomes continue to be framed by socio-cultural and political-economic structures (DHHS, 2001, 1999).

Eaton and Muntaner (1999) cogently explore two frameworks to explain the relationship between poverty and mental illness. The first framework suggests that there is an indirect association of selection and drift, wherein people are selected for or drift into mental illness. Selection occurs, for example, because poorer economic status is associated with less educational success, lower educational status is associated with lower occupational achievement and in turn with higher levels of mental illness. Drift occurs when people with mental illness drift into poverty which then exacerbates the individual's mental illness. In Bourdieuian terms this is the reproduction of class within fields through the installation of habitus, which I explore in chapter four (Bourdieu, 1984; Bourdieu and Passeron, 2000). Eaton and Muntaner (1999) propose a direct social causation framework, wherein the social experiences of poor people – how they are treated and their opportunities for success – have the consequences of generating despair and hopelessness, and if an individual has a genetic predisposition, such hopelessness can in turn lead to mental illness. A more recent article suggests this classed pattern continues to date: "a comprehensive meta-analysis of the prevalence and incidence studies of socioeconomic position and depression indicated that persons with low educational credentials or low income are at higher risk of depression" (Muntaner and Geiger-Brown, 2006: 277, citing Lorant et al 2003).

Race and ethnicity also appear to be a factor in mental health services treatment and outcomes. Despite the fact that about 16% of Canada's population were born outside of Canada (Government of Canada, 2006: 16), just 88 words are given to *Cultural/Racial Origin* in the section 'What factors affect mental health?' in a Federal publication on the state of mental health in Canada. The section on cultural / racial origin ends:

> Identification with a specific race or ethnic or cultural group can influence mental health. Coping styles and social supports tend to be culturally determined. A person's mental health may also

> be linked to broader social issues such as racism, discrimination and poverty (Government of Canada, 2006: 16).

We see in the quote an acknowledgement that an individuals' racial / ethnic origin can influence mental health, and that many aspects of mental illness are culturally determined. Aside from criticisms that the document fails to acknowledge that race is a social construction rather than a difference based on genetics, and aside from the unthinking and automatic confluence of race/ethnicity with culture (thus not demonstrating any cultural competency), this section on 'What factors affect mental health?' does little to actually suggest how discrimination against minority groups in Canada may, or may not, be present in either the Canadian health system as a whole or within mental health system specifically. It is clear, however, from Arnett's review of Canadian mental health systems that minority groups do not receive the same level of treatment as the white majority (Arnett, 2006: 179-182; see also Olson, 2006b). For example, Olson states that "[b]oth inadequate funding and the uneven distribution of mental health service personnel throughout Canada are barriers to achieving equitable access for this [First Nation] population and other minorities" (Olson, 2006a: 244).

The Japanese example I discussed above might suggest that the imposition of bio-psychiatric services onto First Nations' mental health problems is likely not to be culturally appropriate, and furthermore there may be alternative actions designed to alleviate poverty and general ill health that would bring about a commensurate improvement in mental health.[8] Notwithstanding this caveat about cultural appropriateness, it should still be noted that mental health services for both First Nations and other minority groups in Canada are often both inaccessible and under-funded. In addition, the issues of indirect drift and social causation, which have been identified in the relationship between income and mental illness, may also be influential for ethnic minorities facing poverty in disproportionate numbers (Crooks, 1998).

There also appears to be a relationship between gender and mental illness, with women in Western societies experiencing significantly higher levels of psychiatric distress (Turner and Avison, 1998: 238). Data from the Canadian Community Health Survey (Statistics Canada, 2002) suggests that there were 1,444,000 women and 1,222,000 men with mental disorders and substance dependence in the 12 months prior to the survey (rounded to the nearest 10,000), which implies that 54% of all mental disorders and substance dependence sufferers are women and 46% are men (See Table 2-1, below). This overall difference between women and men might not appear too great as there is only an 8% difference between women's and men's prevalence numbers for mental disorders and substance dependence. It does, however, hide trends in mental illness diagnoses and only accounts for those instances when mental disorders and substance

Table 2-1, Twelve-month Prevalence of Mental Disorders and Substance Dependence Measured in 2002, with estimated co-morbidity, adapted from Statistics Canada (2002) and Government of Canada (2006: 31))

Type of Mental Disorder/Substance Dependence	Number men	Number women	Difference
Problem Gambling	320,000	170,000	1.88
Substance dependence	550,000	210,000	2.62
Eating Attitude	60,000	360,000	6.00
Mood	510,000	800,000	1.57
Anxiety	430,000	730,000	1.70
Total	1,870,000	2,270,000	1.21
Actual total	**1,220,000**	**1,440,000**	**2660000**
Estimated co-morbidity	650,000	830,000	1480000

Dependence that are actually recognized. It is difficult to statistically describe the gendered prevalence of mental illness, because people often have symptoms of more than one disorder (leading to a co-morbid diagnoses), and the statistics are presented in such a way that total number of diagnosis exceeds actual reported numbers. By analyzing Statistics Canada (2002) data I suggest that 58% of female Canadians present symptom co-morbidity, while 53% of males have a co-morbid diagnosis. Again, this means that more women than men are suffering more complex mental illnesses, which are more difficult to treat. The biggest difference in prevalence is that women are 6, 1.6 and 1.7 times more likely than men to experience "eating attitude problem," "any mood disorder" and "any anxiety disorder" respectively, while men are 1.6 and 2.8 times more likely than women to experience "moderate risk for / or problem gambling," and "substance dependence" respectively. These differences account for 83%, 36% and 41% of the total prevalence for women with eating attitude problems, mood disorders, and anxiety disorders. While the differences in problem gambling and substance dependence account for 47% and 62% of the total prevalences for those problems presented by men.

These figures suggest roughly 150,000 more men than women have problems with gambling, and 340,000 more men than women have a substance dependency. There are, on the other hand 300,000 more women than men suffering from eating attitude problems, 290,000 more suffering from mood disorders and 300,000 more suffering from anxiety disorders. This, in turn, means gambling and substance dependency are substantially more likely to affect men; while women are significantly more likely to be affected by mood, anxiety or eating disorders. Furthermore, the prevalence rates of each diagnostic category are presented in relation to total population rather than in relation to the instances of recognized mental disorder or substance dependence. This *further hides* the gendered disparity in prevalence as percentages are presented as 11.7% for women, and 10.2% for men (Government of Canada, 2006: 31), rather than as 54% and 46% respectively for all issues. Another typical example is for mood disorders where the data is presented as 6.3% of Canadian women and 4.2% of Canadian men have a mood disorder, but in relation to just those with mental disorders or substance dependence 55.6% of women and just 42.5% of men have a mood disorder, a difference of 13.1% rather than just 2.1%. It is also well recognized within the literature critical of Canada's mental health systems that women are over-represented in certain disorder categories, but that such groups also have "historically not been well served by public mental health centres" (Davis, 2006: 7). Furthermore, Anderson et al (2006) present interesting qualitative data that exemplifies what happens to service access when two elements of social status – gender and income – interact. In brief, their study demonstrated that barriers to care, perceived and financial, meant that from a sample of 127 women who met diagnostic criteria baselines for depression/anxiety, only 29 had met with a mental health professional in the two months prior to interview, and only 29 women were taking prescribed psychotropic medications, which is often the first line in mental illness treatment (Anderson et al, 2006: 929).

In terms of age status affecting mental health service provision and access, again there is a privileging of the dominant group in society – adults. Adolescents and children are far more likely to participate in mental health services if they have acted in risky ways, such as underage drinking, teenage sex leading to pregnancy, or drug taking (Schneider, 2006: 321-324), or if they have been convicted of illegal activities (Finn and Nybell, 2001; Shook, 2005). In Canada, mental health policy and monies appear to be directed towards adult services far more readily than child or youth services. Indeed, in a report on *Best Practice in Mental Health Reform* there was a strong focus on adult services, and just six references to children and two references to adolescents (Health Canada, 1997b). It is within this aspect of social status that the variation between the province's mental health provisions are apparent (Arnett, 2006: 170-173), although provinces such as British Columbia and Ontario are attempting to improve standards and availability of child and youth focused mental health services (Ontario, 2006). Again, I suggest that these patterns reflect the dominance of the bio-psychiatric model within Canadian mental health services, as well as the dominance of adult disorders within the APA's diagnostic and statistical manuals, which is the key tool of the bio-psychiatric model. I will now present one short case that illustrates the intersecting links between mental health/illness and age, ethnicity and social class.

In Ontario, a high school diploma is essential certification for many above minimum wage employment, as well as higher education and training opportunities. As part of the Ontario Auditor's report on school curriculum development it was noted that 36,000 students failed the Ontario Secondary School Literacy Test (OSSLT), with a failure rate of just 15% of students in the Academic stream and 62% in the Applied stream (Ontario, 2004: 12). Success in the OSSLT is used both an indicator of education problems (a 'diagnostic' tool), but also a requirement for gaining a high school diploma. Despite attempts to integrate Ontario's education system, curriculum is streamed into three tiers – academic, applied and locally developed. It is well documented that regardless of actual ability, young Canadians from middle-class backgrounds are often encouraged to enter the academic stream, while young Canadians from working-class backgrounds are more likely to be pushed toward the applied stream, resulting in many students from working-class backgrounds underachieving (Connell, 1993; Curtis, et al, 1992; Nash, 2001). Furthermore, Indigenous and black Canadians are disproportionately represented within special education programs and those designated "At-risk" of not gaining an Ontario high school diploma (Dei, 1996; Dei et al, 2002; Ontario, 2004), which is fairly typical of special education programs within Canadian and United States education systems (Scheurich, 2002).

Although the Ontario Auditor's report on curriculum development does not examine the 36,000 failures by their social backgrounds, it would be fair to assume if the classed and raced patterns discussed by Nash, Dei, and Scheurich are consistent, then a disproportionate number of failing students will be from economically poor, black, or Indigenous groups. Thus I can state that that there are classed and raced consequences within Ontario's education system, with consequences to future economic well-being. But how does this trend link with mental health?

Above, I discussed the inverse relationship between educational attainment and mental illness. From this I can state that people with low educational attainment are more likely to suffer from debilitating mental illness, and also be diagnosed with more severe disorders. Although this relationship is complex, and not a simple matter of cause and effect, the relationship is clearly there. In addition, most mental illnesses "often develop during adolescence and young adulthood" (Government of Canada, 2006: 34), so while young people are being tested for educational competencies they are also at considerable risk of beginning to experiences mental illness. I suggest that if we accept that Ontario's educational system remains classed and raced, and is regularly unable to assist those in applied or special education streams to succeed and gain a high school diploma, then the Ontario education system itself becomes an indirect determinant of mental ill-health.[9]

Before concluding this section, I wish to make one comment on the research literature and policies reviewed in it. While my fieldwork is based in Canada, it will be apparent that in my discussions so far data and research findings are as much from the United States as from Canada. However, this appears to be typical of research and policy documents in Canada. For example, many references in the recent Government of Canada (2006) publication entitled *The Human Face of Mental Health and Mental Illness in Canada*, which I criticised above, are drawn from research and policy based in the US. The geographic and assumed cultural proximity between the two nations, as well as the dominance of the APA diagnostic criteria within Canada's bio-psychiatric approach to mental illness (as discussed above in section 3.2.2), likely contributes to this cross-fertilisation. As I have argued in this section, there is growing evidence that similar sorts of pressures face the diverse population of Canada. On the surface, the Canadian health system appears considerably fairer than that in the United States and in many ways it is concretely so, especially for "medical-physical conditions" to use Olson's term. Yet if we delve beyond the surface, into the marginalized mental health system in Canada, it becomes evident that it is, in many ways, as *uninsured* as in the United States, with ensuing inequalities in service access and success. To illustrate this point, I presented brief examples of how social stratification interacts with both prevalence of mental health / mental illness and access to provincially provided services. Next, I turn my attention to the application of anthropology research.

3.2.5 Anthropology and Application

In the introduction to the *Bodies, minds and social locations* section I described three un-stated aspects of modernist rhetoric about *bio*medicine, the third of which was: how and where do alternatives and unheard voices interact with *bio*medical models? I suggest that it is through medical anthropology research and its application that alternatives and unheard voices begin to be incorporated in *bio*medical approaches. Much of the research undertaken under the auspices of medical anthropology, and subsequently the anthropology of health and illness, has been intended for both theoretical or academic, and applied, or clinical, use (Baer, 1993; Chrisman and Johnson, 1996; Helman 2001, Helman, 2006; Hemmings, 2005). The relationship between the two arenas (theory and application) within the academe can be considered uneasy, and it has been fraught with tensions among academics over applied research (Warry, 1992). Research intended for practice and advocacy is often considered the lesser bedfellow of 'proper' (i.e. theory-based) research, while applied reports are definitely considered the lesser bedfellows of peer-reviewed articles (van Esterick, 2007). Yet applied anthropology, and I include CMA within this, aims at analytic accuracy (Singer and Baer, 1995: 61; see also Brown, 1998; Ervin 2000). Such analytic accuracy is necessary if more anthropological researchers' interpretations and recommendations – intended as they are for use in improving the lives of people, their health, and relieving social suffering – are to be heeded by policy writers and practitioners. Indeed, for Singer and Baer critical medical anthropology should do more than merely describe the social reality (an academic endeavour) – it should provide data that can ameliorate the disparities and suffering that take place in the social reality (Singer and Baer, 1995: 61; see also Hill, 1984). For Fassin (2007) such practical ideals of CMA in noting and affecting structural violence and social inequality is what moves anthropology of health beyond constructivist descriptive interpretations (Fassin, 2007: 256, 262-263).

Anthropological approaches to health and illness often explicitly seek out the non-dominant knowledge that is overlooked by biomedical discourse, and attempt to incorporate such Indigenous, local and alternative approaches to ill health and its cures with the approaches influenced by western biomedicine (Hahn, 1994: 54; Waldram et al, 2006). Research that attempts to comply with dual academic-applied purpose has taken place both in North American contexts and in third world countries and is linked often to Public Health endeavours (Craven, 2006; Foster and Anderson, 1978; Frankenberg, 2007; Helman, 2001; McElroy and Townsend, 2004; Pigg, 2003; Rubel and Moore, 2001; Schoepf, 2001; van Hollen, 2003; Wood, 1996). Such applied work attempts to incorporate and privilege the role of specific cultural contexts and beliefs (local explanatory models) of illness and its treatment, as it relates to (often failing) biomedical approaches in these locations (Harward, 1998; Heurtin-Roberts and Reisin, 1998; Trotter

1998). I shall discus three brief examples to illustrate how applied medical anthropologists have worked to improve transmission prevention projects and also with people suffering from the various impacts of HIV/AIDs in disparate settings as this is a disease entity and illness experience that is predominant in applied and medical anthropology literature.

Farmer (1990) highlights how people in a rural village in Haiti initially considered AIDs to be an urban issue, frequently associated with the tourist industry (1990: 8-9). Yet, as this industry's economic decline forced many people to return to the rural areas, they brought with them *sida*, known as HIV/AIDS in English, and as its debilitating impact was felt, villages peoples' perspectives on *sida* changed, especially as people died from its effects (Farmer 1990: 11). The causes of *sida* began to be explained through both natural and supernatural sources, germ theory and voodoo magic (Farmer, 1990: 20, 21). Although Farmer does not explicitly state recommendations to health policy or practice in this article, except to emphasise the need to historicise understandings of the AIDS pandemic, his later works do (Farmer, 2003; 1999). Wojcicki (2002) highlights the political-economic factors that lead to 'decisions' regarding safe sex practices, and provides evidence that women in Gauteng Province, South Africa, have considerably restricted choice to practice safe sex, in light of the systemic and physical violence that they face (2002: 284-285). Wojcicki provides recommendations for Public Health, educational, and social policy endeavours to reduce the impact of both violence and HIV/AIDS on women in South Africa (Wojcicki, 2002: 285). Kosova's work highlights the social stigma associated with HIV/AIDS, which inhibits health care endeavours to reduce mother to child transmission during pregnancy, child birth, and especially breastfeeding (Kosova, 2007). In each of these cases, the authors privilege the perspectives of those experiencing HIV/AIDS as an illness with social ramifications, and then attempt to situate these perspectives in relation to biomedical approaches. The latter's solutions and practices are not accepted as automatically correct or the only approach. Rather, individuals' (partial) adoption of and interactions with biomedical approaches are contextualised within specific socio-cultural and political economic frameworks that inhibit 'compliance' to biomedical and Public Health approaches.

My research is a long way (both in location and focus) from these three HIV/AIDS examples, but it draws on the underlying facets of applied anthropology. My research takes place at mental health services which implement a variety of treatment modalities, and have considerable waiting lists for their services. As part of the negotiations for access to the services for research purposes, I had to offer to provide informal feedback as well as formal reports to the services' administrators and staff. Application, then, was integral to the research process – I could not use data to answer 'theory' questions without also offering answering 'application' questions. My research attempts to combine both theory and practice – collecting and analysing data with two interconnected goals in mind: first, it is 'socially conscious' as I have incorporated mental health staff questions and concerns, and delivered data summaries and recommendations for their attempts to improve service capacity and delivery (applied questions); and second, it is an investigation of institutional and social realities, explored through understandings of how treatment takes place and how young people participate in it (academic questions). In this way my approach is particularly influenced by Warry's *praxis model* for applied anthropology, which attempts to reconcile the theory-applied fissure (see also Habermas 1983; Helman, 2006; or Illich 1977). For Warry, "[p]raxis, as a particular form of activity, can serve as a focal point through which the discursive testing of theory is grounded through decision making and experience" (Warry 1992: 156). Furthermore, as the following quote underscores, the *praxis model* acknowledges the role of power in the production of knowledge and, by inference, the role of power in social relations (akin to Kleinman's approach described above):

> Applied anthropology is not interested in producing knowledge for contemplation, but rather knowledge that, according to Partridge, *compels* ethical and political decisions ... Praxis theory challenges social scientists to reflect crucially on the relationship between power and rationality and the social scientists' role in the production of knowledge. Empowerment of research 'subjects' can take place only by allowing theory to inform practical action and by returning knowledge for use to its point of origin (Warry 1992: 157).

Although I am attempting to transcend the theory-application rift by aiming to integrate the two into *praxis*, my research should not be considered the epitome of a *praxis* approach, as the research setting and its constraints have not made it feasible for *all* research participants to be involved as "equal partners" (Warry, 1992: 156). In short, the young people who have been research participants have not been part of the research planning process, which is not a-typical of research that includes young people (Roberts, 2003: 35). I have asked client-students for their message – "what is the one thing I should tell the people in charge" (young person interview protocol, 2006) but they have not added to the project's goals or directions. I have, however, endeavoured to repeatedly outline my approach and "theoretical assumptions that underpin the search for pragmatic solutions to everyday problems" (Warry, 1992: 156) to research participants and service providers. In the following section, I discuss academic understandings of Childhood and Adolescence as social categories and how essentialised understandings of people within these categories impacts service delivery.

3.3 Academic Constructions of Young People, Childhood and Adolescence

> [The] body of anthropological work on the historical and cultural development of 'the body' and 'the self' is instructive. Like 'the child', 'bodies' and 'selves' have, until recently, been taken as universal and biological entities. More recently, there have been important explorations of the historically and culturally specific nature of these notions, and ethnographic work has been done to outline the ways in which these constructions are shifting (Nybell, 2001: 219)

3.3.1 Theorising Childhood and Adolescence as social categories

Understandings of the characteristics of Childhood and Adolescence as social life-stages have shifted considerably in the last fifteen years (Christensen and James, 2001:

71; Engalbert, 1994: 286; Kuczynski and Lollis, 2004: 197; Näsman 1994: 169; Nybell, 2001: 213-215). Academics have come to know Childhood and Adolescence as historically and culturally situated and contextualised. That is to say, Childhood and Adolescence, as social categories and life stages, are generated within specific situations that reflect the societies in which they are witnessed (Nieuwenhuys, 1996; Hockey and James, 2003; Nybell et al, in press; Stephens, 1995: 5). In this 'new' view, the literature on Childhood and Adolescence distinguishes between children and youth as social actors or individual young people, and Childhood and Adolescence as concepts or social categories (Alanen, 1998; Hendrick, 2003: 36). There is clear evidence of 'Childhood' and 'Adolescence' as ontological categories with certain specific traits and characteristics having a fairly recent historical genesis (Cólon and Cólon, 2001; Hall and Montgomery, 2000; Hirschfeld, 2002; Valentine et al, 1998). These essentialised categories are not static, but should be considered emergent, shifting and repeatedly redefined (Bucholtz, 2002; Hockey and James, 2003; James et al, 2001).[10]

While in this thesis I discuss evidence from two distinct programs serving relatively comparative populations, I do not wish to homogenise the experiences of the young people at both sites, as this would be complicit essentialism. Nor do I assert that the actions and processes at these services, which young people participate in, are *exactly* the same. They are, however, similar enough to enable lessons to be drawn, because my research sites are 'typical' of mental health services in Ontario, Canada, and also 'typical' of adult-built spaces, places and discourses. Such lessons, I suggest, are transferable to other services and institutional localities.

3.3.2 Essentialized Childhood and Adolescence

Above I suggested that there is a collection of characteristics which are often ascribed to those within the life stages of Childhood and Adolescence, and that young people are often presented as a singular: 'the child' or 'the youth' (Frankenberg, et al 2000; James et al, 2001, Swadener and Lubeck, 1995). What is integral to the discussion and case studies that follow, is that core characteristics for 'the child' (innocence, dependence, cuteness, lacking control) and for 'the youth' (disruptive and deviant, unknowing of consequences, and resistant to authority) are often ascribed automatically to those in the Childhood and Adolescence categories *prima facie*, and are often presented as 'natural' character sets in an essentialising and othering process (Frankenberg et al, 2000; Hockey and James, 2003: 129). These misrepresentations are then used to justify policy, practices and services directed towards children and youth, and those connected with them (Finn and Nybell, 2001: 139). One regularly repeated discourse is the metaphor that "young people are our future," in which we see 'the child' and 'the youth' centrally located as resource or asset, which is in turn used as a justificatory argument for services / practices and the associated (and necessary) public funding (Crosson-Tower, 1998: xviii; Delgado, 2006: 4; Wolf 2002).

The singularity of Childhood and Adolescence has been criticised as being *essentialised* by Vandenbroek and Bouverne-de Bris (2005) and by Frankenberg et al (2000). This singularity means that service providers, policy makers, and Childhood researchers have drawn heavily on specific and outmoded understandings, which obfuscate differences between children and between adolescents:

> some evolutions in discourse and practice show that this vein of research [incorporating children's voices seriously] and of research-related practice may also be silencing specific groups … children are constructed as a separate but *homogenous category, masking age, gender, ethnic or cultural dimensions or inequalities*, and assuming all children would benefit from the 'authoritative' approach, which still remains to be proven (Vandenbroek and Bouverne-de Bris, 2005: 139).

An example of such essentialization and homogenization can be taken from Downs et al's (2000) social welfare text designed for neophyte social workers, where we witness 'The Child' as a human in potential with the future of the country intimately tied to the quality of the adult that develops from the child.

Downs et al, highlight the interconnectedness of Childhood and Adolescence issues, services and concerned parties: "This book then, is about children. It is about their needs and their problems. It is about our society and its influence on children, and therefore it is also a book about families, governments, agencies and professionals" (Downs et al, 2000: 2). At the same time, there appears to be a lack of (even singular) 'The Child's' role, action, or participation in services – the child is very much a 'something', and is objectified as a ward of the state/family, and services provided for its benefit. I suggest that Downs et al's presentation of 'The Child' is very much in the essentialized framework presented and criticized by Frankenberg, et al (2000).

Yet it is difficult to summarise the core tropes or characteristics of two life stages (Childhood and Adolescence) that have many commonalities but also can be seen as distinctly different, especially by those people living within them. Indeed, research and services appear to focus primarily on one or the other. One unifying metaphor within public discourse is often descriptions of young people as either in danger or dangerous (Prout and Hallett, 2003; Roberts, 2003; Shook, 2005). For Stephens, the "dominant theme is of children as innocent and vulnerable victims of adult mistreatment, greed, and neglect" (1995: 9). Cannella succinctly describes the multiple characteristics ascribed to Childhood. It is within such

> construct(s), [that] younger human beings are reified as the 'other.' This othering labels them as innocent (i.e., simple, ignorant, not yet adult), dependent (i.e., needy, unable to speak for themselves, vulnerable, victims), cute (i.e., objects, playthings, to be watched and discussed), and needing control (i.e. savage, lacking discipline, needing structure), to name just a few (Cannella, 2002: 3).

Each of the words and phrases that Cannella suggests are associated with children often have implicit negative connotations within the adult world, because they are linked to the individual's need to be further socialized and enculturated (Lee, 1999, 2001). These children, in Childhood, are not fully human, and Stephens, Cannella, and Lee are aware and critical of the negative connotations associated with such an 'othering' processes.

'The Youth,' too, also undergoes such an othering process. They are studied in very particular ways. Anthropologists, influenced by psychology, have tended to see an age-bound biological developmental stage, while US sociologists have characterised The Youth as deviant by focusing on the social consequences of youth action and risky behaviours; sociologists in the UK have overtly drawn on Marxist theorising to examine the visible cultures of 'the working-class youth' (Bucholtz, 2000: 525-526). Within social science research and public discourse representations of Childhood and Adolescence, we see a specific form of essentialization that regularly negates *any* chance or opportunity to recognise agentive acts by children and adolescents who are within the social categories of Childhood and Adolescence. This is despite young people themselves challenging these adultist stereotypes through their actions (Finn and Nybell, 2001: 145).

3.3.3 Age-Based Essentialism?

Childhood and Adolescence, like all life-stages, are primarily associated with specific ages. It is within these age-based frameworks that we regularly witness discussions of competency and agency. Lacking competency and agency are often used as key characteristics of those within these categories, and are perhaps two sides of one particular essentialized coin or trope of Childhood and Adolescence. Ahearn defines agency as "refer[ing] to the socioculturally mediated capacity to act" (2001: 130). If one has no competence, one cannot act with agency (Giddens, 1982; Karp, 1986). In short, this means that when competence is achieved, agency can be performed. Thus, being in Childhood or Adolescence (an essentialized age-based social category) means being *automatically* almost-human, which in turn automatically negates their human abilities (i.e. competence), and agency (Canella, 2000; Christensen, 1998).

Recently, such an age-based competency/agency focus has been criticized along at least three lines. Firstly, the social categories of Childhood and Adolescence have come to be understood as having both biological activities but also social processes (although this differentiation was noted by van Gennep in terms of physical and social puberty as early as 1908). Bogin, a biological anthropologist, offers a useful five-stage model which outlines general expectations of transitions linked to physical development that occur during Childhood (Bogin, 1998: 18, 24). Bogin's model illustrates the inferred parallel increase in human growth and development with increases in cognition and competency. In some ways, it is similar to cognitive psychology's developmentalism, which continues to have a strong influence over education and social work understandings of Childhood and Adolescence (Toren, 1993). Bogin's five-stage model, however, discusses both biological activities and social processes, which begins to break down encompassing terms, and allows for the nuanced contextual variables within Childhood and Adolescence, and between young people, to be contextualized and considered. Secondly, and linked to this nuanced position, is the realization that children and adolescents are multi-faceted. Valentine et al, in particular, see youth not as "uni-dimensional"; instead, they argue that youth is perceived as the "intersect of various identities (ethnicity, gender etc.) that go beyond constructions based on a notional classification of biological age" (Valentine et al, 1998: 6). Thirdly, as a result of research in the 1980s and 1990s, competence "can now be defined as including any skills, abilities or attitudes that might enhance children's success at dealing effectively with the physical and social environment in which they live" (Pike, 2003: 185). Here Pike implies that competence is context specific, and I would go further to suggest that while competence is often tied to understandings of age-based categories, there is potential to move beyond this stance by incorporating cultural and experiential knowledge in the context of the participants' social worlds. That is to say, unlike earlier attempts to understand the socialisation of children using primarily adults' perspectives (Benedict, 1959; Mead, 1975; 1956), recent understandings of young people suggest that the social agency and competency of a particular individual reflects not just physical age but the cultural and social contexts in which they perform their daily lives.

It should also be noted that Childhood and Adolescence are *temporary* states. These age-based categories, with their associated characteristics, have a temporality which brings with it "the continuing constitution and reconstitution of persons – cognitively, emotionally, socially – as they move through the life course" (Thorne, 2004: 405). Temporality can be seen in the variations of age-related social competencies (like being able to vote or drive), which can be noted as varying from country to country, and between different cultural groups. Adult-like competence is described as commencing in ages ranging from seven to eighteen, and in the US separate categories of 'emancipated minors' or 'mature minors' have been instituted in some locations (Koren, 1993: 8). 'Emancipated' and 'mature' minors are usually teens who have in some way demonstrated control of their financial matters and / or significant independence from their parents or guardians, and / or are themselves responsible for the welfare of their own minors as a parent (Koren, 1993: 7-9). Individuals within these two youth-based categories can demonstrate social competence. Social competence rhetoric is significant for my discussion as it often is used as a demarcation point, dividing 'the child' and 'the youth,' whilst also separating 'the youth' from 'the adult' – remembering that even 'competent' youths are not 'true' adults (or humans) because of their age.

Building on these critiques, and following James et al (2001) and James and Prout (1997), I assert that it is through the process of essentialisation and othering of 'the child' and 'the youth' that agency is not removed; rather, it is limited. If we recognise young people as active participants in their own social world (Holloway and Valentine, 2003: 8; see also Corsaro and Eder, 1999), and that their identity, agency and voice are constituted within particular relationships, spaces, and institutions as well as the discourses, or tropes, on 'The Child' or 'The Youth,' then we might consider the agency demonstrated by young people as *confined agency*. This reflects Valentine et al's perspective that the agency of young people is "strongly mediated by others" (1998: 22; see also Mandell, 1991). Put simply, young people do practice agency but do so in limited or confined ways. My assertion counters Giddens' (1982) suggestion that those in 'powerless' situations cannot attain agency in any form. I analyse in more detail my notion of confined agency in chapter five.

There is already some evidence that supports this view. Agentive action by 'youths' has been described as a form of resistance to the powerful institutional setting of schooling (Bucholtz, 2002; Lahemla, 2002). Sociological focus on 'spectacular' resistive youth culture (i.e. Punk or Goth identities) has been described as neglecting the youth culture of the many that do conform to more 'mainstream' identities and social expectations (Valentine et al, 1998: 24). Indeed, Elkin and Handel critique this spectacular or sub-cultural focus by arguing that some child peer groups are explicitly orientated towards adult values and models (1989[1960]: 180-181).

There is also evidence from the UK-based project to suggest that even young children (and apologies for my use of age-based criteria) can demonstrate agency. The ESRC-funded (Economic and Social Research Council) *Children 5-16 Programme* "comprised of 22 linked research projects" (Prout, 2002: 67) across the UK, has begun to report some interesting and noteworthy findings. The multiple projects sought to treat children as competent social commentators on their own lives. Alan Prout, the project's director, concludes by asserting that children act with agency in their everyday experiences – particularly with regards to social interaction and friendship formation. Epstein's (1989) ethnographic evidence demonstrates that children within school settings act with what can be broadly defined as *confined agency* and that their abilities go beyond supposed developmental capabilities. It follows that there is a,

> need to explore the possibilities of children as active and competent members of society … follow from the idea that children are capable of making sense of their own social environment and that it is no longer appropriate to consign Childhood to marginal cognitive and moral categories (Wyness, 2000: 25).

In a way my Ph.D. research is one attempt to relocate young people out of marginal cognitive and moral categories. Above, I used the sub-title *Essentialised Childhood and Adolescence*. This was for semantic and rhetorical purposes – it reflects an essentialised positioning. That is to say, I purposefully put forward a singular Childhood and Adolescence. I suggest that the categories of Childhoods and Adolescences might read clumsily but would perhaps begin to better reflect the plurality of experiences and situations of the great number of young people who are considered to be within these categories or life stages. In part my research, specifically chapter six, explores understandings of how young people "make sense of their own social world" and act in it. But my research is also concerned with how society views both people within these categories (children and adolescents) and the categories themselves (Childhood and Adolescence) with the accompanying essentialized characteristics and metaphors.

3.4 Historical, Medical and Educational Contexts

> We believe that there is sufficient evidence from social science to maintain that social class, gender, and racial / ethnic inequalities in mental health stem from social structures rather than from personal choices. Furthermore, a contemporary definition of public health – as organized efforts by society to improve the health of populations – implicitly acknowledges both social determinants and collective responsibility for the public's health (Muntaner and Geiger-Brown, 2006: 279).

Following Bloch (1975) and Wolf (1982), this section attempts to situate the daily practices witnessed during ethnographic fieldwork within a historical context (see also Firth, 1975; Foucault, 1975; Habermas, 1984 and 1983; or Pigg 2002). It is an explicit attempt to contextualise the sociality of my fieldwork settings so that a particularly psychiatric medical hegemony can be critically examined and better understood (Figlio, 1987: 77, 79). Such *historicising* is a key strength of critical medical anthropology approaches that attempt to situate an illness experience within a contextual and structural framework rather than solely within diseased individuals (Singer and Baer, 1995). By taking the fieldwork settings out of an a-historic, or timeless, existence which often happens in case-controlled scientific research (Banaschewski et al, 2003; Brandâo et al, 2006; Cohen et al, 1996; McCarthy et al, 1986; NIH, 1998), our understandings can begin to account for the *body politic* determinants, and also begin to account for the sociality and interactional aspects of the illness experiences witnessed. That is to say, in my experience of the fieldwork sites, societal and historical changes such as those to policy, funding and knowledge have clearly impacted and continue to impact on the services delivered, with consequences to illness experiences of attendees as measured by therapeutic practices and outcomes.

I draw both on primary and secondary sources, as well as interview data from staff who described their history at the sites (i.e. service histories accessed via staff career paths) and the site's history that is 'public access' via publicity material and WebPages. The brevity of this section is because I do not attempt a detailed history such as Foucault's *Birth of a Clinic* (1973) or *Madness and Civilisation* (1967), in part because that is another project, and in part due to a relative paucity of accessible primary sources. I am, however, able to present an understanding of the services' transition, or "evolution," over time, through multiple secondary sources.

One clear influential trend that affected both sites is the shift towards community services during the 1980's and 1990's. This governmental-driven policy, as opposed to a purely *bio*medical one, has moved mental health services away from long-term residential institutional settings towards day-treatment and "localised," or community, services. A second clear trend towards an increased demand for accountable evidence-based medical best-practice (often equated with staff qualification and accreditation rather than experience) is in part a response to the need to justify spending, as has been generally the case with government-funded activities since the mid-1990's (Sinclair et al, 2005: 1), and in part a response to societal questioning of psychiatry and psychology's accuracy and ability to claim the status as a 'real' science or medicine, which is not necessarily a new phenomenon (Wright and Moran, 2006: 6-7; see also Gaines, 1992; Helman, 2001 or Littlewood and Dein 2000). I briefly explore both of these trends below.

3.4.1 A brief history of mental health services in Canada and Ontario

From the available sources, it is apparent that mental health services in Canada have undergone repeated and regular reviews, revisions and adjustments over the last eighty years. Simmons argues that "[a]lmost every five years from 1930 to 1985, a report, analysis or critique of Ontario's mental health system appeared, recommending major changes and reforms. Without exception, each report recommended a major extension of community mental health services" (Simmons, 1990: xiii). The shift has been towards community-based services which reflects changes to available medical knowledge about "best-practice" for mental health service provision (more on this below in section 3.4.2), as well as attempts to contain cost and rein in spiralling Federal and Provincial deficits. Such a processes is especially the case for mental health services in Ontario, including those provisions for children and youth. As Sinclair et al's (2005) research on Ontarian mental health policy notes, in under fifteen years four reports, all "strongly endorsed" (Sinclair et al, 2005: 61) the move away from residential psychiatric hospitals to 'as required' or 'as necessary' community based care. [11] Yet by the late 1990s and early 2000s Health Canada recognised that offering in-hospital mental health services still remained a large cause of health care costs: "In 1999/2000, 9,022,382 hospital days were utilised by individuals with mental illnesses" (Health Canada, 2002: 21), despite the fact that by this time "the majority of people with mental illnesses are treated in the community rather than in hospitals, and many may not be treated at all within the formal health care system" (Health Canada, 2002: 3). Both Simmons (1990) and Davis (2006) imply that the predicted cost saving, or at least cost-relocation, was the key reason for the shift away from residential services, and I would tend to agree with this analysis (more on this issue below).

Dickenson argues cogently that the Canadian health system has numerous problems, and "[on]e of the most significant weaknesses is that it is not primarily a health care system, rather it is an illness care system … less adequate as a solution to the chronic and degenerative health problems which currently predominate in Canada" (Dickenson, 1994: 466). This appears to be exacerbated by the fact that Canada is one of the only G7 country without a *national* mental health program or policy base (Oslon 2006b; see also Wright and Moran, 2006: 5). Nelson et al argue that throughout Canadian provinces the policy reform cycles are very short-lived and thereby inhibit improved structural changes to mental health services (2001: 69), which otherwise tend to be incrementally completed. Indeed such incrementalism imbued Canadian health budgeting during the 1990's as the majority of provincial health costs were not covered by federal tax transfers (Bodenheimer and Gumbach, 2005: 199; Naylor, 1999). This has led to the mental health system being described as "overwhelmed and incapable of effectively dealing with these problems" (Dickenson, 1994: 467). Simmie (1998) too lambasts the ineffective mental health system.

As Warry notes (pers. comm.), policy is a political decision within a monetary framework. For me, this means that in real terms public policy decisions do not always equate with what front-line workers or health care practitioners see as ideal health service conditions. Thus, health care dollars have to be distributed to illnesses that policy makers and politicians see as the (voting) public's best interest – for example, Ontario's move to diverge funds to support early years development, rather than change the structure of schooling, or increasing and ongoing Federal direction of monies intended to reduce wait times for specific surgeries, such as coronary heart bypasses (CBC, 2007). Below, I weave a history of these changes to mental health services in general with those for children and adolescents and with service histories accessed from staff members.

The history of mental health services in Canada can be divided into three, very broad, periods: institutionalisation, deinstitutionalisation, and community, with the latter being the formalised reform response to the de-institutional process. These periods fall roughly in mid-1800-s to 1960's, 1960's to late 1980's and 1980's to the present day. The reasons for these shifting approaches have been widely discussed and debated (Dickinson, 2002: 374). These debates range from changes being medical best-practice to economic imperative, and it is not possible to review them all here (Busfield, 1986; Dickenson 1989; Ralph, 1983; Scull, 1983).

The Graham Report (1988) noted that the then system was still designed to support institutional mental health services rather than community services. Nearly a decade after this consultative review of mental health reform in Ontario, community services were in effect still secondary to institutional ones (Newman, 1998: 12).[12] Arnett too, while comparing Canadian mental health system to those of America, Britain and Norway, notes that across Canada "current mental health services are largely *institutionally focused* rather than patient-centred or community-based" (Arnett, 2006: 169). So, despite rhetoric of moving mental health services away from residential institutional settings, the Ontarian (and indeed Canadian) mental health system retains a largely institutional approach (Dickenson, 1994: 474; Davis, 2006).[13] In addition, this rhetoric was based in a language that justified the changes to mental health services in terms of service improvements, but the reality was that de-institutionalization was as much about the (physical) deterioration of institutions and spiraling costs as it was with the appropriateness of institutional residential mental health services. What we see more recently with the Kirby commission (2006) is an increased public and national discussion about mental health and mental illness within Canada, and indeed I am hopeful that this commission will lead a national policy. However, provincial level public policy responses to past reports and commissions on mental health and mental illness have not been overly effective in improving service provision. As Simmons so poignantly maintained, over a decade and a half earlier than the Kirby commission, the

> Minister of Health and government of the day never planned more than four years in advance, that is until the next election. Bureaucrats said Ministers of Health were interested in mental health policy only when the opposition parities raised tough questions in the legislature, or when the *Globe and Mail* or the *Toronto Star* carried articles exposing a scandal or publicising defects in the mental health system … Mental health policy might suddenly emerge as a priority – but only as long as it took to resolve a crisis. Otherwise it was ignored (Simmons 1990: 244).

Next, I turn our attention to the growth of both the Ontario Ministry of Children and Youth and Children's Mental Health Ontario

As noted, the mental health literature is adult-centric. One example is Nelson et al's (2001) text that historicises and politicises mental health services in the United States, Canada and Ontario. Throughout the case studies of mental health care policy and reform, Nelson et al have a clear adult bias. Everett (2000) provides a clinical history (much like auto-ethnographic approaches) to mental health reform from the perspective of ex-mental health patients variously described as consumers to survivors, but again this in-depth perspective is from an adult viewpoint. As a result of such adult focus in research on mental health services, much what follows is from interview data, situated in excerpts from key researchers on child and youth mental health and mental illness.

Boyle notes that "[c]hildhood mental disorders encompass complex, serious and persistent difficulties of cognitive functioning, emotional control and behavioural expression. In the present context, the term mental disorder is used generally and not restricted to disorders thought to have a biological basis" (Boyle, 1991: 75; see also Read and Harré, 2001). This broad range of issues leads to an estimated prevalence rate near to 18% of the school-aged population, which is well within Canadian norms (Boyle, 1991: 85, citing Ontario Child Health Survey; see also Government of Canada, 2006; Health Canada, 2004b). However, not all of the young people with mental illness have adequate access to appropriate services (Arnett, 2006; Barwick et al 2004; Fieldman, 1996). This is also reflected by staff at both *Cornerstone* and *NOS* who expressed concern over wait times, and is likely due to the fact that mental health services for young people in Ontario are highly fragmented, with services provided through the auspices of Children's Mental Health Centres, Children's Aids Societies, Integrated Health Networks, and funded in part through the Ministries of Children and Youth Services, of Community and Social Services, Health and Long Term Care, and of Education. This fragmentation occurred over a number of years. Simmons argues that it was gradual and coincided with the increases in services provided specifically for young people. By 1977 a 'normalisation' ideology had taken hold in the Ministry of Health, which meant that treatment was moved out of hospitals and Ministry of Health mandates, to residential settings and the children's section of the Ministry of Community and Social Services (Simmons, 1990: 204).

Certainly child and youth mental health services in Hamilton reflected the institutional and de-institution phases. *Cornerstone* formed out of two services: *Benebrith* and *Cool School. Benebrith* was a residential mental health ward, based in a separate building on the grounds of the Chedoke Hospital site, which was at the time primarily an adult psychiatric hospital. *Cool School* was an alternative education program for adolescent students with emotional and behavioral difficulties. The two were amalgamated into a day treatment mental health service in the early 1990's, yet the institutional tone of adult mental health services also seems to play a role in current child and youth provisions as, during fieldwork, Hamilton Health Sciences was developing a residential psychiatric ward at McMaster Children's Hospital to serve those young people with the most severe mental illness symptoms. While *NOS* also offer residential services, these are primarily for adolescents and take place both in home and in institutional settings. Their Day Treatment / Education program is offered in part through Ministry of Child and Youth Services funding, in conjunction with the local School Board. Staff suggested that the service developed in response to difficulties faced by both parents of young children and the School Board.

3.4.2 Exploring the medical / therapeutic contexts and discourses

> "While there may be some disagreement about how public psychiatric programs define the priority population, there is little debate about the significant effect of mental health problems.

> Mental disorders have a substantial impact on the quality of life of affected individuals, their families and loved ones, and on society in general because of health care cost as well as loss of employment and productivity" (Davis, 2006: 9).

As is clear from the above historical contextualization of Canada and Ontarian mental health systems, "[i]n Canada the field of mental health has seen considerable change in a relative short period of time. Starting in the 1960's, the locus of treatment shifted from institutions to the community with the downsizing and closure of the 'asylums' " (Davis, 2006: xi). This has certainly been the case for the mental health services that I have completed fieldwork with, and I will address how changes to therapeutic knowledge and service formation have occurred, by drawing on the insights of frontline staff.

Staff all suggested that from the mid 1980s onwards the diagnostic criteria developed and approved by the APA have increasingly become the hegemonic identification tool for psychiatric diagnosis in Canada. The APA system is "modeled after the classification of infectious diseases, in that each named mental disorder is identified with a unique set of diagnostic features and is assumed to have a distinct etiology" (Young, 2002: 223). In a critical approach to the APA's DSM, Davis suggests that people with disorders are eligible for a diagnosis,

> to the extent that they meet some or all of the following criteria: (1) the disorder is *persistent*; (2) the disorder causes significant *functional impairment*; (3) psychotic symptoms and/or bizarre

> behaviour are manifested; (4) behavioural problems appear to be *involuntary*, rather than willful; and (5) the disorder is *treatable* – in particular, responsive to medication … The reader may also note that criteria are defined *operationally* rather than by some 'objective' standard (Davis, 2006: 8)

Since the early 2000s, Provincial Level discourse for service to be founded on evidence-based practice has become far more prevalent within Ontario child and youth mental health service provision. This stark increase of claim to and use of evidence-based practices by policy makers, administrators and clinical leaders is used to justify the need for, and efficacy of, Ontario's mental health services (Barwick et al, 2004; Ontario, 2006). It also reflects the fragmentation of service provision that I described above, which has apparently led to a weaker quality of service delivered:

> With few evidence-based treatments in use in clinical practice, little data regarding the types of disorders with which children present for service, and no systematic evidence of outcome, the system is hard pressed to move forward in a rational way (Barwick et al, 2004: 105).

Barwick et al's comments also hint at the increased need for accountability within publicly funded services within Canada. This, I contend, reflects trends in *bio*medical care in general in Canada. As Hayden (no date) reasons,

> The EBM [evidence-based medicine] program is indeed compelling. It calls for a more explicit, transparent, rational, and

> methodical practice in health care, bridging the worlds of research and practice. EBM is often the "right thing to do" for many reasons – moral, scientific, political, economic, social, and practical. On the downside, it is deceptively straightforward. Using the "best available evidence" becomes complicated not just by the complexities of "best" and "evidence" and the implications of "available", but because medical practice and health care are so broad, potentially divisive, and vital (Hayden, no date: 24).

Thus, evidence-based practice (that is assumed to be efficient and efficacious) will increasingly be used to justify mental health services expenditures, such as in the following quote, "[s]tandardized screening and outcome tools are key building blocks for improving the quality of service and promoting the use of evidence-based practices across the system" (Barwick et al, 2004: 105).[14] Evidence-based practice is therefore becoming the mainstay of the mental health system's description of the services they provide (Gambrill, 2005; Howard et al 2005; Lenhart and Marsh, 1996 Reid and Colvin 2005). It is also impacting service delivery.

In practical terms for front-line staff in Ontario's mental health services – usually called Child and Youth Workers (CYWs) – this shift towards evidence-based practice has meant the introduction and use of two key screening and assessment tools in recent years: Brief Family and Child Phone Interview, or BCFPI, (Cunningham et al, 2004) and Child and Adolescent Functional Assessment Scale, or CAFAS (Hodges, 2000). Both intake and ongoing treatment outcome assessment are now rooted in these evidence-based measurement tools. Team meetings are essential to both fieldwork sites' assessment of their ability to take on client-students; their decisions are in part based on BCFPI information, but also on extensive psychiatric assessments and a review of medical history in the case of *Cornerstone*, where referrals tend to be from medical practitioners, and multiple reports and initial observation in the case of *NOS*, where referrals tend to be from schools. Both services offer a range of cognitive behavioural therapy, in conjunction with pharmacological treatment options. Each client-student has a highly individualized treatment plan, goals and objectives, and now with the use of CAFAS has an evidence-based mechanism to measure progress.

In addition, the presence of an onsite psychometrist assists with decisions over treatment options and educational directions. CAFAS's have begun to play a key role in pre-discharge preparations and assessments on the part of clinical leaders. However, CYWs' knowledge of their client-students readiness for discharge is rarely inaccurate when compared to CAFAS data. This is in part because of CYWs' extensive experience (both in the case of staff at *Cornerstone* and at *NOS*) and also because of client-student demonstrative increase in participation in education components and decreased reliance on therapeutic ones. As with intake, whole staff meetings address discharge options. The interdisciplinary approach is an attempt to ensure that a client-student is ready for discharge and that the location / situation into which they are being discharged is itself ready for the client-student as well as being the best option for them.

3.4.3 Mental Health *and* Education

In my discussion of childhood and adolescence (section 3.3), I asserted that Canadian society has expectations that children and adolescents attend school to be educated. It appears that Day Treatment and Educational services that are funded in part through Section-23 monies is a clear response of the Ministry of Education, in conjunction with the Ministry of Health and Ministry of Children and Youth Services, to meet these expectations. Section-23 of the Ontario Education Act states that educational services must be provided for all those young people who otherwise cannot attend community (regular) schools. Section-23 funds generally cover educational programs in Correctional, Day Treatment and Care settings. In the case of the fieldwork sites, it is provided in connection with day treatment programs.

At *NOS* there are two service sites, which reflect geographic division within the city. Both the north-end and south-end sites are located in elementary schools and have two rooms – one of which is primarily designated a classroom and one is designated a program (therapy) room. Use of other facilities within the school is possible, and gyms, playgrounds, libraries are used by both services. However, at one site the second room is down a corridor and is not big enough for all the client-students to use at the same time. The classrooms look much like any other classes in the school, except for the relative lack of desks – as *NOS* caters for up to eight client-students at a time and each child has their own individual space in addition to group work spaces – and the presence of couches. The *NOS* school day is shorter – by about an hour – than that of the rest of the school, which was justified by CYWs and teachers alike in terms of attention spans and the client-students having the possibility of good work days (by this they meant that the regular school hours were beyond the capabilities of client-students). Learning tends to be categorised into two broad subjects – language and maths – which reflects the age of client-students. Each child is given individually differentiated curricula and is encouraged to work at their own pace, but with the expectation that tasks are completed regularly (more on the impact of this in chapter five). This curriculum is based on the Ministry of Education guidelines, but each client-student is usually considerably behind where their age-based peers would be expected to be. CYWs assist with the exercises, both in terms of keeping client-students on-task and also with any particular difficulties they face. In this way, there is no distinct division in adult roles in these classes. *NOS* services are at the margins of mainstream educational practice, which is reflected in the large number of adults in the classrooms (one teacher and two CYWs, as well as volunteers and trainees), the small number of client-students (maximum eight – but the most I observed was six), and the individuated education program.

Educationally, the two small official classrooms at *Cornerstone* are also marginal to the mainstream of educational practice. The classrooms and the teachers are officially accountable to a Principal who oversees all of the 45 Section-23 classrooms in the city (HWDSB, 2007).[15] While conforming to many of the provincial mandates, the teachers practice self-paced learning and self-goal setting. This means that the educational practice at this treatment centre is marginal because although the curriculum conforms to provincial standards and criteria, most 'classes have students of different ages, with differing academic abilities and interests, and cover multiple subjects. Often there are as many subjects 'being taught' as there are client-students in the room. Put more clearly, many of the academic classes are highly individualised, with the teachers adapting many specific curricula to fit the skills or interests of the client-students – curricula that have been approved at the provincial level. Two examples include the incorporation of a for credit dramatic arts course which included set design, production plans and adaptation of plays by the Humanities/Social Science Teacher, and the incorporation of accountancy focussed credits for a student with notable maths functioning by the Science/Math teacher. These two examples are illustrative of the daily flexibility performed by the teachers in their teaching practices. The second discourse is that of *Small Group Learning Theory* which correlates with *Self-Paced learning,* and means that the client-students frame the pace of their educational progress to focus on their strengths and interests, at least in the beginning.

3.5 *Situating* young people and mental illness

In this chapter, I have reviewed two broad social science literatures that discuss elements of the *body politic* which affect the sites that are central to my fieldwork, and the interactions between people attending them. I discussed the anthropological literature pertaining to health, bodies, biomedicine, power, and mental health / mental illness. I also considered how the social categories, or life stages, of Childhood and Adolescence affect adult perceptions of the young people within such categories, what characteristics young people are often ascribed, and how a more pluralistic and contextual understanding of Childhoods and Adolescences might be a more pertinent way of viewing the complexity and varied lives of young people. These literatures begin to contextualise the social constructions of biomedicine, bio-psychiatry, childhood and adolescence and how they interweave with issues of power, control and participation at the ethnographic fieldwork sites.

Fundamental to the presentation of these discussions is an attempt to describe anthropological approaches to a series of discourses that permeate the *body politic* – discourses about biomedicine as a social institution, and childhood and adolescence as life-stages. I have suggested that implicit within these discourse are dualisms, such as normalcy and pathology, that are both the foundations and reflections of western societal and institutional approaches to difference and inequality. I have described how attempts to situate biomedical practices and responses to disease within a framework that considers illness as an experience rather than just as a disease or bodily malfunction, lead to better understandings of the social aspects and individual's experiences of a disease event. By situating disease within multiple contexts, the boundaries of a given disease entity are widened to include not just the biomedical explanatory model, but also the "relevant social, political and economic forces" (Singer and Clair, 2003: 424) that interact with disease.

In this thesis I am not attempting a full-scale *Critical Medical Anthropology* approach, as I have found that data necessary was neither available nor accessible. What I have attempted to do is to incorporate *CMA*'s demand for contextualisation into my research endeavour. I am not alone in attempting to understand service delivery by situating it within broader contexts. Davis, who critiques the often over-simplistic governmental and policy understandings of post-deinstitutionalisation community mental health services in Canada, argues that such broad contextualisation is necessary for a comprehensive perspective of mental health systems and their effects:

> While the notion of covering both systemic and technical concerns in one volume may seem overly ambitious or presumptuous, it has been this author's experience that an appreciation of the political, cultural, and organization context of mental health care is necessary if clinical interventions are to be effective or if we are to understand why they are less than effective (Davis, 2006: xii).

Desjarlais, too, offers an insightful ethnography on mental illness and homelessness that benefits greatly from situating "the category of experiences not as a universal, natural and supreme authenticity – as many take it to be – but as a process built sharply out of cultural, historical, political and pragmatic forces" (Desjarlais 1997: 10). I used the word insightful because of Desjarlais' detailed contextualisation and the subsequent thickness (to paraphrase Geertz [1973]) of Desjarlais' descriptions and analysis. This dissertation aspires to such depths.

In the main, I have discussed adult-focused mental health literatures, and not addressed how essentialized notions of young people interact with services designed specifically for them. In addition, my discussions in this chapter's first two sections on the broad academic *body politic* and its discourses may appear to be static. However, young people and mental health services and treatments should be considered to be processes in flux, institutions in (perhaps slow) motion, bodies in history, life-stages in transformation. In the final section of this chapter, I explicitly contextualised the histories of the services with which I completed fieldwork. In doing so, I have begun to situate young people and mental health/illness, by outlining the particularities of the historically transitioning *bio*medical and educational contexts of the fieldwork sites; sites which attempt to relocate individuals from illness to health by traversing the mental illness – mental health divide. Within this *body politics* chapter and later in this thesis, I present material that links mental health services to social control. In this way, I am influenced by Baer and Lambert who argue that "[w]hat is important about dominant ideology, regardless of its degree of sophistication, is its capacity to explain, justify and even, in some cases, to see justice itself in social inequality" (Baer & Lambert 1982: 174). In relation to Baer and Lambert's phrasing, I connect mental health services in Ontario with the practice of advancing the dominant ideology, with biopsychiatric knowledge and evidence-based practices, which justify the individualized and internalized 'nature' of mental illness (Baer & Lambert, 1982: 174; see also Wells, 2000: 59).

As will be clear in my later discussion on de-stigmatizing mental illness as well as the apparent need to change the systemic forms of the mental health services in Ontario that result from the need for non-racist and culturally appropriate services, I am not certain that merely more mental health services is ideal, and I would be reluctant to recommend simply spending more on services. This is in part because of the link between mental health services and social control. There is, however, clear need for more service capacity – exemplified by long wait lists – that is culturally appropriate. Yet it is also clear that mental health services do offer important opportunities for client-students;

opportunities necessary because of the failings within Ontario's mainstream educational system. I discuss the complexities and ironies involved with this issue in greater depth in later chapters. Suffice it to say, the situation is a thorny negotiation between apparently positive outcomes for individual client-students and the requirement that the client-students *have* to conform to societal norms to access these outcomes.

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[1] Jensen and Allen (1994) define a developed dualistic framework following a synthesis of qualitative research on health. They argue that wellness-illness acts as the social experience of health-disease (Jensen and Allen, 1994: 362). Alexander (2001) usefully explores the prevalence of binary dualisms within western thought.

[2] See Helman, (1985), Lock & Scheper-Hughes (1996), or Turner, (1994) for introductions and further references concerning Cartesian dualism and its role in medicine.

[3] I explore othering as a process of essentialization in more depth in section *2.3.2 Essentialised Childhood and Adolescence.*

[4] The clearest example of the imperfection of Canada's Health Care System is the continued lack of success with regards to improving the health (and living conditions) of many, if not most, First Nation's Peoples in Canada (Bourssa et al, 2004; Jacklin and Warry, 2004; McElroy and Townsend, 2004; Waldram et al, 2006).

[5] Lavis notes that there was a shifting trend in health promotion in the 1980's to population health in the 1990's within Canada policy-making relating to nonmedical determinants of health (2002: 107). Canadian public health endeavors, then, have shifted over time away from bottom-up approaches and towards a "top-down approach to change, often emphasizing public policy at the expense of other options" (Lavis, 2002: 110)

[6] I myself continue to grapple with proving my research's relevance in settings dominated by psychiatry and psychology approaches.

[7] In this vein, Mitchell (2003) discusses the ideological foundations which enable adults to pathologize childhood behaviours, and calls for cognitive developmental theory to be reconstructed in light of advances in understandings of children's rights and competencies (2003: 285-288).

[8] I thank Wayne Warry for reminding me of the need for culturally appropriate services.

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[9] The continuation of systemic educational racism is despite calls for *active* anti-racist pedagogical practice by researchers at OISE (Dei et al, 2002; see also the many insightful arguments on anti-oppressive practice in education and society edited by Shera, 2003).

[10] Despite such shifts in understandings, like many other characteristics that those within the Childhood or Adolescence categories are 'known' for, agentive capacities are still reconceived in *essentialised* ways (Crosson-Tower, 1998; Jenks 2005). There is a demonstrated need to present and examine tropes that are ascribed to these social groups within adult-built spaces, places and discourses (Alenen, 1994; Backe-Hansen, 2003).

[11] These included the "Heseltine report, *Towards a Blueprint for Change: A mental health policy and program perspective* (1983); the Graham report, *Building Community Support for People: A plan for mental Health in Ontario* (1988); *Putting People First: the reform of mental health services in Ontario* (1993); and *Implementation Planning Guidelines for Mental Health Reform* (1994)" (Sinclair et al, 2005: 61).

[12] The Graham report (1988) signified "the transition from an institutional-medical approach to a community-based approach" (Nelson et al 2001), which Simmons (1990) suggests coincided with the 1985 Ontario election wherein the Conservative party lost a 40 year control over the provincial government, and was replaced with a Liberal one

[13] There were two reports by the Ontario Ministry of Health (1991a and 1991b) that examined the final phases of community mental health service implementation, which suggested large steps still needed to be taken in completing the de-institution process.

[14] Such claims to evidence-based knowledge has escalated the pace of research seeking the biological (neurological or genetic) basis of mental illnesses in recent years – especially in terms of nueroimagery and diagnostic tools (Brandão and Graeff, 2006). Busfeild argues that "advances in genetics, the neuroscience and pharmacology currently appear to be confirming the ascendancy of the natural sciences in contributing to the understanding of the body and behaviour and, more particularly, the explanation and treatment of both mental and physical ills"(2000: 543). This genetic and neurological work aims to confirm medical science's ascendancy over mental illnesses which biomedicine believes to be a "complex mix of biological and psychosocial; features,

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blurring distinctions between mental and physical illness" (Frank and McGuire, 2005: 223), but as I discuss in later chapters overlooks the sociality of mental illness experiences. What occurs within this medicalised model is that disease symptoms are located and observable within individual behaviours (Stolzman, 1994: 451).

[15] Yet in my time during fieldwork the Principal only visited twice. Teachers did, however, attend regular 'school' meetings that they described as being about forming a collegiality between the disparate Section-23 staff and about feeling like they were part of a unified 'school.'

4. Sites of re-enculturation: *habitus,* hexis corporeal and further anthropological theorising of a Canadian mental health service for youth

4.0 Preamble to 'Sites of enculturation ... '

The preceding chapters have outlined my methods and the *body politic* in which fieldwork was undertaken. The next two chapters explore the sociality of these fieldwork sites. This chapter examines one particular fieldwork site, *Cornerstone*, and analyses data through a theoretical lens that draws on Bourdieu's and Foucault's theorizing to suggest that these two often disparate perspectives might be combined to generate an understanding of *habitual self disciplining* as it takes place through therapeutic recovery. In keeping with my assertion that there is interaction between the *Three Bodies,* I argue that that the installation of durable dispositions can be witnessed at institutional, professional *and* patient levels. This approach offers an analysis of the link between mental health service and educational expectations.

The chapter is being revised for re-submission for peer review with *Medical Anthropology Quarterly* and incorporates my responses to reviewers' comments. Other than the numbering of subheadings it follows the journal's formatting, which is based on the *Chicago Manual of Style.*

4.1.1 Title

Sites of re-enculturation: *habitus*, *hexis corporeal* and further anthropological theorizing of a Canadian mental health service for youth [1]

4.1.2 Abstract

This paper focuses on the processes that I describe as re-normalisation, re-enculturation and re-integration – and the accompanying generation of 'growth' and 'progress' – at a day treatment service (*Cornerstone*) for young people with mental health diagnoses that are so severe that they cannot attend school or work. I outline the applicability of Bourdieu's theorizing through an examination of two case-examples: first, the service's dual position as both hospital and educational facility, and second, the client-students' need to 'fit in.' I argue that the therapeutic and educational activities which take place at *Cornerstone* are involved directly with the installation of *habitus* and *hexis corporeal*, and that this installation can be seen through ethnographic evidence to occur for patients, workers, and the institution itself.

4.1.3 Key Words

youth mental health, theory, *Bourdieu*, social disability, stigma,

4.2 Introduction

In this paper, I draw from both Ph.D. fieldwork research and a project focusing on the role of creative programs at a day treatment service for young people with mental health diagnoses that are so severe that they cannot attend school or work. I explore ideas about the process of normalization that occurs at *Cornerstone,* which is designed to be a stepping stone – and is described as such both in intake processes and in institutional literature – back to "regular" teen sites, such as community schools, work or apprenticeships.[2] While Hahn and Kleinman have argued that biomedicine as a sociocultural system has "distinct elements that interact in a manner which separates them from other systems within society" (1983: 306), I suggest that the biomedical practices at *Cornerstone* are deeply intertwined and interconnected with other systems within society, and that I have witnessed at *Cornerstone* a "confluence of political systems, the law, moral codes, ideology, and beliefs about illness and health" (Romanucci-Ross, 1997: 324).

The focus of this paper is to be the processes that I describe as re-normalisation, re-enculturation and re-integration – the latter of which is *Cornerstone's* self designated purpose – and the accompanying production of 'growth' and 'progress'. I present two brief case-examples: first, the service's dual position as both hospital and educational facility, and second, the client-students' need to 'fit in.' In these case studies we witness the continued adaptation of the Service, patients' medical discharge, their wellbeing and school success, which I suggest reflects growth and development on various levels.[3] This paper explores how by negotiating binary categories and in conforming to normative discourses in order to be a 'valuable' service, or a 'healthy' individual, we witness complex roles that might be understood as installed *habitus* and *hexis corporeal*, in Bourdieu's words (Bourdieu, 1998: 25, and 1977: 93).[4] I begin by briefly explicating key theoretical terms from Bourdieu, my interpretation of them, and how I aim to apply such theorizing. I then present a detailed description of *Cornerstone* and present the case-studies exploring how *habitus* and *hexis coroporeal* are installed at this location. Implicit here, is that the therapeutic and educational activities which take place at *Cornerstone* are directly involved with the installation of *habitus* and, further, that the installation of such durable dispositions can be witnessed at institutional, professional *and* patient levels.

4.3 Bourdieu's Theorizing

Bourdieu's work is undeniably useful in that he clearly explicates the ways class hierarchies are systemically and subtly reproduced within education and by education's pedagogical practices, curriculum and assessment methods (Bourdieu and Passeron 2000). Using Bourdieu's *habitus* / *field* / and various *capitals* are clearly useful, especially in a purely education arena (Nash 1999; Reay 2004; or Robbins 2004). Theorizing which incorporates or supplements Bourdieu's *habitus* and *hexis corporeal* with Foucaultian understandings of the internalized desire for a self-disciplining body illuminates the emotional or mental aspects of being fully human within society. Combining such theorists is akin to the theoretical eclecticism described by Ortner (1999: 66, 83). Following Ahearn, my analysis is an attempt to move towards an understanding of the sociocultural frames that mediate agentive actions and capacities (2001:122).

Bourdieu's and Foucault's theorizing have often been described as oppositional or discordant (Erickson and Murphy, 2003: 161; Fowler 1997: 92; Lane 2000: 6). Yet I see potential merit in using elements of their theories in conjunction with each other. In doing so, I suggest a 'third way' that is informed by both theoretical posits – that of both 'fields' and of 'power / knowledge'. Both Bourdieu's and Foucault's conceptualisations help me to analyze the overarching processes that locate individuals within fields and construct them as agents and actors with agentive capacities as participants or groups, but who are at the same time constrained by the overarching processes. I assert that there is an implicit link between Foucault's discussion of *disciplinary mechanisms* and Bourdieu's notion of *habitus*. Disciplinary approaches begin as external mechanisms, but over time are internalized by the subject – self-discipline becomes habitual.

Bourdieu trained as an anthropologist and turned towards sociology within a French academic context where the demarcation between the archaic unchanging (colonised) societies from the advanced dynamic (colonising) societies also correlated to distinctions between anthropology and sociology as disciplines (Lane, 2000: 119). Such dualistic distinctions between home and away, coloniser and colonised was not untypical of anthropologies during his indoctrination into the academe. There are clear problems with such dualities and ascribed characteristics; too many to give details here. But it perhaps is this reification of anthropological endeavours, ethnographies and theorising alongside Bourdieu's unflinching criticism of the then anthropology (Lane 2000: 120) that has predisposed many medical anthropologists to prefer Foucault's to Bourdieu's theories. I argue, however, that there are potential benefits to considering two of Bourdieu's theoretical concepts – *habitus* and *hexis corporeal* – the former being already well-utilised within anthropology and sociological research, while the latter less so.[5] Bourdieu (1990:10) notes that these terms have been utilised with varying degrees of accuracy and appropriateness and so it is necessary to define the terms using his own words, and state how I interpret and intend to apply them. [6]

For Bourdieu, *habitus* "are generative principles of distinct and distinctive practices" (Bourdieu 1998: 8), and these principles and practices are "necessarily internalised" and function as individual's "life-styles" (Bourdieu 1984: 170). Elsewhere, Bourdieu adds that such "*generative capacities* of dispositions ... are acquired, socially constituted dispositions" (Bourdieu 1990: 13) and, importantly for Bourdieu, that these "dispositions [are] *acquired through experience*, thus variable from place to place and from time to time " (Bourdieu 1990: 9, authors italics). They are installed (partially or fully) by the existence and practices of systemic institutions (Bourdieu and Passeron 2000). Bourdieu and Passeron examine how *habitus* is instilled by societal-wide compulsory educational systems (2000:199). Moreover, such institutions do more than teach skills of reading and writing. Not only do they generate nationalities, install normative gender expectations, and construct internalized acceptance of class-based hierarchies (akin to Apple and King's (1983) *hidden curriculum*, for example), but they, being the education system and associated *habitus*, also install the "the naturalisation of its own arbitrariness" (Bourdieu 1977: 164; see also Bourdieu 1998: 22).

For Bourdieu, then, *habitus* is a multifaceted complex and fluid process of enculturation that justifies, normalizes, and internalizes societal expectations, practices, *and* hierarchies. However, Bourdieu's *habitus* does aim to alleviate the subject-, or agent-lessness of Foucault's structuralism by incorporating individuals into action, practices and cultural productions (although this is admittedly a potential contradiction):

> In fact, 'subjects' are active and knowing agents endowed with a *practical sense*, that is, an acquired system of preferences, of

> principles of vision and division (what is usually called taste), and also a system of durable cognitive structures (which are essentially the product of the internalisation of objective structures) and of schemes of action which orient the perception of the situation and the appropriate response. **The habitus is this kind of practical sense for what is to be done in a given situation** (Bourdieu 1998: 25, my emphasis).

From this lengthy quote we can witness Bourdieu's conceptualization that *habitus* should be understood as individually internalized, but reproduced and practiced as unifying dispositions at both the individual level and at the *class* of individuals level (Bourdieu, 1998: 8; 1988: 150). Further *habitus* dispositions are both practical and ontological categories, both ways of doing and ways of knowing.

Closely aligned to *habitus* is Bourdieu's discussion of *hexis corporeal*, which can be understood as the embodiment of *habitus.* Bourdieu quotes Erikson, "Bodily *hexis* is political mythology realized, em-bodied, turned into a permanent disposition, a durable manner of standing, speaking and thereby *feeling* and *thinking*" (Bourdieu 1977: 93-94, quoting Erikson, 1945). Significantly for my discussion, is that *habitus's* location within *hexis corporeal* and its durable dispositions can be physical *and* mental. In other words, *habitus* has both body and mind components (Grenfell, 2004: 27). Furthermore, Bourdieu reminds us that the body and mental characteristics of *habitus* are "charged with a host of social meaning and values" (Bourdieu 1977: 87). I interpret *hexis corporeal* to be the bodily and mental performance of *habitus*.

Fowler, in exploring Bourdieu's theorising, argues that "[i]t seems to me that – like Giddens – Bourdieu has been struck by the sheer level of expertise involved in run-of-the-mill human accomplishments" (Fowler 1997: 18). I, too, am struck by the expertise necessary for everyday teen life. The adolescents attending *Cornerstone* and their happiness and joy at being able, at last, to go back to high school, get on a public bus, go to the supermarket and pay the cashier – simple, mundane accomplishments that they were unable to do before attending *Cornerstone*. These human accomplishments strike me as interesting foci which may be examined to generate wider understandings of the process of becoming fully human. It is to the setting where these accomplishments take place that I now turn our view.

4.4 Fieldwork Setting

The *Cornerstone Youth Service* is a division of Hamilton Health Science's Integrated Child and Youth Mental Health Portfolio and is based in Hamilton, a large urban center of 500,000 people in Ontario, Canada. *Cornerstone* offers community-based psychiatric Day Treatment to adolescents aged 13-18 with severe emotional and psychiatric problems, such that they are unable to attend school or to work. The diagnoses are frequently co-morbid and include, but are not limited to: mood disorders, anxiety disorders (including specific disorders such as Post Traumatic Stress Disorder, School Refusal, and Obsessive Compulsive Disorder), Tourettes Syndrome, Aspergers Syndrome, schizophrenia, eating disorders, and drug and alcohol abuse. Typically, client-students are unable to form friendships and are isolated socially. Prior to attending

Cornerstone, most client-students have not been in school for an average minimum of 1 year, many have not been attending for 2 or more years.

Cornerstone's client-students have an impaired self-image and few coping skills. Regaining 'self-control' and 'self-responsibility' are key therapeutic aims for the service, and must be addressed as a part of treatment. I must stress that all of the client-students are at the very margins of what could be considered 'healthy' teenage experience; recently, clients have included survivors of physical, sexual and emotional abuse, as well as significant other medical trauma arising from, for example, cancer and severe car accidents at an early age.

4.5.1 Case Study: *Cornerstone's* Dual Role

Cornerstone uses the therapeutic community model – a model which considers being part of a supportive community to be in and of itself therapeutic – and within this model something as simple as saying "hello" to the secretary in the morning and her remembering your name and giving a smile back is considered therapeutic. This position suggests that all aspects of the Service are potentially therapeutic. In this model, all members are responsible for treating everyone in a considerate manner, and in this way members are charged with responsibility for their behaviours. One Child and Youth worker (CYW) suggests that the model enables the client-students to *"get a feeling of acceptance, and it's almost like an unconditional acceptance, because they usually do get an unconditional acceptance, and in the initial meeting I think it's really, really important to talk about the safe feature of the place and, and I think kids buy into that right away,* *around not being teased that not being tolerated, around not being bullied." (Staff Member Interview Dec 06).*

Officially, *Cornerstone* offers a diverse range of small group opportunities as vehicles for mental health improvements. Creative programming accounts for 60% of available weekly activities and includes crafts, ceramics, for-credit 'general arts,' photography, and woodworking. Other activities offered by the service include formal therapeutic groups (relaxation and coping skills, stress management, Men's and Women's Problem Solving, and specific cognitive behaviour groups), recreational activities (bowling, gym and hiking), academic work in a classroom setting, and life skills (cooking, computer use, and work preparation). Formal therapy also takes place during meetings with a personal tutor-therapist (Child and Youth Worker) – client-students monitor their progress weekly during hour-long one-to-one sessions, which are designed to evaluate their participation and successes with reference to their goals on admission. Here we see a clear discourse –being as productive a member of society as one is capable of is characterized as becoming healthy.

Cornerstone's vision is to be a stepping-stone back to mainstream or alternative school programs, work placements, apprenticeships or volunteering. Officially this vision is achieved by providing, "a safe, enriching environment that empowers the individual growth of youth through an innovative partnership of Education and Mental Health Treatment" (Cornerstone, 2006). While funding for therapeutic programs comes from the Ministry for Health and the Ministry for Child and Youth, the educational components' funding comes from Section 23 of the Ontario Education Act, a provincial (equivalent of

State) mandate. Thus, availability of on-site teachers and for-credit classroom activities, as well as day treatment programs, enables remedial schooling to potentially be therapeutic and take place in tandem with 'official' therapeutic processes and improvements (Author and Colleague, 2005). Again, I argue that here we see the confluence of discourses which demand young people to be healthy and productive members of society.

The following quote summarizes a generally held opinion among the staff: that having a dual medical and educational role is practical and sensible in light of the client-students' characteristics:

> *"I think the school aspect normalises it ... I think you have to balance that, that the societal expectations that kids are in school until a certain age; and also again it's a very therapeutic tool it gets the kids used to an environment of re-clicking their brain into an academic kinda thing and that they can do two things at once, that's huge, you know if they were just working on their self esteem and confidence – your programming and that kinda stuff – and then did not have the academic aspects too it would, I don't think you could do that it would not be a therapeutic environment for the kids they'd just feel like everything was passing them by again"* (Staff Member Interview, January 2006).

Juxtaposed to the "normalising" role, the "school aspect," is how the staff present *Cornerstone's* activities to Hospital managers and external reviewers. The dual role is carefully negotiated in presentations by managers to such groups. At all times, the balance of therapy (medical practice) and learning (school practice) is carefully monitored – no client-student is ever presented to the external hospital world – they are always clients or patients. In fact, my decision to use the term client-student is an attempt to conciliate both the senior medical professionals, who see clients as clients or patients, and the kids who see themselves as students – in one lunchtime 'Rounds' presentation at a main Hospital site, I used the term 'student,' and staff member of the hospital asked me who these students were (Stride-Darnley, 2005).

Official discourse, then, presents *Cornerstone* as having only clients, clients who are on their way to being healthier productive members of society. Here, I suggest we are seeing the staff and administration use language that justifies their service's existence to the main funding source. *"We can help these kids become healthier, we are keeping them out of long-term residential or hospital beds, and we are using evidence-based medical practice to do so"* (Staff Member Interview, February 2006). Thus, I suggest that staff and administrators are publicly conforming to the demands that the larger system has on them – their funding is primarily through the Hospital – while at the same time, formally and publicly overlooking the concerns of the client-students (by describing them as clients rather than students), who want to fit in and want to be normal.

4.5.2 Case Study: Client-students' need to "fit in"

An emerging theme within my fieldwork data is that client-students have a need and desire to feel like part of a community, to be 'normal' and to 'fit it.' Although it is not a simple dualism, all of the above needs and desires tend to be juxtaposed with the personal and social stigma associated with their mental ill health. It is through their desire to 'fit in' that we see the multiple layers of *habitus* and *hexis corporeal* at work. The re-socializing aspects of *habitus* become internalized and valorized by individuals, while at the same time framing and determining, to a greater or lesser extent, the desires and wishes of the individuals themselves. Thus the 'need' and 'desire' are at the same time a goal and an expression of durable dispositions. To explore this process, I briefly examine aspects of one therapeutic program which appears integral to such 'successes,' and which culminates in a celebration.

One key therapeutic program is the Relaxation group in which I participated from February to June 2006. This program is based in Cognitive Behavioural Therapy (CBT) techniques and *Esme* and *Nancy,* the two CYWs who take turns to lead the program, have attended specialist-training courses in CBT above and beyond their other qualifications. Relaxation is used t remedy levels of anxiety or stress (which are often conflated by the front line workers and the client-student alike). Relaxation takes places in the Relaxation Room, a room dedicated to the program, which has couches and leather lazy-boy style chairs, thick blinds to keep out the light, blankets, low level lighting, and a CD player. There is also a red light in the hall outside which is switched on when Relaxation is taking place so that others know that they should be quiet. The Relaxation program I attended took place one morning every week, and was usually accompanied by a mug of low caffeinated tea – often a flavour called *Tension Tamer* – and a granola bar or other non-sugary snack.

To begin, we would focus on our breathing and after five or so minutes we would take turns to describe how our stress levels were, how we knew what was the right level, and why we were that stressed. One of the CYWs would always remind us that "it's ok to feel stressed, everyone does." Staff (1 or 2), client-students (5-8 depending on attendance) and myself, would give our stress levels on a scale from 0 (dead), through 50 (more or less normal) to 100 (far too stressed), and give physical symptoms of the stress – how much our legs were shaking, how we had sweaty palms, how tired we were, how tense our shoulders were. These levels and symptoms were often linked to specific issues from that day or the preceding one. The reasons most often cited for causing the given stress levels were a lack of control, homework, arguments, journey to *Cornerstone*, bad sleep, too many tasks, or visiting a new school. After this tea, would be made and time would be dedicated to working through CYW-lead activities and lessons about identifying stress, its symptoms, and practical ways in which anxiety and stress can be tackled or reduced. The second half of relaxation was given to actually relaxing. This was described by client-students in interviews as reminding them that taking time to relax, in and of itself, was ok and a good thing. The lights would be dimmed and meditative music would be played. Everyone would find a space to get comfortable – some on mats on the floor, all with cushions and blankets. Then *Nancy* or *Esme* would remind us that "thoughts will push themselves from the back of your brain but just push them away" and to take deep tummy breaths – breaths that fill your lungs right from the diaphragm. Invariably, a number of us would fall asleep only to be awoken by the sounds of chairs moving in the Lunch Room upstairs.

Knowing personal symptoms and triggers of stress and anxiety and being able to reduce them without self-medication (such as alcohol, drugs, or over the counter pharmaceuticals) are Relaxation's key CBT goals. To reach these goals, client-students learn to use breathing to physically relax by reducing the fight or flight response. Client-students are shown that they often hold their breath during stressful situations, and that this automatically increases their physical stress. Through the activities there is a realization that self control can be regained – by doing things a step at a time, and by being able to write and talk about their symptoms and stressors in a personal and private space. Having a safe space to discuss and acknowledge the specifics of personal triggers for their anxiety, and having group input into how such triggers might be better reacted too, avoided or reduced, greatly dissipates personal burden. In addition, Relaxation is meant to be practical. That is, client-students are encouraged to take their skills beyond the Relaxation Room. Skills are described as transferable, and client-students are encouraged to bring to the group examples of successful implementation from the previous week. The combination of remembering similar situations that were successfully navigated, often through taking time to breathe, were often cited.

Cumulatively, Relaxation inculcates skills that work to reduce anxiety and stress. I would suggest, however, that it is through the breathing practices specifically that we see the *hexis corporeal* aspects of Relaxation. Through the intake and discharge of air, as individuals within the group breathe, they are physically altering their bodily reactions, which in turn enable their future performance of more normal, de-stigmatized, social positions. I suggest that the contra-stigma rhetoric and performance of both the client-students and *Cornerstone* as a service are a refraction of the need for normality, which emerged as a central theme in the research data. I would suggest that the ways in which this is performed and embodied are clearly framed by the conditions in which they are practiced and reflect their social and institutional positions (Author, *In press [a]*). Moreover, the desire to 'fit in' can be seen as resistance to the disabling affects of client-students' mental ill health, but also compliance to medical processes and social regimes that focus on individuals as the site of disease rather than the social determinants that contribute to illness and disability.

The epitome of success for client-students and *Cornerstone* is the return to 'normal' teen life. An example of this culminating achievement occurs as the 2005-06 fall semester ends and a handful of the client-students are ready to move on, some transitioning back to community high schools full time, some going back half-time. This is a great success to be celebrated; an achievement to be used to encourage further success within the therapeutic community. In January, thirty minutes of a two-hour staff meeting are dedicated to the nature of the celebrations and, having already sought input from some of the client-students, staff decided to try to make a Piñata. In the discussions, one staff member comments that none of these teens have ever had one – not overly surprising given their mostly poor, urban and European backgrounds – and therefore the celebration can be framed as an educational experience too.

So, in early February, twenty or so client-students, one teacher, one CYW, one CYW student and myself head out to one of the large trees in *Cornerstone's* grounds after lunch. After a little difficulty the Piñata is raised and I get nominated to pull it up and down as the client-students swing. *Nancy* gives a little speech reminding everyone why we are there – to say good luck and good-bye – and the client-students by consensus decide that those leaving should have first swings. One by one, the leaving students, who are a little embarrassed, come up, get blindfolded, spun and have their three swings at the Piñata. The fifth client-student opens up the Piñata and candies are sprayed across the tarmac and grass. The public celebration is even accompanied by the occasional honk from passing cars. Candies are bartered and redistributed among the client-student friendships, some of their first friendships since entering their teens. As we return to the building client-students chat about how they hope to continue the friendships even after leaving. For the client-students this is clearly a very important occasion. But how have these teens, formally incapacitated by their anxiety and depression, reached the point where they are ready to return or transition to 'regular schooling', act silly in a public space, be able to make friends and feel 'normal'? Both staff and the client-students state that it is through therapeutic programming such as the Relaxation program.

4.6 Theorizing with Bourdieu *and* Foucault

What I am attempting to describe through these ethnographic vignettes are interconnected trends: for client-students I am describing the influence of medical and therapeutic activities and practices for re-installing *habitus* and *hexis corporeal* – clients had failed to gather the coping skills necessary for 'regular' teen life, and at *Cornerstone* they undergo programming that will enable them to newly ascribe such skills. For practitioners, frontline workers and the Service as a whole, I am describing the (re)production of socially 'normal' youth in efficacious and efficient ways while also drawing attention to the tensions associated within such processes.

I have been arguing that Bourdieu's embodied *habitus*, the *hexis corporeal,* framework can emphasise the social construction of disability parameters – in this case debilitating mental health. Marks convincingly argues that disability is "a social construction" (1999: 187). Söder anchors the construction of disabilities within socially desired values and beliefs (1992: 248), implicitly acknowledging the conferral of cultural capital onto the body. What we are witnessing through medicalised re-enculturation and through the therapeutic improvements is the re-skilling of individuals so that they have the coping mechanisms that help to reduce, rather than nullify, the disabling aspects of their mental ill-health. Through *habitus* and *hexis corporeal* the individuals adjust to socially ascribed norms of behaviour, with *Cornerstone* as a service implicitly contributing to these competencies.

The level of expertise – both cultural competencies (knowing where to get the cheaper bus tickets and how to use them on the bus), and the mental health competencies (being able to cope with the stress involved with standing on a packed and cramped bus with no personal space) – necessary in everyday activities is gradually inculcated through participation in the therapeutic activities at *Cornerstone*. Expertise is instilled as part of a *hexis corporeal* and I would argue, *hexis* psyche. It is this, perhaps ironic, self confidence and mental health (rather than mental ill-health) that is often overlooked by those who use Bourdieu to explicate the continuation of social class divisions within western societies, despite attempts to ameliorate the social impacts of raced, classed, and gendered divisions (this list of structural barriers could of course be expanded). From the client-students' perspectives there are clear benefits to be gained from attending *Cornerstone* – a position highlighted by their recommendation of the service to relatives, friends and teachers at their new high schools.

Yet the clear ironies associated with the processes of *habitus* installation is that they are considered by parties at various levels to be beneficial. That is to say the activities alter individuals, and justify the service, rather than address the broader systemic problems that likely contribute to the disabling factors which adolescents with mental health problems face. It should be noted that such an approach is outside the remit and power of the individuals and service: "What we deal with are weeds who grow in the cracks in the system and help them turn into flowers and trees" (Staff Member interview, March 2005). Goodnow cogently argues that a principle element of socialisation is that the "well socialized individual not only encounters a world of control but also comes to accept this state of affairs as natural" (Goodnow, 1990: 280). I suggest that if we accept that in the three case studies outlined above *habitus* is being socialized and instilled, then we are also witnessing a process that Foucault describes as self-disciplinary action (Foucault 1997, 1980, and 1971). Further, I suggest that the ironic benefits in which skills and coping mechanisms are newly acquired, the institutional productivity is enabled by evidence-based best practice, and the fledgling student successfully negotiates a key rite of passage, are results of a naturalized bio-power and internalized *hexis corporeal.*

4.7 Conclusions

This paper has been an attempt to explore the implication and ironic juxtaposition of tensions between conforming to the demands embedded in seeking 'well-being' and 'productivity,' and the feeling of growth and development this engenders, and perhaps necessitates. The systemic structures that create such problems for these youth remain unaddressed by the service that defines conformity to a system – a system that was originally damaging – as healthy. We should remember that *Cornerstone* itself is embedded in systems of biopower (Baer 2001). Not only does the service re-enculturate individuals so that they have an internalized *habitus* that will (hopefully) enable them to succeed, but it also has to conform to the systemic pressures of productivity and success that leave it little scope or time to address the hegemonic social and systemic underpinnings that generate the disabling of the adolescents it exists to serve. Let me reiterate that in the ethnographic vignettes presented, we witness both the installation and internalization of *habitus* and *hexis corporeal*. Thus, Bourdieu's and Foucault's theorizing can be combined to generate an understanding of *habitual self-disciplining.*

I conclude with a final example. During the 'role of the arts' project I completed a series of small group interviews with a total of 10 former client-students (Author and Colleague, 2005). Two of the groups wanted to start the interviews by stating how much they had gained by attending *Cornerstone.* Completely of their own volition they suggested that prior to *Cornerstone* they would *never* have been able to get on a bus by themselves and come to chat about their experiences with a total stranger (admittedly a stranger introduced to them by *Esme*, who was someone whom they trusted). These former *Cornerstone* client-students said they had grown so much, and developed such self-confidence, a process that I witnessed over 18 months that the ironies illustrated by their 'progress' seems to belittle their achievements. While *Cornerstone* Youth Service helps prepare the client-students to return to systems that have essentially failed them, this seems irrelevant when the human benefits are considered – happiness and confidence. After all, these adolescents are not asking much – getting on a bus, going to the supermarket, which are "quote un-quote" normal activities – and here we have the ironic conundrum crystallized.

4.8 Notes

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2. While institutional names are accurate, all personal names given are pseudonyms to assure anonymity and confidentiality.

3. In this paper, I use the phrase client-student. While it is awkward, it aptly represents the tensions between the nomenclature of adults and youth at *Cornerstone*. Medical staff predominantly describe the service and the youth as day treatment for clients or patients, while the youth describe and perceive themselves as students in an alternative-education program. Elsewhere I have analyzed in detail the generation of these, perhaps contradictory, tensions (Author, *In press [b]*; Author and Colleague, 2005)

4. These concepts can be seen as parallel to Foucault's concept of bio-power that controls and disciplines bodies and social interaction (Foucault 1980).

5. Bourdieu is often used by sociologists, and others, for his exploration of *capital* and *class* influences in social reproduction. However, this paper's focus is not to be a *capital* and *class* – or socio-economic – analysis. What I am exploring are the nuanced ways in which individuals and institutions are disciplined into having *habitus* which may, and do, have *class* characteristics – "systems of durable, transposable *dispositions*, structured structures predisposed to function as structuring structures" (Bourdieu 1977:72; see also Bourdieu 1998: 26) – that direct possible actions within given settings. Bourdieu argues cogently that within the *habitus-field* "[s]ocial classes do not exist [...]. What exists is a social space, a space of differences, in which classes exist in some sense in a state of virtuality, not something given, but as *something to be done*" (Bourdieu 1998: 12). *Class*, then, is a conglomeration of actors, predisposed to act in certain ways, rather than an economic grouping.

6. There are many variations in representational style of *italicizing* key theoretical words. I will use Bourdieu's apparently most frequent style, *habitus*, unless authors quoted do not do so.

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5. Children and Youth in a medicalised world: Young people's agency in mental health treatment

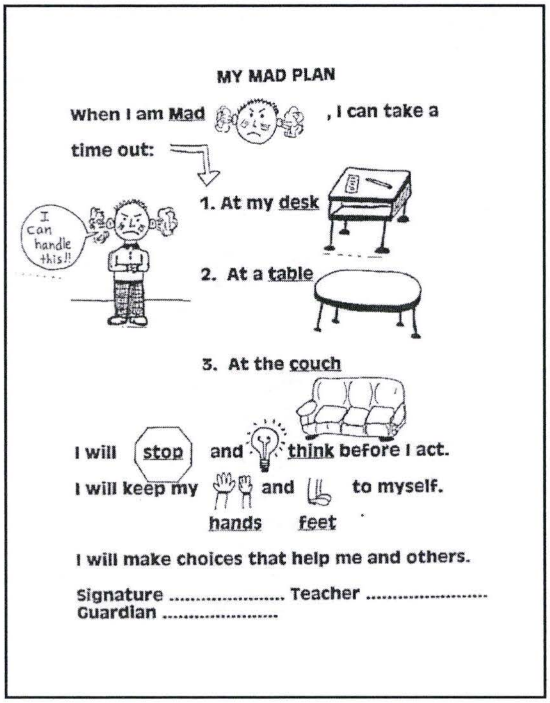
5.0 Preamble to *confined agency* chapter

This chapter is forthcoming in an edited text (Nybell et al, *In press*), whose intended audience is social work practitioners that specialize in working with young people. Its content is integral to the present thesis for a number of reasons. Through this chapter I demonstrate my attempts to communicate anthropological interpretations of settings that are traditionally considered the domain of other disciplines, and thus the chapter speaks to both the inter-disciplinarity of my Ph.D.'s research topic and to the necessity of applied products to 'caring professions' practitioners who are some of the involved adults at the fieldwork settings. The chapter also clarifies my definition and use of an important theoretical concept – that of agency – as I interpret it to apply to young people. By advocating that my notion of *confined agency* is applicable to *both* children and adolescents I thereby augment the existing social science research relating to young people's power to act within their social worlds. Finally the chapter adds considerably to the ethnographic depth of the thesis as a whole through the numerous case studies used to explore the everyday situations where biomedical discourses are usually dominant.

11

Children and Youth in a Medicalized World: Young People's Agency in Mental Health Treatment

Ben Stride-Darnley



MY MAD PLAN

When I am Mad, I can take a time out:

1. At my desk
2. At a table
3. At the couch

I will stop and think before I act.

I will keep my hands and feet to myself.

I will make choices that help me and others.

Signature .... Teacher ....
Guardian ....

This is a copy of "My Mad Plan." It is designed as a contract between client-student,[1] teacher, and guardian, and it incorporates pictures to help clarify the wording, making it more age/skill level appropriate. It is a key tool of staff in guiding young people at Northern Ontario Service (*NOS*), a child mental health assessment and treatment service, toward better self-controlled behavior, the lack of which is one of the causal factors that contribute to their attending *NOS*. The guardian signature assists in consistency between home and educational settings, which staff noted during interviews as a key feature of successful assessment and therapy. The "safe spaces" of desk, table, and couch are preidentified to assist young people in removing themselves from stressors (such as school/therapeutic work, adults, or other young people), thus giving them space and time to control their emotions and physical response to stressors. It is one of many strands of therapeutic activity highly influenced by Cognitive Behavioural Therapy (CBT), and it supports group and individual sessions aimed at self-recognition of a variety of emotional states and how best to deal with the more negative ones. "My Mad Plan" along with pictures of various good and bad emotions are posted in numerous formats around the classrooms, and the plan is repeatedly described during daily activity by staff at key quiet times, such as registration, as well as during "loud times," when the plan needs to be put into action.

One such instance occurred when the *NOS* group was transitioning from math to language, midway through the morning session. Johnny (aged 7) wanted to continue his work on long subtraction.[2] He had been struggling with it all week but was doing particularly well on this occasion. He wanted to postpone his least favorite lesson, language, until after lunch, which is when group (therapeutic) work was scheduled. This point of tension between the child's wishes and the requirements of routine led to a battle between Johnny, on one side, and the teacher and child and youth workers, on the other. Johnny was angry, vocal, and defiant. When staff members invoked the Mad Plan, Johnny sought to challenge the protocol and demanded that he be able to go to the carpeted area of the class—not one of the pre-designated safe spaces. Eventually, after some disruption, Johnny conceded and went to the couch, where he was praised for his achievements at math but was reminded that language and spelling were just as important. Through a process of negotiation, it was decided that the language class would not be all reading and writing, but time would also be allocated to the word game Boggle, which Johnny and the other the client-students enjoyed greatly.

I suggest that these events are very much framed by adult terms and conditions. Johnny wanted to continue his clear successes and avoid future difficulties. He attempted to achieve this by acting in ways that defied adult controls over appropriate behavior and activities. Because staff wanted to maintain the daily routine, Johnny was effectively able to act with *agency* and negotiate the content of the second half of the morning's programming. Even though the outcome was not to continue with math, which was Johnny's initial desire, Johnny was able to negotiate less lesson time and more game time. By using the Boggle game, staff members were able to continue educational activities while the client-students practiced their spelling, and Johnny was able to gain by having fewer "book lessons." The scenario is also framed by adults on a second level—that of the Mad Plan itself. While its content and language suggest that the decision-making power is with the young person—"to make good choices" and head to the safe space of desk, table, or couch—these are predetermined by the contract and staff. Even if the young person would find the carpet or sitting up against a wall a more calming space to think and consider how best to proceed, as Johnny's efforts illustrated, it was the staff rather than the client-student who made that determination.

It should also be noted that these conditions are not necessarily as the staff would wish. For example, this particular site of the *NOS* had recently changed the school location in which it was based so that, as one staff member reported, "in effect, the burden is shared across the city's elementary schools" (interview, March 2006). In the new location, the *NOS* site had been allocated two classrooms (usually divided into a main or education room and a quite or therapy room). However, the second room was down the corridor past four or five other "regular" school classrooms, even though the next-door class room was being used as storage prior to school enlargement in the following academic year. This distance made going to a safe and quiet space exceptionally difficult at times of high stress or noise, when the Mad Plan might most need to be implemented, such as when Johnny was most disruptive. In the instance of Johnny practicing a certain level of agency, staff agency was also limited and framed by institutional and policy conditions. In interviews with the staff at this site, the majority stated they often felt unable to remove the "noise makers" because of the distance between the two rooms, which reduced the effectiveness of the Mad Plan.

Agency Defined and Explored

The concept of *agency* is key to this chapter and therefore needs further definition and explanation before we move onto additional ethnographic examples. For the purposes of this chapter, agency should not be considered to be a service or program, but an individual's or a groups' capacity to make decisions, act, and interact with other people in a socially competent way (Bourdieu 1999, 1998, 1977; Giddens 1982). Ahearn's (2001) exemplary article explores the various definitions and uses of agency, so I will not repeat all of the debates here. I do, however, consider Ahearn's (2001:112) "provisional definition of agency" as "refer[ring] to the socio-culturally mediated capacity to act" to be a particularly useful definition in light of the discussions that follow. Ahearn, as an anthropologist, advocates for an understanding of the cross-cultural specificity in definitions and use of agency. This means that cultural forms of agency, albeit societal or institutional, are greatly influenced by the particular contexts (cultural, historical, political economic) in which agency is performed (Ahearn 2001:113).

It is important for me to clarify and examine agency as a concept because it has undergone considerable shifts in understandings within research and policy literatures in terms of both what it is and who has it. The work of childhood research "forefathers" such as Piaget (1962) and Erikson (1963) has highly influenced psychological and social science theories on childhood and adolescence as life stages and understandings of the young people who exist within these categories. These early endeavors broadly saw children as empty vessels totally influenced by the actions of adults who educated them, both formally and socially. Within this understanding, young people lack agency of any kind, and this largely remains society's view of children and youth (Boggin 1998; Bucholtz 2002; Hockey and James 2003; Lee 1999; Wolf 2002). Recent scholarly literature has questioned this "top-down" model of childhood, adolescence, and young people in two ways: first, some scholarly work has attempted to "historicize" childhood as a social category by presenting it as a defined life stage with a recent genesis and specific cultural context (Cannella 2002; Colón and Colón 2001; Harkness 1996; Hendrick 2003; Seifert 2000; Thorne 2004). Second, some scholarly work has focused on the social worlds of young people and their capacity to act within these social worlds (Alanen 1994; Göncü et al. 1999; Holloway and Valentine 2003; James, Jenks, and Prout 2001; James and Prout 1997; Prout and Hallet 2003; Valentine, Skelton, and Chambers 1998; Wyness 2000, 2006). Both of these more recent approaches question the lack of young people's agency—the former implicitly, the latter more explicitly.

In this chapter, I question the totality of both the lack of agency attributed to children and youth by earlier positions and the full agency of recent scholarly research of childhood and adolescence as life stages. Instead, using examples such as "My Mad Plan" and the following case studies, I argue for the concept of *confined agency*. That is to say, within adult designated localities, such as schools or children's services, young people's social action and cultural (re)production are framed, but not necessarily dictated by, the homogenizing influences determined by adults (Lee 2001; Nybell 2001; Pike 2003; Rasmussen 2004). This recent shift in historical and cultural understanding of agency, or agentive capacity, as a characteristic ascribed to children and youth has become of interest to practitioners, especially in relation to how it might affect services, policy, and daily practice (Foley et al. 2003; Prout 2000; Shook 2005; Stephens 1995). Moreover, wherever possible some of this more recent research has moved toward directly incorporating young people's perspectives (Christensen and James, 2001; Delgado 2006, Mason and Fallon 2001; Roberts 2003; Stride-Darnley and Buchanan 2005) rather than purely taking adult views and recollections of their childhoods (Chaput-Walker 1991; Lahelma 2002; Musgrave 2002). I too follow this more recent approach (Stride-Darnley, 2007b). In doing so, I explore and examine simplistic, essentialized notions of childhood and adolescence and begin to elucidate why such essentialism is problematic for both those within the categories and those offering services designed for them (Frankenburg, Robinson and Delahooke, 2000).

Although this chapter was conceived and largely written prior to Vandenbroek and Bouverne-de Bie's recent examination of agency and educational norms through textual examinations of childhood, parenthood, and day care, I see parallels between their call for a "recontextualizing of children's agency" (2006:139) and my proposal of confined agency as a suitable heuristic device with which to better understand the lives of children and adolescents associated with medical mental health settings and, by an extension, welfare or school settings. I present evidence that focuses on one research site where agency is nearly always contested within academic and policy literature (a service for younger children), and one where agency is less contested (a service for youth). I argue that the ethnographic evidence suggests that both "younger" and "older" young people access agency and perform with it, but that agency is mediated and confined by the contextual and cultural frames of the services, and, by extension, the staff. I do not consider this proposed rethinking as being a definitive or authoritative "final" conception. Rather, I hope that it can be a launch pad for discussion and consideration.

The Study

I carried out more than 18 months of ethnographic fieldwork, which is cultural anthropology's key methodology, with young people who were attending day assessment and treatment mental health programs, and this chapter gives illustrative examples from two sites. Stride-Darnley (2007a) provides detailed explanation of the variety of qualitative methodologies and analytical processes used in my fieldwork. The first site, which I call the Northern Ontario Service, is in a city of more than 100,000 people in northern Ontario, Canada. This site's services are partially funded through provincial (equivalent of state) Ministry of Children and Youth and Ministry of Education, with some connections with local hospital and medical community services. The children accessing services are between 5 and 12, but during my fieldwork most were between 7 and 12 years old. Usually 80% of the children are male, although during my research as many as 93% were male. *NOS* is designed as short-term segregation incorporating assessment and treatment services for a range of presenting behaviors, including but not limited to significant levels of impaired learning, impaired self-control, and impaired social performance when compared with their peers. It would not be atypical for client-students to be diagnosed with Attention Deficit / Hyperactivity Disorder (AD/HD), Oppositional Defiant Disorder (ODD), Conduct Disorder (CD) and at times Obsessive Compulsive Disorder (OCD) in conjunction with severe learning impairments during their assessment process with *NOS*. First contact with *NOS* generally occurs because the children's behavioral difficulties are so severe that the children cannot function in their "home schools." Although these services are physically located within two "regular" elementary schools, they are separate from the main school's activities and regulations. For example, neither staff nor children are answerable to the school principal for disciplinary matters, and, unlike the other classes, *NOS* students do not have to attend school assemblies. Onsite staff consisted of two child and youth workers and one special education teacher, with visits from registered nurses, a psychometrist, and other mental health professionals working with the *NOS*.

The second site, Cornerstone Youth Service, is in southern Ontario, Canada, and is part of Hamilton Health Sciences (HHS) Integrated Child and Youth Mental Health Portfolio. This site offers day-treatment services using the Therapeutic Community Model to adolescents aged 13–18, who present a range of internalizing psychiatric diagnoses with about 80% comorbidity. Diagnoses include, but are not limited to, mood disorders, anxiety disorders (including specific disorders such as post-traumatic stress disorder, school refusal, and obsessive compulsive disorder), Tourette's Syndrome, Asperger's Syndrome, schizophrenia, eating disorders, and drug and alcohol abuse. Most client-students at Cornerstone have impaired self-image, and all have histories of substantial nonschool attendance. Usually 55–60% of clients are female. The clients served by Cornerstone lack both the social and coping skills required to deal with their mental health problems (Stride-Darnley and Buchanan 2005). Staff described the service as a "last-resort safety net" for students who could not cope with regular high school, and as "stepping stone" back to good mental health and a "more normal life" (interviews, April 2005–May 2006). Onsite staff consisted of six child and youth workers, a psychometrist, a social worker, two teachers, and a child psychiatrist (the clinical director). Cornerstone's funding is predominantly through Health monies, with funding for education programming being derived through section 20 of the Ontario Education Act of 1994. Cornerstone is physically independent of all other HHS hospitals as it rents two floors of a downtown building that is relatively anonymous for a psychiatry facility (the only Cornerstone sign is located on a quiet side road at the entrance to the parking lot).

During the fieldwork period, the hospital was able to rent the remaining two floors, and so this anonymity and relative independence has begun to change. One of the processes of the therapeutic programs at Cornerstone is to "shift [the] locus of control so they're actually in the driver's seat in terms of their treatment" (interview, April 2005), whereas at *NOS* the therapeutic processes were aimed at encouraging understanding of emotions and achieving "good decisions" and "good behaviors" (interview, March 2006). During interviews, nearly all Cornerstone staff stated or implied the former, and nearly all *NOS* staff stated the latter as the goals or accomplishments of their service. This "relocation of control" is especially important for reducing the impact of behaviors, and reactions to situations, that might previously have led to either removal from the class setting (in the case of *NOS* children) or self-withdrawal resulting from high anxiety (in the case of Cornerstone adolescents).

Both services used "evidence-based" cognitive behavioral therapy to encourage the young people to learn how to recognize the physical and emotional feelings associated at times of "bad" reactions, and to stop and think prior to acting on those feelings. Such "relocation of control" could be considered as the service's and staff's attempt to increase or improve their client-students agentive capacity. However, I suggest that because relocation of control takes place through a medicalized process of assessment and treatment, it is semantically parallel to encouraging confined agency. To explore this assertion, I present four further ethnographic examples. First, I will discuss the use of "free" time and computer time at *NOS*. These times in particular are used by adults as a reward for children's good work and behavior as well as being one arena where staff hope that "good choices" are made ("good choices" being a demonstration that therapeutic lessons have been learned). I will then turn to use transportation to Cornerstone and the process of scheduling and timetabling as illustration of teen confined agency within their medicalized setting.

Confined Agency and “Free” Time at *NOS*

During interviews with the children at *NOS*, they all described how important having choices was to their daily routines at school. This leads me to ask an important question: if the children describe and carry out choice, are we witnessing the expression and performance of agency and competency? The ethnographic evidence is that the answer is a partial yes—the children at *NOS* do access and perform agency, but the access to and performance of agency is framed and confined by their social and institutional setting. Here I present illustrative examples of events and discussions about recess, which is probably the biggest portion of “free” time in schools in North America. Most often children have to go outside for this time, which is motivated in part by the need of adults to have a break from the children as well as a need for children burn off some energy. During my time as a classroom volunteer, recess was often used as a reward, but this does not necessarily motivate students to do their best. We can see from the interview transcript with Simon below that adult assumptions (both mine and the system’s) do not necessarily guarantee full understandings of children’s behavior.[3]

> I:
> What you like best about being here and what you like least about being here?
>
> R:
>
> P6 The best thing about being here is I have the choice to go in or out
> because at Williams [old home school] they say if you
> don’t have no detention you go out but if you have a
> detention you stay in.
>
> I:
>
> And were you getting lots of detentions at Chapman.

> R:
>
> No.
>
> I:
>
> OK.
>
> R:
>
> But that's why I always go outside—but I don't want to P3 so I'd hit kids and get to stay indoors P3 and the least I like is work.

This appeared to contradict my observations of outside recesses from earlier in the week, which Simon had appeared to enjoy. So I asked a follow-up question:

> I:
>
> So um when you're outside do you like playing by yourself or do you like playing with other kids?
>
> R:
>
> Other people.
>
> I:
>
> P3 And do you miss that when you are here, because recess when we go out there aren't any other kids out there?
>
> R:
>
> No I like it when it's just me and another person.
>
> I:
>
> You're happy with that?
>
> R:
> Yup I am happy with two players, I don't like lots of people.

Midway through the first exchange, I had presumed that Simon, who had extreme behavioral difficulties (and was later assessed to have an ODD diagnosis), had received so many detentions so often that extra resources from the *NOS* were sought by the home school and by Simon's parents. I had presumed that Simon's detentions for school-yard violence were a reflection of his medical diagnosis and resulted in a negative consequence (losing his free time). I was wrong. Because detentions require students to stay indoors at recess, I had not even imagined that Simon would purposefully seek out a detention so he could stay indoors. At his home school, Simon had worked hard—exercising agency—to get detentions. At *NOS*, where having a choice to go outside or not depended on responding to behavioral cues and working well, Simon would regularly comply with requests, thereby earning the right to choose. The second exchange explains some of Simon's reasoning for wanting to stay in at his home school but go outside at *NOS*: "I like it when it's just me and another person" and "I don't like lots of people." Big crowds of children were not an issue at this *NOS* site because their recess was at a different time from the rest of the school—a decision by *NOS* staff taken specifically to avoid violent confrontations. To me, Simon's actions—lacking self-control, getting detentions, and losing free time—initially appeared to demonstrate a lack of competence. However, it seems that Simon was expressing his agency, albeit in socially negative ways.

At one site, I was encouraged to head outside at recess with the client-students, who quickly found out that I had never played hockey (field hockey just did not cut it) and could not skate. These Canadian children where astounded. They were shocked that I had grown up in a place (England) that did not get cold enough for lots of snow in the winter. Not skating seemed to be paired with my strange accent. As we were transitioning to an outside recess, Johnny said to a staff member, "Don't worry about him—it's just Ben. He sounds funny because he's from abroad. He's friendly but he's never played hockey though. I thinks [*sic*] he's from France." My "being foreign" and lacking hockey experience meant that I was designated the goaltender, by another client-student Josh.

And if I excelled at this position in their eyes, I could, at the next recess, attempt to play another position and take a few shots on goal. Now let me be clear. We were not playing ice hockey proper. We were in our outside boots and bundled up suitably for an early March recess. We were using plastic hockey sticks and a ball with holes in (to prevent it from gaining too much speed and hurting anyone). The imagined space was a rink, though, marked out by the school building on one side and the kindergarten's play space on the other. We practiced our passing and had to pretend coming to a two-foot halt as though we were on ice (it being fairly chilly, there actually was some residual ice from small puddles on the tarmac). While the children got to choose the content (going outside over staying indoors, hockey over soccer, for example) and what the rules of their hockey game were (number of passes before shooting, making me a net minder), the decisions regarding where it took place, with what equipment (despite Josh's complaints), and in what time and space were all made by adults (probably rightly so). This example is illustrative of a confined agency. At the scale of the children's lives, they had a significant level of autonomy and decision-making capacity for this recess—indeed, some children opted to stay indoors and play card or board games. The hockey example, with usual "control" over an adult witnessed through my positioning, participation, and education by the young people at *NOS* was a source of pride for Josh at least. He spoke animatedly to Ms. Clair, the class teacher about my skills and how he had made the right choice to put me in goal; my saves challenged him to really aim properly and shoot well. It is apparent that the young people's decision-making capacity motivated them to participate and behave at *NOS* at times when they had to decide whether to present good decisions and behaviors, such as during times when the Mad Plan might need to be implemented, making *free time* a part of the ongoing therapeutic processes. However, I would suggest that a nuanced interpretation of these children's agency, witnessed in their autonomy and decision-making capacities, is very much framed or confined by the options staff had made available.

Computer Time at One *NOS* Site

At one of the two *NOS* sites, the school has a bank of 8 or so internet-ready computers in the library, and staff make use of "computer time" as a considerable motivational reward. Each day, "credits" could be earned through good work or effort, as well as behavior that followed the Mad Plan or other CBT processes. If credits were earned, then the next morning, as the first activity after roll call, client-students could go down to the library for up to 20 minutes of computer time. They could choose from a considerable range of online freeware games that were not only educational but fun. Client-students could not access computer time without having handed in homework or without having a good report from home. The homework usually entailed completing unfinished math or language exercises from that day's classes. The actual time with computers was carefully monitored by the client-students themselves. To ensure they got their 20 minutes, they checked the library clock and confirmed with a child and youth worker (CYW) the time they entered the library. Staff generally described computer time as helping to motivate the client-students, and one member of staff said it helped to "very quickly switch on their brains, so they could start thinking and not just acting" (interview, March 2006). In many respects, computer time is much like an extra period of free time—the young people had control over the content the games, but not over the format or the rules that structured their control. Below I explore one flashpoint in more detail.

One morning Daniel, a 7-year-old male client-student, had not completed any of his homework, but before the teacher had a chance ensure it had all been finished, he snuck downstairs with the rest his classmates and the CYWs. Daniel was unusually quiet in the walk downstairs. He continued to be quiet while sitting at the computer, until the teacher arrived a few minutes later. Daniel almost immediately became very upset, to the level of disturbing the others' computer time, complaining that he just was "not able to finish the work, not had time at home, and anyway it was too difficult." The teacher was adamant that the previous day he had been doing well on the assignment even if he had been a little slow. In fact, Daniel only had three more sums, and the teacher argued he could easily get them done and still have time for the computers. Daniel moved to a table, a "good" choice, but gradually became so wrapped in the time he was losing and how unfair it was that he eventually lost all of that day's computer time and still had one more sum to do. The teacher and the CYWs, who usually reinforced successes rather than failures verbally, suggested to Daniel that his loss was a direct result of his actions and not theirs, and he should not blame them for it. He had decided not to complete his very brief homework, and he had decided to hide this from the teacher. Once caught, he had not quickly done the sums, and therefore *he* had lost an enjoyable reward. All of the potential was his; he just had to make good decisions. The rest of Daniel's day was fairly unsuccessful academically, and he had to take a relatively large amount of homework home. He did, however, regain control of his behavior and by lunchtime had ceased to be disruptive. His good choices in this arena were praised on numerous occasions both in direct conversations between the staff and Daniel and as an example to the whole group at the end of the day. His choice to move to a desk when he was frustrated in the library was noted as a particularly good action. The next morning his homework was completed and he had computer time.

I interpret this flashpoint as a prime example of the *NOS* therapeutic aims in action. During this illustrative example, we see an attempt to retrain a young person so that when frustrations arise, he has options other than defiance and violence—options that show the young people that they have control over their actions or, in my words, that they have *agency*. Through repeated examples—throughout the daily routines and through specific therapeutic times—the client-students at *NOS* are reminded that they have options and are in control of making their own choices. While Daniel's progress was not a steady linear improvement from this point forward, gains were small and ongoing. The bonus of computer time with its choices and enjoyment clearly worked to encourage good participation and behaviors. Yet it is a fairly structured reward, which required a good day, followed by a good night, rounded off with the completion of homework. And the actual computer time itself had specific parameters. As most of the client-students did not have access to home computers, the reward was motivational enough to genuinely encourage compliance with all of these structures. These structures help frame the young people's agency within the context of this *NOS* site, where their agency is being directed to a certain confined form—away from having agency to make "poor" decisions and toward having agency to make "good" decisions.

These ethnographic illustrations of free time and computer time at *NOS* are important examples of confined agency because play has traditionally been associated with children's worlds (Göncü et al. 1999; James, Jenks, and Prout 2001; Piaget 1962). Staff use both negative and (more frequently) positive examples of children's agentive actions at recess, such as choosing to "flare up" or making "good decisions," as part of the ongoing therapeutic process. The ethnographic evidence suggests that while the children attending *NOS* are making choices and learning about choosing how to behave, these choices are very much framed both by adults making options available (caliber of hockey equipment, access to computers, etc.) and by adults delivering cognitive behavioral therapies in which the young people participate. In the next two case studies I present data from Cornerstone that suggests that confined agency also influences the daily practices and performance of teens.

Transportation, Self-Performance, and Confined Agency

The primary medical theory or discourse at Cornerstone is the Therapeutic Community Model, which posits that a community in and of itself can be therapeutic, and that the atmosphere of a therapeutic site becomes therapeutic (Kennard 2004). This means that, on a daily basis, members of the community all have a responsibility for creating and maintaining the community's calm, caring, and supportive atmosphere. The Therapeutic Community Model has become known in Canada as best practice for programs dealing with vulnerable client-student populations (Bloom et al. 2003). An implication of the Therapeutic Community Model is that client-students have as much control as possible over their interaction with others as well as their programming. Indeed, after referral and an initial tour, the decisions to attend a formal "intake" interview and then, if space is available, to join and attend Cornerstone lies entirely with the client-students. Staff see the process of choosing to attend the intake interview, and choosing to be part of the therapeutic community (with its responsibilities), as a demonstration of "opting in" to the community and the beginning of a client-student's therapeutic recovery. In terms of this chapter's theoretical discussions, the model enables a significant reduction of the *confined* elements of young people's confined agency.

Yet a broader understanding of the context of daily routines at Cornerstone suggests that client-students' agency is not so clearly unconfined. Part of the medicalized intake process includes an assessment of transport needs to get to the service. At both *NOS* and Cornerstone, some client-students are transported to and from the sites by taxi.

This is in part because the services cover a wide geographical area, in part because client-students' behavioral difficulties make long journeys on buses with lots of children nearly impossible (in the case of the *NOS*), and in part because regular early morning commitment to getting into a taxi reduces the hurdle of making a journey on a public transit or on a school bus (in the case of the Cornerstone adolescents). At Cornerstone, taxis are justified by staff as increasing the likelihood of successful attendance, participation in the therapeutic community, and thereby opportunities for successful participation in the various therapeutic programs. Over half of the client-students come to Cornerstone by taxi, and the remainder either walk or get rides from parents, guardians, or siblings.

My participant observations from September 2005 to June 2006 included informal conversations with client-students about their taxi rides. These conversations developed out of client-student comments about having to share the taxis with students who attend "regular" high schools downtown. Cornerstone client-students all complained that they regularly had to wait for the other students. They also commented that they had the longest days of any of the taxi riders, which seemed "tedious" and a "little unfair." While they got picked up from home first and dropped off at Cornerstone first each morning, this situation was reversed in the afternoons—they got home last. This arrangement was negotiated to ensure a certain level of confidentially for the client-students. As part of the conversations we held, client-students addressed how they justify Cornerstone to the other three kids with whom they share the cab. While they get the taxi and choose to attend the psychiatric day treatment program, all 12 client-students said they described Cornerstone as an "alter-ed" (alternative education) program, or a special school; none said they described it as a psychiatric facility. Ironically, their taxis are paid for by the local school board, not the hospital, because the client-students will be completing some high school classes each day, and the local schools cannot meet these kids' educational (or mental health) needs. Client-students gave reasons of confidentiality and desire to seem "normal" and "fit in" for giving partial truths to the other taxi riders (Stride-Darnley 2007b).

Although this may not seem too significant an issue, the ethnographic "flashpoint" of the client-students' external performance toward the other taxi riders and their attempts to limit the stigmatizing impacts of their mental ill-health are an interesting site for exploring understandings of agency. The Cornerstone teens all demonstrated agency in order to attend the day treatment program. They had made the "big decision" to get help with their psychiatric problems and were acting with agency by getting the taxi on a (nearly always) daily basis, thereby using resources available to help them increase the likelihood of successful attendance and therapy. Here we see agency in opposition to the confining elements that are part of their mental illness, rather than adult-designed and adult-designated places, spaces, and activities, as discussed above in the *NOS* case. Indeed, some staff suggested during interviews that Cornerstone's therapeutic processes teach client-students how to live with their circumstances—to have agency within a confined context. Yet through the client-students' denial of Cornerstone being a primarily psychiatric facility, we witness two further processes. We see them acting with agency by claiming their right to confidentiality, but we also see the content of their agency being confined by societal expectations. These teens call on the marginal (but still less stigmatizing than a psychiatric hospital) space of an alternative or special education site, which in reality is a partial truth. The client-students are trying to limit the social stigmatizing impact of having a mental illness—this is agency that is simultaneously confined and exercised. Moreover, that these teens *have* to get a taxi reflects the societal and monetary pressures on services for teens with mental health difficulties and diagnoses. Taxi rides are necessary because there is neither the political will nor the resources (even in the relatively rich setting of Canada) for services to be locally situated. Rather, the single intensive service is in a central downtown location purportedly accessible to all. This illustrative example suggests that even for a population presumed to have more agency than their younger counterparts (within an essentialized age-based understanding of life-stages), there are still daily negotiations and contestations of performance, which I suggest forms confined agency.

Scheduling and Timetabling at Cornerstone

One of the roles that a teacher at Cornerstone has taken on is to track attendance for each programming session (two before and two after the lunch hour). Usually, two or three therapeutic programming options run concurrently in addition to an English/humanities and a math/science class. During a weekly staff meeting, the lead child and youth worker raised a concern over attendance. The collated statistics showed that too large a percentage of client-student hours were in the two classes, which apparently meant that not enough client-student time was being spent in therapeutic programming. The lead CYW suggested that hospital administrators would not fund a "special ed school" with some medical practices, but it would continue to fund a day treatment program with educational elements. Views were sought about how to remedy these uneven statistics. Staff noted that many of those who attended regularly—those well on the way to therapeutic recovery—were preparing to return to a "normal" high school and had committed to getting various high school credits while still at Cornerstone. This meant their need for, and attendance in, therapeutic programming was considerably diminished, although they did diligently attend their scheduled therapeutic programs. Staff also commented that the incoming client-students—who were those most at need for participating in the therapeutic community and programming, and also who were at the nadir of their mental ill-health —while scheduled for a greater proportion of therapeutic programming, were also least likely to attend. So the statistics were accurate but did not reflect the variety of readiness to attend and participate.

I raised the issue of how each client-student's schedule was organized with staff and client-students during interviews. All responded by stating it was usual for one of the first meetings between client-student and tutor/ CYW to focus on organizing the weekly schedule. Client-students and staff expressed the importance of picking the programming elements they felt confident would enable short-term successes—most often the nonacademic/non classroom-based activities such as crafts, photography, ceramics, woodworking, hiking, bowling, YMCA, or relaxation. The client-students described their scheduling choices as just that—*their* choices—and some even used the variations in the "relocation of control" metaphor to describe this first step. Staff, on the other hand, described how they could push the client-student toward certain programs either as a recognition of the client-student's specific clinical diagnoses or, at times, because a particular program was at capacity: "Obviously, they get a lot of control, a lot of choice, but ultimately its up to us to get them into the programs that are best for them" (interview, April 2006). Schedules were regularly discussed at the weekly individual sessions between client-students and their tutor/CYW in order to assess progress and successes, as well as deal with difficulties. Many CYWs, in interviews, spoke of "directing" the schedule, especially at the end of a semester or when therapeutic progress had been accomplished, in order to keep client-students moving: "Cornerstone is a stepping stone, not a long-term facility," and we "don't want them too comfortable, too reliant" (interviews, 2006).

Here we again see ironic tensions surrounding the therapeutic work at Cornerstone and other mental health services like it. On the one hand, staff want client-students to take control of, attend, and benefit from the programming offered. On the other hand, staff have to negotiate these choices within the contexts of individual therapeutic needs as well as the confines of space and availability, thereby reducing the amount of real control client-students have. Having increased control or agency over participation is an expressed key element in the young person's therapeutic recovery—through these experiences it is hoped that they, as client-students, are no longer disabled by their mental ill-health. Furthermore, it is hoped that by making the decisions, having agency to do so, client-students commit to an individually tailored schedule and begin their "investment" in Cornerstone, and, in turn, become more likely to attend regularly and thereby gain from the therapy. Like the choices over free time in the *NOS* setting, Cornerstone's client-students' expression of agency, I suggest, is a good example of confined agency: the choices made were clearly directed by the adults' expertise and knowledge, whose framing is, in turn, under surveillance by senior hospital administrators.

There has been a distinct gender imbalance in the ethnographic vignettes explored above. Apart from staff perspectives, very few female voices have been presented. This is especially the case for the ethnographic evidence from *NOS*. During fieldwork at *NOS*, there was only one girl out of 15 or so client-students, and staff recollected in interviews that in the preceding three years just 3 girls had attended *NOS* (interviews, 2006). To assure the girl's anonymity and confidentiality, I presented all the young *NOS* voices as male. Such a male focus is perhaps to be expected, as relatively few girls present the clinical levels of behavioral disorders that *NOS* best serves through day programming (Brochin and Horvath 1996; Frankel and Feinberg 2002). I have no concrete conclusions on what this imbalance means in terms of cultural expectations for behavior, mental ill-health, and psychiatric disorders, and how these areas relate to young people's competencies and agency. I do, however, interpret this imbalance as being symptomatic of a cultural and societal bias in the limits of acceptable behaviors and who is most likely to breach these limits, thereby needing additional support. This imbalance generates three initial questions that warrant additional research: Are we missing the agency of girls who are perhaps quietly disruptive, noncompliant, and underachieving academically? Are young boys in fact expressing unacceptable forms of agency when they exhibit behavioral levels that meet with *DSM-IV-R* diagnostic criteria? Does the classroom structure itself contribute to these male-orientated biases?

In my introduction, I presented a simplistic view of young people's agency within an understanding of childhood and adolescence, in which their capacity to act as individuals within institutional settings is often called into question. This questioning occurs for at least three reasons. First, young people are automatically seen as vulnerable and incapacitated (Finn and Nybell 2001). Second, agency is deferred to adults because they are the people who provide services to children and youth, and because young people in many circumstances cannot care for themselves (Backe-Hansen 2003). Third, young people are often described as either not knowing how to behave or not being able to behave within these settings (Crosson-Tower 1998; Downs et al. 2000), and indeed part of the *DSM-IV-R* symptom descriptors for various behavioral and mental health disorders are made in comparison to peers' performance within specific settings (American Psychiatric Association 2000). However, I have argued that young people do have agency, and that we should begin to think about complex and plural childhood*s* and adolescence*s*, rather than singular or essentialized childhood or adolescence. Through my utilization of illustrative case studies I have explored how confined agency takes place in two mental health services in Canada. Rasmussen (2004:155) highlights the design and designation by adults of (often institutional) places for children. It is perhaps the adult design of these medicalized institutions in conjunction with their social location that contributes most to the confining and framing of the young people's agency. I assert that in each of the case studies, young people's agency is directed by adult, societal, or institutional frames. Through My Mad Plan, free Time, and computer time, we witness various motivations interacting with choices and desires, where even "successes" all are framed by adult and institutional constraints: the bonus of computer time, with its choices and enjoyment used to encourage good participation and behaviors, is an option at only one *NOS* site. At Cornerstone the taxi rides are, at the same time, a supportive frame that increase client-students' ability to act with agency and participate in therapy, and a point of friction that generates stresses that the therapeutic context is meant to alleviate. Scheduling "choices" are an expression of agency that encourage successful therapeutic participation but are negotiated to reflect staff knowledge and institutional parameters. It should be noted that adult actions and their agency are also framed in part by the young people's agency and in part by restrictions made by policy or institutional requirements. In these contexts, confined agency is an ongoing and multilayered interaction and dialogue.

In closing, I present a brief section of David's interview transcript, which I suggest epitomizes confined agency at *NOS*:

I:

Do you think there's anything really important I should know about this place?

R:

(P6) That the teachers give us lots of maths and language?

I:

(P3) Is that a good thing or a bad thing?

R:

So, so, we hate working but they make us, cos they're adults.

I:

OK.

R:

And we're, we're not adults.

In this relatively simple response, David acknowledges both his status within a social category and that this status dictates a limit to choices in what he can do at *NOS*. Perhaps this is to be expected. After all, the quote above comes from a (mere) 8-year-old, who is (in the classic view of childhood and children) supposed to do as he is told when at school and needs to learn the skills of reading writing and arithmetic. I am not suggesting that this is not the case. Rather, through this fairly astute quote, David demonstrates competent understanding of the social stratification between adults and children within the *NOS*'s medicalized setting. We would do well to remember that children's agency can still be demonstrated in these settings, especially as part of therapeutic activities.

Questions for Discussion

1. Stride-Darnley examines assumptions of the cognitive behavioral theories that help to shape practice with young people at two mental health agencies in Canada. What theories about children and youth are prevalent in your work? What assumptions about children and children's agency are embedded in these frameworks?

2. Many contemporary interventions with children and youth stress terms that emerge in this chapter, such as "making decisions," "having options," or executing "good choices." Why might preoccupations with children's choices be so prevalent at this particular historical, political, and cultural moment?

3. What notions about childhood emerge in "My Mad Plan"? What notions of children's agency or confined agency does it contain?

4. The author identifies some spaces and times in which children are able to exercise greater agency (e.g., playing hockey at recess). In your work with children, where do you observe spaces and times that afford children greater agency?

5. What would it mean to consider the ways in which children and youth "coconstruct" social work practice, albeit from confined positions of limited power? What new ideas or practices might emerge from considering children and youth as agents in "making up" social services?

Notes

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[1] I have chosen to use the term "client-student" as an attempt to be conciliatory toward both the senior medical professionals, who see clients as clients (or patients), and

the youth, who see and describe themselves as students. See Stride-Darnley (2007b) for further discussion of this negotiated presentation.

[2]. All individual names are pseudonyms, and all child or youth examples are based on accumulations from fieldwork situations, interviews, and conversations. No individual child or youth is identifiable. However, institutional names for one site have been given at the request of staff and administrators. All participants were made aware of this format as part of the free and informed consent/assent processes.

[3]. All of my interviews were transcribed verbatim, with the following notations: I = interviewer; R = respondent; and P3 = pause for count of 3. Italics for a word or portion of a word indicates a volume increase for that word or part of the word.

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6. *Rites de Passage, Liminality* and Power at fieldwork sites

> "The life of an individual in any society is a series of passages from one age to another and from one occupation to another" (van Gennep, 1966: 2-3).
>
> "If our basic model of society is that of a 'structure of positions', we must regard the period of margin or 'liminality' as an interstructural situation" (Turner, 1967: 93).

6.1 Introduction

In this chapter, I discuss and analyze ethnographic data, which, I posit, evidences the stresses of sociality of individual bodies. I argue that such sociality is integral to health settings where relational interactions reflect, refract and reproduce social roles and status (doctor-patient being the most obvious). It is perhaps in emphasizing these *relational* aspects that I move away from the cleaved separation of individual-social-politic bodies of Lock and Scheper-Hughes, wherein the social body refers "to the representational uses of the body as a natural symbol with which to think about nature, society, and culture" (1987: 7), and away from Scheper-Hughes' and Lock's division of "three theoretical approaches: phenomenology (individual body, the lived self), structuralism and symbolism (the social body), and poststructuralism (the body politic)" (1987: 8). I characterize my shift as being towards a more dialogic, interactional, or relational approach (Holquist, 1981; Luria, 1987, 1968; Nichter, 2002; Preston, no date).[1] This relational aspect addresses the influence on mental health and mental illness of a variety of factors as noted by Good (1997):

> Although psychiatric medication often have significant impact on symptoms and may help some individuals recover or lead normal lives, social, psychotherapeutic, and educational interventions are still the only known forms of prevention and are among the most effective components of treatment for most persons suffering mental illness or psychological distress. *Mental health, mental illness and mental health care remain social, psychological and cultural to the core; they are powerfully influenced by macrosocial processes, shaped by local worlds of power and meaning, and constituted as distinctive cultural psychologies* (Good, 1997: 230-231, emphasis added).

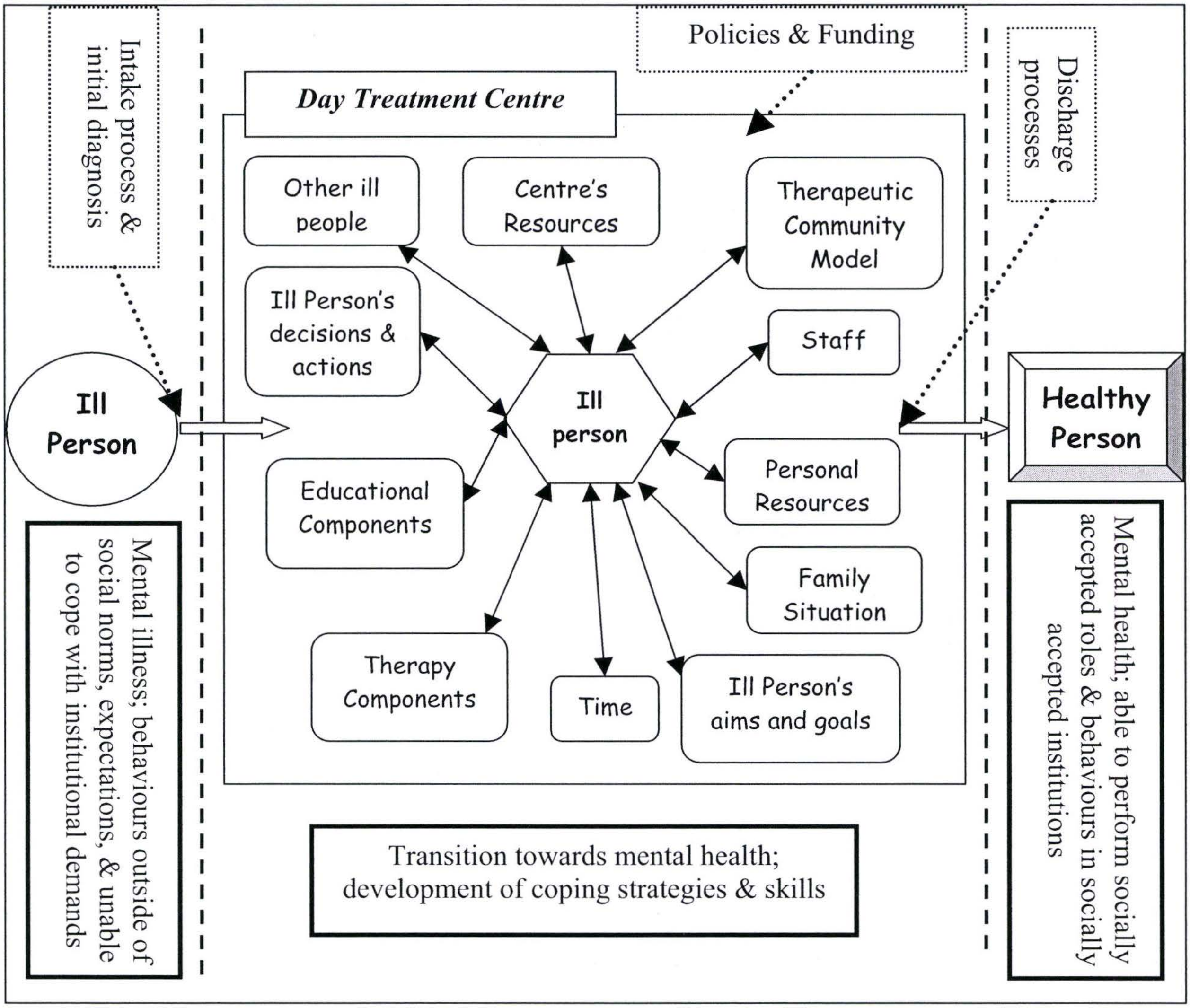
In order to speak to this shift away from Scheper-Hughes' and Lock's position, I engage with aspects of van Gennep's *rites de passage* supplemented largely by Turner's conception of *liminality*. I will begin with an explanation of my use of these two heuristic frameworks to examine the daily occurrences at the two fieldwork sites. Following this explication, I use van Gennep's three stages of *rites de passage* as a metaphoric structure to explore ethnographic data pertaining to the medical processes of intake, treatment and discharge.

6.2 Parallels in service and anthropological approaches

It is perhaps easy to initially consider van Gennep's and Turner's anthropological terms as obsolete, being as they are from a structural-functionalist era pre-dating recent endeavors in post-structuralism, post-modernity and feminism (Benhabib, 2001; Butler, 1992; Martin, 1987; Mohanty, 2003; personal communication with Warry, 2007). I acknowledge that in using such theoretical frames, which do not fit the data *perfectly*, I might be considered to be moving too far from grounded approaches advocated by praxis and critical anthropologists as I outlined in section 3.2.5. However, I came to this area of anthropological literature after a period of reflection during my fieldwork, when I took stock of my understanding of the events and processes at *Cornerstone* (I had not yet begun research with the *NOS*), in order to ask pertinent questions and focus my observations.

During this reflective period, I asked myself how I understood the processes at the site, as well as the various roles individuals, practices and policies play, and how they might be understood to interact and influence one another.[2] To depict these processes I drew a flow chart of sorts (see Diagram 6.2 below). It is a pictorial representation of how I understood the various processes and roles involved in creating "mentally healthy" individuals as the ultimate goal of *Cornerstone*. It is a stylized and idealized representation in which an individual moves from a state of mental illness to a state of mental health, interacting with various stages, interventions and therapeutic practices. Notwithstanding pertinent criticisms relating to normative categories, or ideals, and self performance associated with mental health (i.e. what is normal mental health, and who defines it, wielding what power), this flow chart indicated to me that mental illnesses, as a whole, might productively be considered to be a *liminal* period that is interspersed with a series of *rites of passage*, hence my revisiting and use of Turner's and van Gennep's now fairly outdated theoretical approaches. Let me first further clarify my use of such a heuristic devices in my analysis of ethnographic details. I will first outline my understandings and intended use of *rites de passage* and then *liminality*.

Diagram 6.2: Therapeutic processes at Cornerstone



Note: ↔ is used to represent interaction

I suggest that there is merit to considering van Gennep's three stages of rites, being "*rites of separation*, *transition rites*, and *rites of incorporation*" (van Gennep, 1966: 11), which are parallel to mental health services processes of intake, therapy or treatment, and discharge. Apart from both having three stages, there are a number of additional features that appear to exist in both models. In short, I suggest that young people with mental health issues appear to be symbolically and territorially separated from accepted social states, have considerably different expectations placed on their behaviours, undergo tasks and trials and then return to new or regular states and roles. Thus, like van Gennep's *rites de passage*, these processes mark the movement from one state of being to another (1966: 3-4). The following quote from Turner's examination of *rites de passage* and the implications of being "betwixt and between," while lengthy, addresses many of these features and is relevant to my approach:

> van Gennep has shown that all rites of transition are marked by three phases: separations, margin (or *limen*), and aggregation. The first phase of separation comprises of symbolic behaviour signifying the detachment of the individual or group either from an earlier fixed point in the social structure or a set of cultural conditions (a 'state'); during the intervening liminal period, the state of the ritual subject (the 'passenger') is ambiguous; he [sic.] passes through a realm that has few or none of the attributes of the past or coming state; in the third phase the passage is consummated. *The ritual subject, individual or corporate, is in a*

> *stable state once more and, by virtue of this, has rights and obligations of a clearly defined and 'structural' type, and is expected to behave in accordance with certain customary norms and ethical standards* (Turner, 1967: 94, my emphasis).

It will be clear from earlier chapters that young people attending the day treatment mental health services are often identified as non-school attendees or, indeed, as pupils who have been excluded from school. I suggest that they have been symbolically and physically separated from usual or normal 'states' or roles for young people in Canada – namely that they should be students compliantly attending educational sites. I will comment more on the separation and isolation during liminality shortly.

Another implication of Turner's summary is that people who undergo *processes of rites de passage* do not have to behave "in accordance with certain customary norms and ethical standards" (Turner, 1967: 94), and indeed part of the mental health service's treatment programs are to enable young people to cope in 'normal' settings and be able to perform in socially acceptable and expected ways. That is to say, the young people who attend the mental health services have histories of not acting in accordance with customary norms and standards. A further aspect of the *rites de passage* model is that the characteristics of young people who attend the mental health services are socially ambiguous – they are neither culturally one thing nor another. I interpret this to be akin to Turner's position on people's states when "betwixt and between", and whist Turner more usually writes about religious rituals, the position holds for the case in point.

Those people within liminal periods are betwixt and between, having few attributes of "the past or the coming state" (Turner, 1995: 94), and might be understood as socially neither alive nor dead or both at the same time (Turner, 1967: 97). In any case, liminal people or liminal personae, to use van Dongen's (2005: 191-194) term, are unstructured and therefore ambiguous because they are "at once destructured and prestructured" (Turner, 1967: 98). Turner's position is that we must take "'liminality' as an interstructural situation" (Turner, 1967: 93). Here I am arguing that, despite their relatively aged theoretical positions, van Gennep's *rites de passage* and Turner's conceptualization of *liminality* are particularly apt, because aspects of both appear to take place within the mental health services at the centre of my fieldwork.

Both van Gennep and Turner tended to use these phrases to describe specifically religious rituals and symbolic ceremonial practices in what traditional anthropology considered 'primitive' cultures, where kinship and *rites de passage* were assumed to be the foundation of societal cohesion. Such structural functionalist perspectives on colonized peoples' cultures have been criticized for overlooking the presence of Europeans, a history of colonization, and the incorporation of so-called primitive peoples and their cultures into global economic power systems (see, Grinker and Stiener, 1997, for multiple examples).[3] Clearly, any *rites de passage* taking place at the mental health services of my fieldwork have little or no religious symbolism nor, as I demonstrated, are any such rites rigidly structured in unchanging rituals pertaining to specific social roles or ranks. Despite the apparent lack of religiosity and formal ritualized content, I still consider *rites de passage* to be a useful metaphor to understand the processes and practices at mental health services in Ontario. This is because the events at both *Cornerstone* and *NOS* reflect symbolic processes of transformation from one state to another, symbolic processes that have little difference to transformations noted in religious or ritual practice. There is one additional point I wish to make here: In the movement from ill to healthy – or from 'abnormal' to 'normal' social roles, from failing to meet with societal expectations to meeting them, or even from danger to purity (more on this metaphor in the chapter's conclusion) – the process is not a smooth transition, nor is the process the same for each individual who might be seen to enter in on the left side of the flow chart and travel along to the right. This non-uniformity, or fluidity, within liminal states has been noted by others who have utilized liminality to shed light on their varied research topics (Bettis and Mills, 2006; Zukin, 1991).

In summary, the six components of *rites de passage* include: physical and symbolic separation from the rest of society and societal norms; a strict hierarchy between instructors and neophytes, and egalitarianism among neophytes (as they are all in the same state); liminal people enacting behaviours that are outside those accepted as normal for social roles or states; liminal people having no individual property nor any demarcation as individuals; neophytes having to undergo tasks and trials (often very difficult) as necessary precursors to their soon-to-be new role; and, a return to society during an incorporation rite. Many of these six aspects appear to be present in the three stages of mental health services, and I address each stage in turn.

6.3 Separation – intake, and diagnosis

As I have noted above, in general young people who attend the day treatment mental health services self-identify as being non-school attendees or are pupils who have been excluded from regular school. In fact, this is a condition for service delivery: as I outlined in chapter three, to access *Section-23 Education Act* funds, either they as students must not be able to attend their 'regular' school, or their former schools must not be able to meet their specific needs. This means that entry into either *NOS* or *Cornerstone* as therapeutic settings requires significant impairment (in terms of attendance or educational attainment) in relation to their age-peers. I suggest that this is one of two ways in which client-students are, prior to entering day treatment, both symbolically and physically separated from usual or normal 'states' or roles for young people. Normal 'states' would be for them to act as compliant and competent pupils or students attending educational institutions, because this is the institutional setting where Canadian society expects young people to be. Such a societal norm is underlined in Ontario by a law which mandates compulsory education for young people until they reach their sixteenth birthday, although there are calls for this to be extended until the age of 18 (Ontario [SSAT], 2006: 24).

A second, and closely related, way in which client-students are symbolically and physically isolated from regular 'states' is through the specifics of their mental illness and behaviours. In terms of this chapter's overarching metaphor, their behaviours are themselves *liminal*. There is an apparent and striking difference between the sorts of presenting problems dealt with by *NOS* and *Cornerstone*. The former location deals with young people presenting "maladjusted externalising behaviours," the latter tends to deal with young people who present depressed / anxious or "internalising behaviours" (APA, 2000). These various presentations are at the limits of socially and educationally acceptable behaviours, and as such I suggest that the mental health services at the centre of my ethnographic research represent a *systemic* response designed to ameliorate two different sorts of problems for schools, as much as they ameliorate the problems of individual young people.[4] One service deals with too much disruption and the other with too little participation. In the words of staff at either service "we're like an escape valve on steam engines but for schools", and "what we deal with are weeds who grow in the cracks in the system and help them turn into flowers and trees" (Staff interviews, March and April 2006).

As I assert above, because the client-students' behaviours are categorically unacceptable, they themselves represent the margins of cultural and social norms for their age-groups. As Stolzman notes, societal reactions "view [mental illness] as a label applied to certain people who either violate society's rules or express unacceptable ideas in an unusual idiom. In short, mental disorders are understood as deviant behaviour" (1994: 451). In part, Stolzman is discussing the impact of the labelling process, which I address in more detail in the following chapter. Here, however, I will draw attention to implicit marginalisation and the amalgamation of client-students' identities, as they are seen by others, with concepts of deviance. The identities of people suffering from mental illness come to embody deviancy not because individuals with mental illness necessarily see themselves as deviant (although some do), but because others do. This position follows

Jackson (2005) who writes about people with chronic pain and whose ethnographic evidence suggests that in some cases individuals do come to see themselves as deviant, but more often it is others' view of them that characterises them as deviant. While I maintain that client-students in these contexts might be described as behaviourally *liminal*, outside accepted roles and states, there is one key mental health service *rite de passage* of 'intake' that connotes both client-student's symbolic *and* physical separation from normal societal roles. I suggest that it is through intake that we see client-student's formally taking on liminal roles and states. In the remainder of this section I address understandings of *sick roles*, then the relational aspects of intake and diagnosis, and finally the apparent racialized aspects of intake and the need to 'buy into' the service.

6.3.1 Sick roles

Above, I suggested that the key separation *rite de passage* within mental health services in Ontario is the intake process (which I also described in detail in section 3.4.2). As part of my analysis of the intake process, I will link the intake criteria with the concept of *sick roles*, which was introduced by Parsons (1951), and which Helman suggests can shed light on the "social construction and maintenance of the symptomatology of mental illness" (2002: 175). I first explicate Parsons' conceptualization of sick roles, and then I comment on the need for client-students to perform an appropriate sick role. By this I mean that certain diagnostic and compliance to therapy criteria have to be met if an individual is to be identified and accepted as having a mental illness that requires treatment.

Parsons (1951) was one of the earliest social scientists to comment on medicalisation as it related to the *sick role* that patients come to perform (Parsons, 1951: 312-313). Parsons argued that it is particularly important for a person's identity to be related to an appropriate social role. Writing shortly after the end of the Second World War, Parsons noted that those not performing a sick role, but still not working and not serving their country, were described as malingerers; people whom, I suggest, were viewed much in the same way that fraudulent Employment Insurance claimants are in Canada today. Parsons outlined four key features of health institutions' expectations of sick roles: First, there is exemption from regular social roles especially work; second, the sick person cannot get well by an act of will alone, which is crucial if help from physicians is to be sought and accepted; third, any state of illness should be viewed as undesirable, which has an associated obligation to "want to 'get well'"; and, forth in wanting to get well, the sick person should first seek "*technically competent* help" most usually from a physician, and also "*cooperate* with him [sic.] in the process of trying to get well" (cf. Parsons, 1951: 436-347, author's emphasis). Parsons is adamant that only by seeking help and cooperating can an individual take on what he terms the *patient role* and thereby distinguish themselves from malingerers (1951: 476).

While Parson's structural-functionalist position has been critiqued by postmodern and feminist scholars for its "inattention to power, inadequate empirical reference, [and] failure to explore contingency" (Fahy and Smith, 1999: 71), it does offer some useful insights in relation to mental health service's intake processes. I wish to draw attention to the subtle interaction between *body politics* and *individual body* in Parsons' model: an individual should be working, and if they are not then only medical reasons can excuse the inaction. This assumption upholds the authoritative knowledge of biomedical practitioners. Furthermore, because a physician is the source of the cure, and a sick individual should demonstrate compliance with medical decisions and approaches, we also see the privileged social position of biomedical discourses. I suggest that Parsons' sick role epitomizes the direct links between the purpose of a health system (to keep people healthy), and the overarching capitalist framework of productivity (to keep people working). In this model, if a person is not working, there must be justification for their inaction.[5]

There are also two implicit relational characteristics of the sick role. First, individuals are categorized and labeled as appropriately not working by the authoritative knowledge of biomedical practitioners, not by the ill individual. Herein lies a clear example of power differential in the relationship. Second, unless ill individuals accept and work with the categorization and label of 'sick' given to them by a biomedical practitioner then their lack of work or progress will not be acceptable. There is one further assumption in Parsons' discussion which I have hinted at: The need for sick people to *try and get well*, which I suggest internalizes and individualizes biomedical model of sickness and enables blame for failures to lay squarely on the *patient's role* for non-compliance, rather than on biomedical and / or systemic failings. I address the issue of ill people needing to want to get well in further detail in section 6.3.3, but first I explore the relational aspects in more detail.

6.3.2 Relational aspects of intake processes

At *Cornerstone*, once the client assessment process is underway, the client and their parents are contacted to arrange an initial intake interview, which includes an introduction to what *Cornerstone* is, what the potential client can expect, and what *Cornerstone* expects from the client. At the end of this initial intake interview, the intake coordinator *Esme* turns to the teen and directs the final phase to just her or him. A pamphlet is passed across the room, and the contact details are highlighted. *Esme* usually says something like, “if you are interested, and when you’re ready, give me a call and we can arrange a formal intake interview and a tour which should not take more than 45 minutes. In the interview we can discuss your expectations and goals, and how we might best go about meeting them here.” In fact, both *Esme* and other staff members during interviews stated that at this point it is usual for parents to interject. When this happens, *Esme* re-directs attention to the client-student and reiterates that it is their decision.

At the second intake interview, more medical approaches to treatment options begin to come to the fore, as by this point a psychiatric diagnosis has usually taken place. This intake interview elicits further information as to the potential client-student’s life history, their perspectives and hopes. These details, along with the details of the psychiatric assessment, are then discussed at the next team meeting so that the staff as a whole can assess their ability to meet the potential client-student’s needs, which on occasion leads to a re-directed referral to a more suitable mental health service. Like the characteristics of Parsons’ sick role, client-students also have to agree to comply with the treatment advice, be that medication, which was often used as an aid to get the client-student comfortable with attending *Cornerstone* and then gradually withdrawn, or the more general therapeutic programming, as well as the formal educational components, and to participate in the tenets of *Cornerstone's* therapeutic community model. A key aspect of *Cornerstone's* intake process is that a client-student demonstrates that they want to improve their lives, as repeatedly stated by staff in interviews and during staff meetings. Over half of the staff interviewed said that the intake process was the client-student's first formal therapeutic event, which demonstrates that they had "taken control" despite their mental illness. Client-students, by showing that they wanted to change to improve on their current situation, were also a repeated feature of discussions at team meetings around intake interview information. I interpret this to be very similar to the compliant characteristics of Parsons' sick role.

At *NOS*, professional adults (psychologists, psychiatrists, medical professionals, CYWs and local Board of Education specialists) along with parents take more central roles in the intake process than do the client-students. This is most likely due to the age of the client-student, and the fact that in part the *NOS* role is to assess the client-student's mental health needs – it is an *Assessment* and *Treatment* service. Here, the relational aspects are between *NOS* and families who need to show a committed and unified front towards the client-student or their child. Parsons' sick role characteristics of compliance and wanting to improve are witnessed in the parents' participation and acceptance of the various perspectives of professional staff and their participation in the best course of action available for their children. Although I did not observe an intake protocol at *NOS*, I asked staff to describe it and its purpose as part of interviews. Members of the concerned family meet with *NOS* staff at the service's Observation room that has a one-way mirror so that professionals can make an initial assessment as to the potential key issues and diagnosis. This also enables initial feedback to be given to the child's family or caregivers. Part of the rationale to this formalised observation process, staff said, was to begin building a relationship between *NOS* staff and the family members, as well as being able to observe, identify and highlight any specific or immediate concerns. These sessions also give the *NOS* staff an opportunity to talk with parents or caregivers about the importance of a joint effort between staff and caregivers. As one staff member stated: at these meetings we "start talking about um (P3) issues of readiness to begin the program essentially," so that *NOS* staff can "find out where we're at with parents and work together in terms of stabilizing them [the child]" (Interview, March 2006). In fact, as part of content analysis of *NOS* staff transcripts, I noted that *parent/parents/guardians* appeared as frequently as *child/children/kids*, which I suggest emphasises the weight staff members give to the crucial role parents can play in the transition of young people's mental health .

Again, at *NOS* through the intake process we see a version of Parsons' sick role and *patient role* being demanded of the client-student. However, unlike the situation at *Cornerstone*, we also witness this process being demanded of the client-student's parents and guardians. These adults have to participate in the treatment process and, in connection to the sick role, have to want their child to improve. In doing so, they defer expertise to professional staff. I suggest that when parents take on these roles, they legitimize the non-functioning of their children, and also confirm their acceptance of and entry into liminal states.

6.3.3 A racialized intake process and 'buying into' the service

So far in this chapter I have argued that client-students take on and symbolize liminal states typified by Parsons' sick roles. There is, however, an implicit contradiction in the explanatory terms liminal and sick role. The former conveys a "condition [that] is one of ambiguity and paradox, a confusion of all the customary categories" (Turner, 1967: 97), and is thus separate from social norms. Being liminal is, then, by its very definition counter-hegemonic. The latter term, sick role, has normative hegemonic characteristics that must be achieved if legitimacy is to be granted to an individual's non-functioning status. I posit that there are hegemonic qualities to the mental health services' expectations, and that these, in turn, characterize liminal states of client-students (and their parents). In this next section, I explore the implication of failing to meet sick role 'standards' even within the ambiguous liminal status.

During fieldwork, only four from a total of sixty-eight client-students at both sites were from cultural / ethnic backgrounds other than that of a European descent. This means that just under six percent of client-students at these two sites were from visible minority groups. When compared to provincial demographic statistics this six percent is well below Ontario's 18.9% visible minority level (Hamilton, 2005: 13), and may be a sign of a connection between racism/ethnicity and access to service. While I acknowledge that the following arguments are in part speculative, they constitute my thinking through the implications of an apparently raced pattern that I witnessed. I suggest that if this pattern (of low race / ethnic intake) occurs at similar child and youth mental health services in other cities in Ontario, there may be cause for concern which would have to be addressed at a policy and practice level. This issue, then, is definitely an area for future research.

Initially, a raced pattern might appear to be incongruous with Canada's universal approach to health care, and while technically there is universal health care within Ontario and Canada, this pattern in fieldwork data suggests that these sorts of mental health services are not being universally accessed. Such a pattern is confirmed by Jones' (1992) assertion that 'universal access' is not the same as 'equal access' or 'equal participation', as well as by findings in the United States that there is considerable inequality in access to mental health services as well as outcomes in terms of recovery, which "is especially true of members of racial and ethnic minority groups" (DHHS, 2002: v).[6]

During my fieldwork time, the intake processes for *Cornerstone* were centralized and standardized for the Health District. This meant that after the first eleven months of fieldwork only those young people who came through central intake were passed on to *Cornerstone* for the intake interview, assessment and tours. While *Cornerstone* staff are implicitly connected to the apparently racist process (as they are part of the system), I suggest that it is the systems and techniques in place rather than the front-line workers that are implicated most readily in the racist practices.[7] In simple terms, *Cornerstone's* intake process can only take place for those client-students who reach the front door, which means current numbers reflect current processes in finding or being directed to the front door.

Critical Medical Anthropology approaches encourage analyses of the un-culturally diverse participation in contexts where there is much cultural diversity. There is supposedly universal access to service, and psychiatric diagnoses are universal categories within Ontario, so why then is there very little cultural diversity in the client-students I have worked with. Again, there is need for more research on this issue as I cannot say definitively if this pattern is something specific to *Cornerstone* and *NOS*, a reflection of service access in the cities they are located in, or to Ontario or even Canada.

Furthermore, even when client-students from, for example, Black-Canadian backgrounds did manage to access services, they appeared to have higher than usual levels of non-attendance. It was characteristic for non-white client-students attending *Cornerstone* to attend and participate in therapeutic activities far less frequently than other client-students, even when compared to others with similar diagnoses and histories of non-school attendance. In terms of the theoretical discussions above, such client-students were not submitting to Parsons' patient role, even though the biomedical and biopsychiatric system had identified them as 'sick.' Front-line staff, too, were cognizant of this "opting out" trend, and discussed at length in weekly staff meetings how to rectify the trend, and the necessity of encouraging such client-students to 'buy into' the therapies offered at *Cornerstone*.

Yet it was not just Black-Canadians who did not 'buy into' *Cornerstone*, although this group did seem to opt out more readily. Nor was such 'window shopping' restricted to those client-students with the most severe diagnoses. In describing these individuals as not 'buying into' what *Cornerstone* has to offer, staff also suggest that they, as client-students, are just not ready to make the changes in their lives, which I suggest is a clear indication that such client-students do not accept a 'sick role.' This, I argue, is a clear transferal of responsibility from the system or service onto the individual who fails to embody the appropriate role. It is therefore a clear site of medicalisation. These client-students go through the official intake process and then, despite the offer of taxis, personalized case management in terms of therapeutic options, and a tailored schedule which allows them to avoid the most hated academic subjects until they are more comfortable with attending, they do not attend. If attendance does not improve, non-attending client-students eventually get discharged without ever really participating in the therapeutic practices because of the pressure for places at *Cornerstone*. Non-attending client-student are usually given a series of warnings over a month or two, but if they do not 'buy in' initially then they will likely struggle to continue with their therapy at *Cornerstone*. Upon discharge, they are reminded that they can come back at a later date and go through the intake process – the shop doors are not shut forever, just at that time.

I did not see any other intake patterns of which sorts of client-students did not 'buy into' the service, either in terms of gender or diagnoses. This would have been potentially useful identify in connection to the applied aspect of my Ph.D. research. Yet I was not the only person who did not identify any patterns. It would appear that a feature of this group is that their mental health was so weak, and their attendance so poor, that they did not get noticed by many other client-students. For example, in interviews, many of the more readily attending client-students could not remember situations where other teens started but did not continue at *Cornerstone*; only one client-student interviewed could name such a person. Client-students certainly did not use the 'buying in' rhetoric, which appeared to be restricted to staff discussions.

As the following excerpt from a staff interview shows, staff are deeply concerned about this phenomenon. The interview has moved towards issues of therapeutic crises (the staff member's term), and what role the client-students play in them:

> I What role do they [client-students] play in those therapeutic crisis?
>
> R I think they're, we can lead them to water but if they don't want to drink from it or they're not ready to hear it, some of it, we can have some pretty sad, depressed, angry, suicidal kids at times … and uh ... as their comfort level and security we're able to establish with them I think it uh leads them to a place, to a place of safety.
>
> I Ok.
>
> R Does it work for every kid that we're going to get the same kind of response? No. No there's no magic wand.*(laugh)* but I think with persistence and sometimes it does take time for one group of kids, one child could be here for 3 weeks and he's like right into the whole "yes I really want this" where another student may just be going "I'm still casing you

> out and I aint going to tell you nothing." *(laugh)* So its . . .
> when they're ready.

Although this staff member uses the term therapeutic crisis instead of not 'buying in' the sentiment is very similar. We see in this staff member's description a tacit invocation of Parson's sick role characteristics. This staff member acknowledges the need for an individual to be ready for treatment, which is much akin to the sick person wanting to get well because their current state is undesirable. Again, like the arguments I made in chapter five around young people's agency, we see the integral role that client-students have in forming any relationships with the service as a whole (and the invoked biomedical discourses) or with individual members of staff. In addition, by using a rhetoric of not 'buying in' we witness what I described in chapter three as the internalization of illness, which is typical of a western biomedical or biopsychiatric model. That is to say, despite the fairly regular occurrence of client-students not 'buying into' the service, there are very few questions asked about what the service, staff or overarching models play in client-students' failures. In terms of the topics raised in chapter three, I suggest this issue relates to the notion of *cultural competency,* as it is understood in the United States. Within a CMA approach, it is perhaps not surprising that cultural competence on the part of mental health services was not an issue that was discussed by staff in connection to client-students 'buying into' services or not. Staff have, after all, led the client-students to the water or, to expand the 'buying in' metaphor, opened up the shop, and if the client-student fails to drink or shop then it is in the main, according to staff, the client-student's own fault. Such an individualized internalization, rather than systemic approach to 'buying in' also reflects Parson's characteristic of the sick role participant deferring to professional staff's authority and expertise. As I noted above in this section, for a sick individual not to be considered a malingerer, or unjustifiably unproductive, they have to want to try to get better – they have to buy into the service, or drink water perhaps.[8]

To reiterate, my above discussions of the implications of the apparent connection between race / ethnicity and access to mental health services are to be viewed in relation to the specific services I completed fieldwork with. This pattern does indicate a potential and necessary area for future research.

6.4 Transition and liminality - attending day treatment

Data from interviews and discussions with staff at both fieldwork sites did not demonstrate that they either used or were familiar with van Gennep's language and definitions of rites of passage. Despite this, I suggest that the intake processes do imply that the liminal connotations associated with such rites are conferred onto client-students. In this section, I will explore two aspects of the treatment programs at both sites that represent the second explicitly liminal level of van Gennep's rites of passage: that of transitional phases and processes which occur for / by client-students. First, I consider time and space at the services – as the liminal phase typically has differentiated time and space. I then turn our attention to a specific instance of therapeutic activity, glove puppetry, in order to analyze the roles that adults and children play in therapeutic recovery.

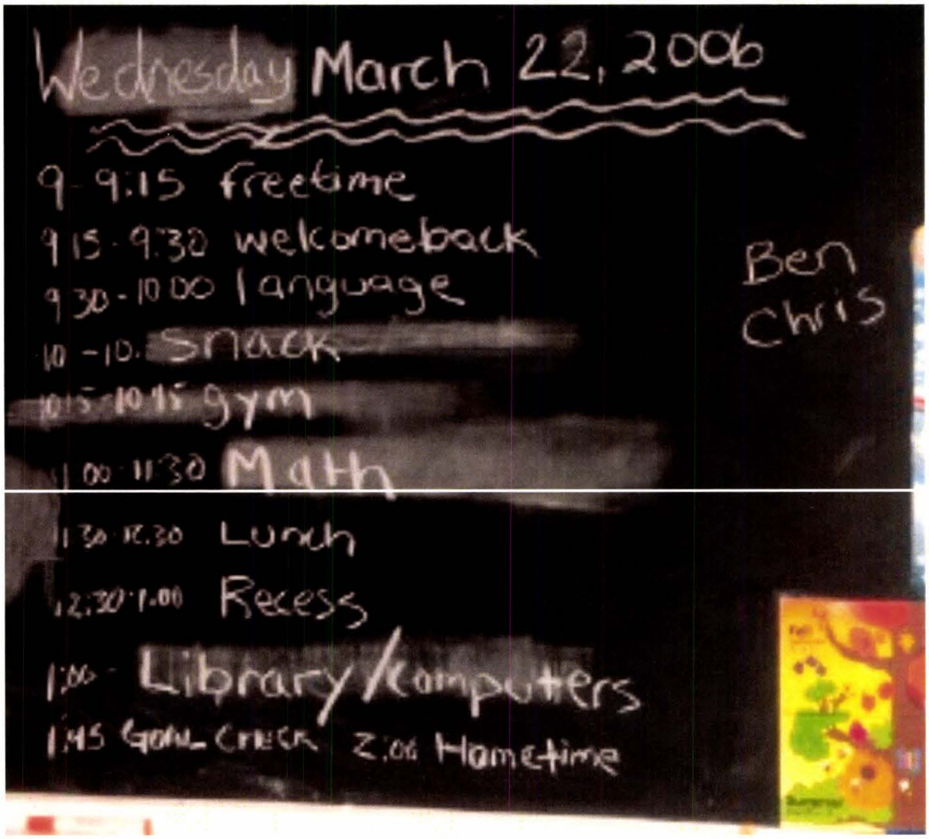
6.4.1 Time and space at the services.

In liminal periods, Turner notes, liminal personae are both in and out of time (Turner, 1995: 96), and also space (Turner, 1980: 159).[9] At the fieldwork sites, as part of client-students' preparation and readiness for transition back to socially accepted states and roles, 'standard' time and space appear particularly important. I interpret this to be a clear reflection of the fact that most client-students will aim to and eventually return to mainstream educational settings where the school day is rigidly structured. However, it is clear that expectations relating to time and space reflect both the client-students' ages and diagnoses. By this I mean that schedules and physical spaces are not exactly like those found in regular schools.

In the case of both *NOS* sites, time is clearly demarcated on the class chalkboard. Through the use of chalkboards, I argue, we witness four elements that pertain to working with young people within *NOS* day treatment programs. Firstly, I suggest chalkboards shows that the treatment day is structured much like a school day, and the public presence of the schedule on the board makes it accessible and familiar to the client-students. As can be seen below from the chalk blurs in Figure 6.4.1, the day and date change, as do the order of some activities, but any day's content is structured much like the previous and the next. Client-students know in advance the day's plan and can be directed to the board for the regular "what are we doing today/next" questions, which eases tensions considerably as client-students like to know their schedules and like to ensure they get the requisite amount of 'free time.' Secondly, the use of the board clearly shows the brevity of each session which directly helps to reduce client-student frustration.

In therapeutic management terms, this means that if an activity is challenging it does not last long. In educational terms, the visual reminder of free time slots helps to keep the client-students on task even if they are finding their assigned questions difficult. This interaction is both visual and verbal. For example, both teachers and CYWs often reminded a client-student that had announced his boredom with a particular task that they he was working on it for just a few more minutes and were directed to the board to see what was next on the agenda. Indeed, in interviews, client-students regularly cited their free time options as being enjoyable moments that helped them cope with their tough

Figure 6.4.1: A Chalkboard at NOS



maths or language lessons. Furthermore, the presence of free time does not mean that nothing is happening therapeutically. These periods have to be filled with activities, which while fun and the choice of the particular client-student, have therapeutic implications.

Like the arts programming at *Cornerstone*, many elements of the *NOS* day treatment program blur the division between therapy and education. Board games, for example, can easily be considered to have been arenas for arguments and confrontations prior to client-students entering *NOS* as a liminal phase, and so CYWs often encourage the client-students to make good decisions about the games they choose and play during their free time (choices that are very much linked to those encouraged in My Mad Plan discussed in chapter five). In this way, we see attempts to integrate therapeutic goals, as symbols of socially accepted roles and norms, with individual client-student's actions and wishes.

Thirdly, anything that is out of the ordinary, like my and Chris's presence in the class is publicly noted (as can be seen on the top right hand side of Figure 6.4.1). This helps the client-students have a reference point in case they forget the new people's names, which again removes a potential disruption. Socially caused disruptions were explicitly noted in two staff interviews as previously creating a sort of cyclical problem where client-students are embarrassed (by failing to remember names) and in turn frustrated, and the frustration can and does then lead to further disruptive events. Finally, the chalkboard is a familiar symbol of schools. It is an essential, if old fashioned tool of classroom learning, teacher-pupil interaction, and its use in the *NOS* assessment and day treatment settings with these younger people is an attempt to normalise their situation. They will, after all, have to go back to their 'home school' and attend and participate in maths, language and gym classes amongst many others.[10] As I noted in chapter five, the spatial arrangement for both *NOS* sites attempted to meet the needs of the client-students, but did not always reflect the identified needs of *NOS* front-line CYWs or administrators. Because of this earlier discussion, I will not comment further on their space here other than to say it does meet Turner's definition of liminal space – being clearly "betwixt and between" (1995: 95). Below I do, however, briefly comment of on the spatial arrangement at *Cornerstone.*

At *Cornerstone*, time is also fairly rigidly maintained. That being said, both the Therapeutic Community Model and staff encouragement for client-students to practice relative autonomy means that time allocations can be both longer and more flexible. Here, client-students are given a copy of their weekly schedule, which usually will be their timetable for the coming semester (the balance between therapy and education is carefully negotiated between client-student and their CYW-tutor and has been discussed in chapter five). The longest break time at *Cornerstone* – lunch – is considerably less structured than at *NOS.* Other than a meal, which is prepared and self-served after 11:45 and over by just after mid-day, and Thursday bingo, there is little activity explicitly organized by staff members. There is however, staff supervision of the two rooms – pool and art – in which client-students spend most of their free time. These are spaces that client-students recognized as spaces for socializing in safety (Stride-Darnley and Buchanan, 2005).

During fieldwork, the building in which *Cornerstone Youth Service* is located was listed for sale. Hamilton Health Sciences investigated the potential of purchasing the property outright, but it was deemed an inappropriate investment. There was much consternation and concern on the part of staff and client-students who were made aware of the proposed sale through the overnight placing of a large for sale sign on the property. The new owners wanted to rent the property as a whole, and while *Cornerstone* took up nearly two floors of the building, there was considerable under-occupancy on the other two floors. For about a six-week period it was thought that the service would have to move. Staff racked their brains as to where else the service could move to, and what they would want of such a space if starting anew. There were regular discussions around space and use needs both as informal conversations between staff and during the more formal setting of staff meetings. Discussion focused not just on *Cornerstone's* square-foot needs, but also how best to recreate the current collegial atmosphere and what might be possible in an ideal circumstance.

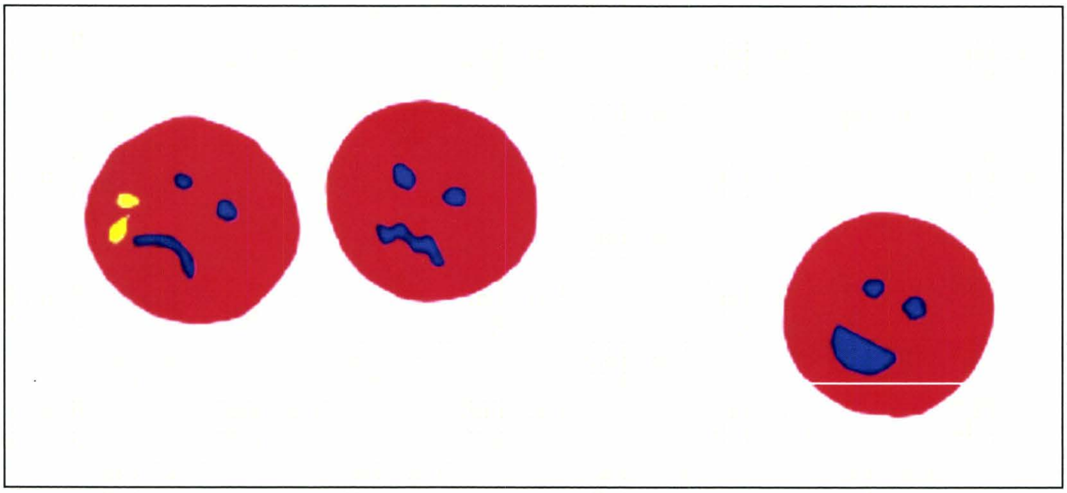
Eventually, the hospital administrators and the new owners negotiated a suitable lease and *Cornerstone* was able to stay in its space with some adjustments. As an aside, the new owners were exceptionally responsive to *Cornerstone's* needs around security and confidentiality, and a very good working relationship developed between the manager/owner and the staff – after all it is a guaranteed income from a good tenant (as the building manager said to me in an informal conversation). In a small way, *Cornerstone's* location and increased identification with a Hospital can be seen as representing an increase in the neophytes' physical isolation from regular 'states' that is typical of the liminal phase of *rites de passage*. With the relabelling of the building to being one that is clearly a hospital site, *Cornerstone's* client-students are not only physically isolated from normal states, but symbolically too. For example, the issue of Cornerstone's purpose as an alternative or mental health site, in taxi conversations such as those discussed in chapter five, cannot be avoided by future client-students.

6.4.2 Glove puppetry, recognising emotions and performing roles

During fieldwork at the *NOS*, I participated in various activities that combined therapeutic goals with other more education tasks. One such occurrence was an art activity that took place on a cold, but bright afternoon. The activity was puppet making, and like many posters and artwork on display at the *NOS* sites in both the north and south ends of town, the activity reflected good and bad emotional states, and the work focused on these various emotions, and how best to identify and respond to them. Figure 6.4.2a below, shows three faces each with a different emotion – (left to right) upset, frustrated/angry and happy – and belonged to one client-student who, on occasion, would point to them or take them off the filing cabinet (they were magnetised) to show them to a CYW. He would do this when unable to articulate how he felt (in the cases I observed it was the frustrated/angry face). If client-students used these faces and later the glove puppets, they were praised for making a 'good choice' (which I have commented on at length in chapter five).

One afternoon, the whole group, except for the teacher who was marking and planning lessons, sat around a large circular table to do what according to the chalkboard schedule was called art. The client-students were animated after a free time period, and

Figure 6.4.2a: Emotion Faces at *NOS*



their excitement was put to use in "being creative." One CYW showed the group a blank glove and her finished puppet and explained we were going to make our own special glove puppets that could change their moods. Using the "magic of magnets" we were going to be able to have puppets that could show not one, not two, not three but four emotions (happy, sad, surprised/shocked, or frustrated). As the class progressed each child was encouraged to make the puppet into whatever they liked using, paints, various fabrics, and squiggly eyes (these appeared toward the end of the session to much jubilance and excitement; clearly the CYWs were used to the [over]exuberance, and even silliness, squiggly eyes can create in young client-students). Over about forty-five minutes, the client-students variously made a dog, a computer game character, a relative, and themselves, and I chose to make a puppet Ben – with a bright shirt, big hair and a goatee beard.

All the time the adults were helping and directed the client-student with their creations – holding glue pots, finding just the right bit of fabric, helping wipe up the occasional spilt paint. Overarching these more material interactions, was a discussion led by one CYW about representing emotions and feelings and how best to do it with the puppets. The CYWs and the client-student chatted about how to know what each emotion felt like and how to identify it. They also spoke about instances when the emotions might occur and how best to deal with them. These instances often related to recent events in the classroom and were linked to the 'good choices' made by various class members and linked to the My Mad Plan's tenets. As we got close to the end, we prepared our three mouths and figured out the best place to put them on the puppets, along with making the relevant sounds such as happy, angry and sad woofs in the case of the dog puppeteer.

During this puppet-making period, there were animated conversations, a few frustrations and much cooperation and input about each other's puppets; it was a very supportive activity. There was also a not so subtle focus on feelings and responses to them, which characterised both the activity and the conversations about the activity. Ultimately, I would argue, the session was more about knowing how to react and what behaviours make up the appropriate reaction to a variety of situations, than about being able to make a puppet, and in this way was clearly part of therapeutic programming.[11] It is knowledge of these reactions that connote a client-student's readiness for return to their home school – that they know not to lash out, violently use their feet or hands, or shout and scream. If this activity is representative of day treatment at *NOS* – and the multiple variations on emotions, and art during my fieldwork observations suggests that it is – then

NOS treatment is about teaching client-students to be able to recognise their bodily reactions as well as their emotional feelings; to know that they should not to be violent or disruptive; and that they should demonstrate their competence as more 'regular' children would, such as by talking to an adult, expressing their feelings or perhaps by even burying them within. [12]

This activity meets at least one aspect of Turner's comments in relation to the apparent hierarchies between instructors and inductees, and among inductees. Turner in particular notes that "between instructors and neophytes there is often complete authority and complete submission; among neophytes there is often complete equality" (Turner, 1967: 99). As I outlined in chapter five, while there are clearly differences between staff and client-students the hierarchy does not always reflect what Turner typifies as "complete authority and complete submission" (1967: 99). Rather, the relatively high levels of autonomy and agency that client-students perform described in chapter five, even if framed largely by adult and institutional constraints, suggest that neither adult control nor submission to adults is total. Yet in the glove puppet exercise, the adults directed the discussion, and highlighted and praised the importance of certain appropriate behaviours and characteristics. In doing so, the adult staff attempted to inculcate socially appropriate life lessons that demonstrated their superior knowledge, as well as status differentiation between staff (instructors) and client-students (neophytes).[13] In addition, the "extreme equality" (Bettis and Mills, 2006: 62) that is assumed to characterize the relationships between liminal personae only occurs to some extent in this glove puppet example. That is to say, there are variations in social status between client-students, even if they are small variations in hierarchy. I suggest that a staggered intake process, the various client-student ages, and varied mental health needs facilitates the creation of hierarchy of sorts between client-students, rather than an equal cohort of "transitional beings" (Turner, 1967: 95).

While the glove puppet activity does not meet all of the specific characteristics of a *rites de passage*, its outcomes are indicative of the transitional and transformative processes that Turner argues take place during *liminality*. By focusing conversations on emotions and linking feelings to bodily states – hot, tense, tickly, low energy – the CYWs are aiming at two interwoven goals. Firstly, they are presenting a medicalised model of emotions, and through the repetition of similarly focussed activities client-students are encouraged to accept the discourses that form the foundation of the therapeutic components. Client-students are also encouraged to take on *sick roles*. Secondly, client-students, through their growing awareness, are shifting their mental health status from one which is entwined with behaviours that are outside those accepted as appropriate norms, towards behaviours and responses that are socially constructed as 'regular' or normal. Through such therapeutic activities, client-students become socialised and enculturated into more regular states (to use Turner's term); they take on *sick roles* through CYW input and direction and gradually move towards healthy ones.

I also suggest the glove puppet activity highlights the *sociality* of individual emotional and mental health. I have argued above that by discussing the bodily feelings linked to the emotional feelings, we clearly witness the linking of a more medical model (physical reactions) to emotions and mental states. In this link, and in the discussions about them held between CYWs and client-students, we also witness the explicit linking of emotional and bodily states to other people and a variety of situations in which the emotions might occur. It should be noted that nearly all of the conversations that took place, as the mouths were being made, added and exchanged to the puppets, focussed on what situations might cause bad feelings or emotions and examples of how best to react to them. In each case, when a client-student was called on to remember feeling unhappy, sad, angry, frustrated, and occasionally even happy, they spoke of their feelings in relation to other events or activities, or people and their behaviours and decisions. That is to say, feelings, negative or positive, were always linked to a broader situation that often involved other people – such as a maths class being frustratingly hard or too long; a teacher or sibling not listening to the client-student; or a good game of 'UNO' or 'Connect Four'.

Furthermore, I contend that this represents a sociality of emotions and behaviours, and that the relational aspects of emotions and behaviours are highlighted in making good choices (in addition to the overt adult power this model augments). In these good choices, such as those described in the I-Care-Rules (pictured below in Figure 6.4.2b), we witness the links between individual body reactions to social events. I contend that these body-mind-reaction triads are always located in social and dialogic contexts (Habermas, 1984, 1990; Holquist, 1981).[14] Young peoples' behaviours in these mental health settings – behaviours that contributed to their entry into the liminal phase – are, I suggest, dialogic and social specifically because in this setting they are monitored, observed, reacted to and responded to on the part of other actors, be they CYWs or teachers, or even other young people. I suggest that young peoples' behaviours are also dialogic and social because the setting is designed to ameliorate their 'malfunctioning' activities and bodies, and assist them with becoming healthy – their behaviours are in dialogue with bio-medical / bio-psychiatric discourses and practices.

Figure 6.4.2b: I-care-rules at *NOS*

I-Care-Rules

1. We listen to each other.
2. Hands are for helping, not hurting.
3. We use I-Care-Language.
4. We care about each other's feelings.
5. We are responsible for what we say and do.

It is easy to note the relational dialogue between professionals and client-students in this mental health setting, even if it is an uneven dialogue. Yet few researchers note the dialogue within discussions about good behaviours and young people practicing such good behaviours, or between their decisions as young people and the people and contexts around them. By this I mean that there is an on-going dialogue between notions of ideal practice and everyday practice on the path to the ideal practice. In terms of Turners' liminality practice, good decisions are like the tasks and trials that neophytes undergo prior to or as part of re-aggregation rituals. Appropriate or correct behaviours as highlighted by staff in discussions with client-students completing the glove puppet activity are foundational to client-students knowing what good decisions are and being able to make such good decisions. My position is that young people who attend mental health services are in relationship to, and with, the service and the people around them. This is witnessed in the I-Care-Rules, which epitomise the relational aspect of therapy in their stated goals: each one is about interaction and encourages 'good' or valued interaction; each one is about building good or valued relationships; each one is about the individual's relational or dialogic behaviours. The I-Care-Rules highlight the sociality of mental health treatment, even when individualised and internalised within bio-medical / bio-psychiatric discourses and practices.

6.5 Rites of incorporation - discharge

In the previous section, I addressed various elements of the transitional processes that individuals go through at the two sites in order to return to 'regular' societal states, roles and institutional locations. In simple terms, the aim of both *NOS* and *Cornerstone* is to enable client-students to cope with the pressures of education – be it in schools, colleges or apprenticeships. Occasionally, perhaps rarely, client-students move on to other therapeutic services – not-withstanding the above discussion of those client-students who do not 'buy into' *Cornerstone*. Bettis and Mills note that "Turner found that liminal individuals were typically guided with help from those appointed to shepherd them through this interstructural stage so that they could begin to learn about their new way of life." (2006: 69). In terms of *NOS* and *Cornerstone*, the client-students have lead-CYWs who act as a "shepherd," it is the CYW who prepares the reports which describe client-student preparedness for discharge, and these reports are discussed at clinical meetings. In this final section of the chapter, I will discuss the striking resemblance between Van Gennep's "*rites of incorporation*" (van Gennep, 1966: 11, author's emphasis) and the discharge practices at the fieldwork sites, the final phase which is integral to staff / service presentation of success. In Flow Chart 6.2, towards the right hand side, there is an arrow labelled "discharge processes," and this is the final confirmation of growth. It is through the varied practices around discharge that social (re)*incorporation* of previously sick client-students takes place, and these practices confer and confirm their healthy status. Ultimately, discharge is the final *rite de passage* at both *NOS* and *Cornerstone*, and I first address these events at the former and then turn to the latter.

6.5.1 Clear-cut discharge at *NOS*

Admittedly, there are problems with the final transition period at *NOS*. One CYW at *NOS* noted that:

> "there's not really a lot of opportunity to go and . . . transition kids essentially. So ideally, ideally we're either discharging kids because we've been successful and they're, they're managing in our classroom and in some cases we have the opportunity to try them in, in a classroom in the schools where our classes are located. Uh that's not in every case but in most cases that's something that people will look at or part of the day go and be with other kids and get a sense of what that's like so we can test, test their wings to some degree" (*NOS* staff Interview March 2006).

Yet this was the only transcript, which hinted at there being a realistic possibility of a gradual (re)*incorporation* period. All others said that this option of "try[ing] them in, in a classroom in the schools where our classes are located" would be an ideal that they would like to occur as part of regular practice. In fact, the discharge process was mentioned by nearly all staff members at *NOS* as being an area that they would try to improve. For example:

I What would be the one thing you would do to change things? To improve things?

R Um it is not a guarantee that we are able to provide transitional support to them so it can be very ... "see you on Friday won't see you again."

I Ok.

> R So I think those kind of supports in transition uh could be beneficial you know us taking the kids to their home school and working with them for half a day or an hour, bringing them back or ... that, and after they've gone on you know dropping by in a more concrete way I think that would be helpful.

That *incorporation* occurs in such a sudden way arises from strict funding boundaries associated with Section-23 education monies, which are not (officially at least) fungible in any way. Rather, they are allocated as long as a student is not in regular classes. Therefore once discharge begins, the separation is such that CYW support cannot be offered. In this formula, young people are either 'in need' or 'not in need' of mental health services, and as a result the (re)*incorporation* process tends to be rather difficult, especially for client-students. As hinted at in the above excerpt, in one case I observed a client-student finish at *NOS* on Friday afternoon, and come Monday morning they would return to their 'home-school,' without having been there in just over 12 months; returning with little possibility of follow-up or contact with *NOS* CYW staff, except for that which is informal.

During the week prior to final transition, the client-student, *David*, had occasional outbursts of behaviour that were clear breaches of those advocated by the Mad Plan. *David* was obviously anxious and concerned about the impending changes, but on his final day there was a celebration and adjustments to the class schedule, and *David* appeared happy and content with the additional attention. In the second half of the day, *David* got to choose the activities and games for the group, which was followed by a celebratory meal of his choosing (paid for by CYWs as far as I could tell), while we watched part of his favourite movie – *Star Wars*. All of the other client-students were made aware of the reasons for the day's changes. CYWs and the teacher repeatedly used phrases such as "David's made great progress," "he's going back to *Williams*, because he's done so well here." All the staff congratulated David, and at the end of the day, there were big hugs between him and the *NOS* staff – hugs initiated by David, who clearly knew that his life was changing and that he was moving outside of his current comfort zone. As staff repeatedly reminded him, he was ready to use the skills he had learnt with them and use them to avoid trouble back at *Williams.* This rite of (re)*incorporation* that separates client-student from *NOS* staff, with whom they develop supportive relationships, can be considered a drastic separation at *NOS.* As the next section shows the transition is slightly gentler at *Cornerstone.*

6.5.2 Phased discharge and the importance of relationships at *Cornerstone*

Turner is adamant that neophytes have nothing: "A further structurally negative characteristic of transitional beings is that they *have* nothing. They have no status, property, insignia, secular clothing, rank, kinship position, nothing to demarcate them structurally from their fellows" (Turner, 1967: 98-99). This is not always the case, however, for client-students at *Cornerstone*, either in terms of material property or in terms of rank. Some client-students have cell phones, some have mp3 players, some have cd players; all bring bags that contain their various equipment for school or gym classes; they all dress in particular ways to connote identity relating to broader social groups (such as emo', sporty, hip-hop, Goth; or what I describe as funky ecological). Outside of these material properties I suggest below that client-students develop social relationships during their time at *Cornerstone*, and as a result they acquire some amount of socio-cultural capital. They develop their skills and abilities through their attendance and participation in therapeutic programs and, importantly, friendships and the abilities to form and keep them. These friendships come to be markers of socio-cultural wealth, and indeed mental health and well-being, which are necessary prior to a gradual discharge from *Cornerstone* to other settings.

Through the various programs, client-students develop skills and knowledge that convert them into informal ranks with variations in social capital, rather than neophytes with nothing. One example is when client-students are asked by their Child and Youth Worker to help newcomers fit in to the break and lunch-time routines, *and are able to do so*, which in turn boosts and confirms their own improved mental health. Their knowledge is sometimes converted and used to small advantages such as knowing where the bingo equipment is stored, and gaining extra treats of candies or pop as a 'thank you,' a secret that is only shared once more trusting friendships develop. In a way, such relationships typify an ideal that *Cornerstone* strives to achieve with their client-students. Developing friendships is an integral aspect of such a process of change and transformation at the site. During the pre-*incorporation liminal* phase, the importance of appropriate behaviours, interactions and relationships is a key change to be undertaken by client-students. Part and parcel of the process of developing relationships at *Cornerstone*, and thereby improving mental health, is humour, fun, and laughter, which appear to be key components of improving self-esteem and friendship formation. Humour and laughter are significant in the building of such relationships, as can be seen from the following two extracts from interviews with *Cornerstone* CYWs:

> I Ok. Um I'm wondering, I've seen quite a lot is that humour seems to be uh a very big part with interaction.
>
> R With the kids or among the staff?
>
> I Both. Can you talk a little bit about that?
>
> R That's just me. *(laugh)* Um I think if humour is used appropriately and not as a sarcasm or anything like that its it's a nice ego boost you know I think there's some skills to be taught in humour. I think kids have an opportunity almost to role play and share and try something different on. Uh ... and they respond to that you know. It teaches them you know I don't mind being laughed at you know there's a sharing to that and uh its fun. Nothing beats that innocent giggle and you know what a nice time of the day, that was a nice point of the day to have a good giggle.
>
> I And uh what role does it play for the staff?
>
> R I think sometimes it can be a tension release indicator you know let's change the speed a little bit let's try something different. Uh sometimes you just need to be goofy. *(laugh)* It has its place. (CYW Interview, February 2006)

> If you can develop a kid's sense of humour or teach a kid to smile and laugh then you've, you've got them, it's just huge; and everybody loves to laugh everybody loves to smile everybody loves to feel good for that moment, it's just an easy way to deal with it, and to do it and not even know it, and then all of a sudden they realise that they are doing it; and it's a great way to make a connection with a kid in a relationship (CYW Interview, February 2006).

I was frankly surprised at the large amount of laughter at *Cornerstone*. Yet laughter enables client-students to feel "good for a moment" and have a "nice ego boost," which helps to form relationships, which are made tangible, and presents the possibility of future positive relationships.[15] In a small way, laughter is the currency of social capital at *Cornerstone*.

At *Cornerstone*, too, there are celebrations and tearful goodbyes (I discussed the Piñata event in chapter four), and at the end of the spring-summer semester when most client-students move on, staff organise a goodbye barbeque (much to the false-grumpiness of the CYW who usually does the cooking) for all the client-students. At the BBQ, the lead CYW goes through the names of the client-students who are moving on and everyone publicly congratulates them. These final rites are a less stark separation than those at *NOS*. They are less pronounced because the discharge process is staggered so that client-students return to high school officially full time but effectively part time. Like the relationships that develop between client-students and between client-students and

CYWs, teachers have very good relationships with certain high school administrators. These informal networks between teachers and CYWs at *Cornerstone* and administrators at specific schools in the city result in the possibility of slow-discharge for client-students. Unless they do not buy into the service as discussed above, client-students tend to undergo a phased (re)*incorporation,* transitioning to a nearby school to complete some credits in the mornings, while returning to *Cornerstone* for therapeutic programming and unofficial education support from teachers in the afternoons.

Staff rhetoric about client-students' treatment and education most often concerns how the site's therapeutic model encourages citizenship and homogenisation – that is an optimum return to society via high school. In a number of interviews, senior administrators recalled times when principals at schools described their ex-*Cornerstone* students as some of their school's best citizens – encouraging to other students, diligent and polite. As therapists and teachers, they see their key role as being the development of client-students' skills and coping mechanisms that will enable them to live as full lives as possible once they have been discharged. Further, there is an implication that the secondary purpose of "tooling-up" (Staff Interview, February 2006) these client-students is to minimise future draws on medical services, especially the expensive in-patient psychiatric services.

6.5.3 Critiquing discharge processes

I suggest that it is problematic that the systems in place, systems that result from funding mandates, do not assist with this final (and obviously stressful) transition in more managed ways. That *Cornerstone* client-students can gradually transition back to more normal roles in more normal institutional settings only occurs because of good faith and ongoing good relationships between *Cornerstone* staff and administrators at specific high schools. It is an arrangement that largely by-passes the funding issue, and is either unknown, or more likely overlooked (by Hamilton-Wentworth District School Board administrators) because of its value. What is witnessed, especially in the staff interview transcripts, is a daily and careful balance between two discourses, medical and educational, and that this balance can be a flashpoint for therapeutic 'crises.' In the case of the *NOS*, a client-student's need to complete homework and educational tasks can often lead to difficulties participating in therapeutic activities (as discussed in chapter five). In the case of *Cornerstone*, formal channels for discharge processes are negotiated and overcome.[16]

6.6 Concluding remarks

In this chapter, I have taken *rites de passage* and *liminality* as heuristic devices to examine how individual bodies (like earlier discussions of childhood*s* and adolescence*s* I am loathe to use a singular individual body here) interact with mental health service practices and policies. Like Bettis and Mills, I have found that neither *rites de passage* nor *liminality* works perfectly to explain every aspect of the fieldwork data concerning therapeutic processes (2006: 62), but they do assist considerably in analyzing certain aspects of the data. I have used *rites de passage* and *liminality* and conceptual tools to understand the daily practices at the fieldwork sites. This is, in part, an attempt to broaden the notion of individual bodies as experienced phenomenologically, in response to Terrence Turner who argues that social and cultural theory has

> a pervasive tendency to ignore or misrecognise the social nature of the body ... [and has] a propensity to ignore the primary character of the body as material activity in favour of an emphasis on the body as a conceptual object of discourse (Turner, 1994: 28).

I have attempted to bring to the fore the daily material activities of individual bodies through the sociality and relational aspect of the many bodies at *Cornerstone* and *NOS.* In doing so, I have argued for the continued applicability of the anthropological concept of *liminality* though the use of *rites de passage* as a heuristic device to structure the chapter. Through ethnographic details, I have characterized the status of having a mental illness as a liminal state, and linked these *rites* to specific shifting states within the mental health services. My discussions have attempted to highlight the *sociality* of mental illness and the *relational* ways in which it is inscribed on and resisted by individual bodies. To clarify, I have begun to explicitly link Lock and Scheper-Hughes's concept of the *three bodies* by emphasizing the interaction between and within them. I have argued that such interaction is framed by the power dynamics involved with knowing and performing sick roles. Here, I emphasize the interactional and relational components of *individual body* performance framed by the contexts of *social* and *politic bodies*.

Through this chapter we have witnessed the apparent ongoing dominance of biomedical discourses and practices within the treatment settings. I have begun to explore how a *medicalised* model (intake [ill person], treatment [person recovering], and discharge [well person]) work in school-aged populations and in school-like environments. The medicalised model can be seen as a continuum of transitional processes that are aimed at altering individual responses to specific and general stressors. I would like to suggest that perhaps mental health services, like the religious practices and symbolic ceremonies analyzed by van Gennep and Turner, could be considered forms of social control and generators of social cohesion within urban cultures. This is not a particularly new idea, as Horwitz (1982) as well as many others (like Foucault) have argued the point. My theorizing of mental health services as a form of social control does, however, emphasize the sociality of mental illness, and is an attempt to relocate and externalize illness away from the internalized location of biomedicine and biopsychiatry.

It should be noted that liminality has been usefully applied to examine a variety of 'states' in modern societies, whether these states are migrants, people involved in HIV prevention, people with disabilities, schizophrenics, or even landscapes (Barrett, 1998; Middleton 2005; Murphy et al 1988; van Dongen, 2005; Zukin 1991).[17] Many of these researchers, as did Turner (1967: 97), draw on Mary Douglas's notions of 'symbolic dirt' that challenges cultural norms, roles, or expectations, thereby challenging order, structure and authority (Douglas, 1966: 38-40). In this chapter, I have suggested that mental illnesses within western cultures might usefully be understood as states of liminality. If we take this to be the case, might mental illnesses also be described, like symbolic dirt, as "matter out of place" (Douglas, 1966: 40), or as behavioural impurities within social order? Leaving aside the fairly abhorrent language around purity, danger and dirt (and the xenophobic and prejudicial implications this has), mental illnesses are regularly represented symbolically as anomalies because they do not fit easily within cultural norms and accepted roles.[18] Mental illnesses' anomalous features are, after all, integral to a DSM-based diagnosis (APA, 2000, 1994, 1987, 1980, 1968, 1952). I will be commenting on the prejudice (more often termed stigma) people with mental illness face in the following chapter, but there is one salient point that I wish to make from Murphy et al's (1988) preference for a liminality instead of a stigma framework in relation to their work in understanding the lives of people with physical disabilities.

In contextualizing data around American paraplegics' life experiences, Murphy et al (1988) compare the prejudice faced by Black, Asian, and American Women to that faced by people with disabilities. Murphy et al suggest that it is easy to identify events and periods in US history that make sense (if not justify) the cultural and social stigmatization of Black, Asian and female Americans. Yet, they argue while it apparently serves little economic or political purpose, the discrimination against Americans with disabilities is still intense and real (Murphy et al, 1988: 236). I suggest that, in part, people with disabilities (and by implication people with mental illnesses) are vilified and stigmatized because they are examples of non-participants in capitalist economic frameworks – they cannot exchange their labour for money, and therefore cannot participate in society in appropriate or accepted ways. In this view, people with disabilities, if they do not or cannot work, represent and symbolize anomalous and ambiguous states that fundamentally undermine capitalism, and thereby undermine society itself. As people betwixt and between states, people with disabilities are ultimately (to adapt Mary Douglas) economic 'matter out of place' – 'costing' society while not contributing anything economically. It is noteworthy that about half of the staff members at both sites invoked the future economic benefits to their work during interviews. For example, one stated, "because of what they accomplish here very few of these kids will be drawing disability benefits for the rest of their lives" (Staff member interview April, 2005). So, while utilizing aspects of Douglas's purity and danger theorizing may be abhorrent, in some ways it illuminates the potential reasons for social stigmatization and links it to staff rhetoric. In the following chapter I address the implications of stigma in detail.

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[1] Estroff (1981) uses the term *intersubjectivity* as being necessitated within such contexts (1981: 216-219). That is, one's understanding the meaning of one's reality, one's identity, one's status, is always in relation to others, and requires interaction and (often tacit) agreement with what one recognizes as one's self, reality, identity etc. (Estroff, 1981: 219).

[2] Latour's (2005) conceptualization of actor networks is a potentially useful "side-theory" to my discussions of the relational aspects in the daily therapeutic practices at the fieldwork sites.

[3] To clarify, the cultures wherein *rites de passage* and *liminality* were presumed to play integral roles were presented as static, unchanging and underdeveloped (I discussed the importance of historicizing ethnographic data in chapter three).

[4] Low et al use a public health approach to try to highlight the significant negative societal impacts that result from academic failure, in addition to the obvious disadvantages the individual dropout faces during their adult life (2005: 141), but they do not go so far as to say that educational institutions fail the individuals who require mental health services.

[5] Two quick examples from the academe illustrate how such sick roles are still important today. Documented medical reasons are one of the few exemptions for tardiness of university level assessments and / or examinations, and taking time for health issues or maternity leave is one of the few justifications for 'gaps' in academic careers for graduates, post-graduates and faculty in Federal Tri-Council funding.

[6] There may be concerns with this comparison to the situation in the United States. I cited this research report from the United States because there is no similarly comparable research of this type based on which people in Canada are accessing, or being denied access to, mental health services. Further, while there are clear racialized determinants of health service access in the United States (namely access to health insurance) Canada's "universal" health insurance does not necessarily mean that in practice there is universal

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access and outcomes – see discussions in this thesis's introductory chapter. I am considering preparing an epidemiological scale post-doctorate research proposal that would measure the access, uptake and success rates for child and youth mental health services in Ontario.

[7] Front-line workers are, of course, implicated here, as they are integral to the operationalising of day treatment practices. As my External Examiner reminded me it may very well be that the staff have internalized the structural racism of the system, and not realize it.

[8] As an interesting aside, this rhetoric (of not buying in) was also used to explain the resistance on the part of mental health staff to the implementation of province-mandated use of CAFAS and BCFPI's as screening and measurement tools (Barwick et al 2004).

[9] Turner (1980) goes on to develop the notion of a liminal space-time 'pod' to conceptualize this alternative and inter/intra-state setting (1980: 165).

[10] Part of the *NOS* funding is for attempts to prepare their client-students to return to regular schooling – aiming to maintain and even improve their educational progress.

[11] I suggest that this art period is very much like the activities that qualitative researchers who work with children on their social worlds use to move away from a more formal interview setting (Christensen and James, 2000; Punch 2002), as were many of the other therapeutic activities at both *NOS* and *Cornerstone*.

[12] Such notions of competence might be considered to overlook the competence inherent and demonstrated in being violent and disruptive.

[13] I am thankful to Wayne Warry for reminding me of this interpretation.

[14] This perspective is similar to those proposed by Habermas (1990, 1984).

[15] Evans (2003) notes the importance of schooling in the creation of Canadian citizens, both through direct curricula and indirect curricula that enculturate societal norms and expectations. Laughter at *Cornerstone* can, perhaps, be considered to be indirect curriculum.

[16] Following the discharge process promises to be a fruitful avenue for future research especially in light of the discussions in the next chapter.

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[17] In fact the metaphor of liminality has even been used to describe childhood and adolescence as life stages (Bucholtz, 2002; Cocks, 2006), and Bettis and Mills, in particular note that Turner's theorizing was mostly in relation to *rites de passage* that demarcated the social categories of childhood and adulthood (2006: 68). To further clarify the point, I propose that Childhood and Adolescence might be conceived of as interstructural states – again suggesting that children and adolescents are culturally constructed as humans beings in potential, which I argued in this dissertation's introductory and *body politic* chapters.

[18] Here I wish to stress that I am discussing the social construction and symbolic representation of mental illness as a role within society. I do not consider people with mental illness to be 'matter out of place': rather, they and their behaviours are often culturally construed as such.

7. Stigma and Normality

> "Mental health disorders are undeniably stigmatizing. Stigma operates at the individual, family, community, and societal levels. At the individual level, mentally ill persons who fear rejection due to their illnesses are often socially isolated and behaviourally are less likely to seek and be adherent to therapies. At the family and community levels, these prejudices against those with a mental illness affect members of some minority groups more than whites " (Muntaner and Geiger-Brown, 2006: 284).
>
> "For Douglas [1990], while such stereotyping may not be desirable, it is always unavoidable. This is because stigmatizing is essential to cultural practice" (Radley, 1999: 168).
>
> **It is noteworthy that** "the terms *normal* or *normality* are rarely even indexed, much less discussed, in psychiatric textbooks. This suggests that either such a crucial concept is so well understood in that professional group and its meaning and reference so widely accepted that there is no reason even to discuss it or that a discussion is missing because of the difficulty of speaking its operational indicators" (Hughes, 1996: 137).

7.1 Introduction

This final ethnographic chapter is an attempt to situate certain aspects of the fieldwork data within a context of societal expectations and expressions of stigmatised roles. Like many of the issues analysed throughout this thesis, the research literature on stigma and its connection to mental health and mental illness is vast. In Canada, the existence of stigma associated with mental illness is well established (Kirby, 2006), but as might be expected, it is linked to research from the United States where the complex relationship between mental illness and stigma is evidenced (Frank and McGuire, 2005; Kaplan 2004; Link and Phelan, 2001; Mechanic 2007, 1999; Mechanic et al 2005).

Two articles are useful for the purposes of this introduction to exemplify such complexity. Camp et al's (2002) paper investigates the multifaceted interplay between mental illness, stigma and low self-esteem, and the importance of whether or not the ill person internalizes or rejects the negative societal reactions to their diagnosis. Camp et al's work is particularly interesting as it demonstrates the need to consider the social construction of a stigmatized identity, in which the stigmatized person can resist and even reject their stigmatization when they believe "the majority position to be wrong, to be based on ignorance, or to sustain particular power relations" (2001: 832).

After a fairly small meta-analysis – "49 studies with 52 separate samples" (Mak et al, 2007: 248) – Mak et al concluded that "causal inference should not be drawn between stigma and mental health" (2007: 259). Yet their results did confirm that the relationship between stigma and mental health "is strong enough to be observed in everyday life. In other words, stigma does have an observable association with stigmatized groups" (Mak et al, 2007: 256). I suggest that these two examples highlight firstly the medicalisation of mental health (i.e. trying to identify singular internalized cause-effect relationships), and secondly the importance of the everyday perspective of those people identified by the majority (mentally healthy) as being in a minority group (mentally unhealthy) who subsequently face negative connotations (stigma, discrimination). Furthermore, there are clear discontinuities between the perspectives of the majority (stigmatizing) and minority (stigmatized) on stigma and its effects (Link and Phelan, 2001). This leads to the interesting situation wherein stigma is both an externally and internally imposed experience, amplified by the fact that mental illness's definition is managed by a discipline (psychiatry) that can be said to increase social divisions (or power differentials) as it is founded on identifying difference (Appleton, 2000: 24, 33, 43; see also Read and Harré, 2001). Thus, I suggest, stigma is both a real life experience and a 'symptom' of relative powerlessness.

I begin by briefly reviewing and examining primarily social science (anthropology, sociological and disabilities studies) approaches to stigma. I then utilize this theoretical grounding to first analyze fieldwork data concerning client-student experiences of and reactions to the social stigma that appears to be attached to their having a mental illness, and second the apparent gendered patterns within the ethnographic data as well as the impacts of homophobic stigma / discrimination faced by some client-students attending *Cornerstone*. Like the previous chapter I wish to emphasize the importance of the interplay between individual and social "bodies." That it to say, while these are individualized stigma experiences, they are also experienced socially and constructed in relational contexts.

7.2 Reviewing stigma literature

There is an inordinately large amount of stigma-related research literature, with multiple academic disciplines utilizing the concept to explore difference, prejudice and discrimination. Goffman's (1963) seminal text is nearly always at their core, and many research publications that examine stigma-related issues begin with or include a summary of his work (Coleman, 1986; Corrigan, 2005; Dudley, 2000; Gralinski-Bakker et al, 2005;

Markowitz, 2005; Redfield, 2006; Sanderson, 2006; Williams, 1987). For example, Bock (1988), himself a seminal contributor to psychological anthropology, argues that an understanding of Goffman's exemplary contribution to the discipline is integral if an anthropologist is to grapple adequately with the "ways to relate the abstractions of social structure to real persons acting out their relationships in concrete situations" (Bock, 1988: 18). For Goffman, stigma is "the situation of the individual who is disqualified from full social acceptance" (Goffman, 1963: Preface), and "[t]oday the term is widely used in something like the original literal sense, but is applied more to the disgrace itself than to the bodily evidence of it" (Goffman, 1963: 1-2). While Goffman notes the importance of the "relationship between attribute and stereotype" (1963: 4) for stigma to take place, I wish to draw attention to my conceptualization of stigma in which there is a relationship and power dynamic between people who stigmatize and those who are stigmatized. This position is informed by Link and Phelan's (2001) theorizing which attempts to account for and analyze the essential role that power plays in stigma, stigmatization and those stigmatized (2001: 375-376). I argue that the relational aspect is key to understanding stigma associated with mental illness.

Particularly pertinent to the present thesis is that many people with mental illnesses do not necessarily have any physical 'deformities,' a key aspect of Goffman's stigma, which might act as cues for stigma. Rather, their 'disgrace,' to use Goffman's word, arises via their often marginal behaviours and bodily (usually verbal) performances, as well a near 'paranoid' level of concern within public / media discourse that equates all mental illness with violent schizophrenia (Morris, 2006; Olsted, 2002). I will return to stigma and mental illness presently, but first I briefly address anthropological uses of stigma, and second, debates about stigma's conceptual usefulness within disability studies literature.

7.2.1 Anthropological research on illness and stigma

A simple search for stigma on *anthrosource* suggests that much medical anthropology research published under the auspices of the hegemonic American Anthropological Association approaches stigma as associated with range of bodily diseases, for example HIV/AIDS (Bloom, 2001; Lekas et al, 2006) or Hansen's Disease (Barret, 2005; White, 2005), or bodily 'malfunctions' such as male infertility (Inhorn, 2004; Donkor and Sandall 2007), rather than on mental illness. HIV/AIDS appears to be the "disease of choice" for medical anthropologists, and there appears to be much research discussing the lived impacts of stigma relating to the disease. Schoepf (2001) offers an extensive review of anthropological research on AIDS, much of which highlights the importance of social stigma associated with the disease on societal (mis)conceptions of the disease, how an individual's illness experiences are framed and also on the disease's spread. Radley's (1999) work on stigma and AIDS confirms the negative social implications of contracting the disease; negative implications that are additional to the bodily ones (1999: 167).[1] As discussed in this thesis's *body politics* chapter this anthropological work identifies the difference between the experience of the disease (biomedical approach) and the illness (anthropology of health and illness approach).

Farmer (2003; 1999) argues that there is still ongoing stigma attached to the four H's (Haitians, hemophiliacs, heroin users, and homosexuals) in association with HIV/AIDS, despite changes in incidence rates, which in reality mean that, worldwide, poor women are most at risk as a result of the impact of structural violence on their lives.[2] Anthropological research evidence continues to emerge that argues the stigma attached to HIV/AIDS affects groups other than just the "Four H's." Clarke et al (2002), for example, demonstrate that the stigma attached to AIDS by society has a significant impact on the illness experience of Aboriginals living with HIV/AIDS in Canada. Root (2006) explores the stigmatization faced by Malay women working in factories, because of prior concerns over their "lax" morals, and current concerns over risks associated with HIV/AIDS. Middleton (2005) explores attempts to reverse the stigmatizing attributes associated with and experienced by people with HIV/AIDS, and the relative lack of success they have (more on de-stigmatization campaigns in this chapter's conclusion).

In theorizing about 'the body' Turner notes that "[w]hen Foucault discusses populations consisting of multiple bodies, he assumes the disciplines and discourses are addressed uniformly to all the bodies comprising the population" (Turner, 1994: 38). While Turner is critical of this uniform application, for the purposes of this chapter I suggest that it is useful to consider all client-students as having the potential for stigma, and normalise discourses addressed to or at them. I agree with Littlewood and Dein's summary of the importance of knowing the context(s) in which apparent mental illnesses are performed. They argue that, "[t]he same pattern [of behaviour] may be variously identified as norm, illness, aetiology, or treatment, as resistance or performance"

(Littlewood and Dein, 2000: 27). What I am attempting to convey with the present discussion, is that mental illness experiences are not *all* negative and that much can be learned from detailed examination and interpretation of the fieldwork data. Sections 7.2 and 7.3 explore these aspects in detail.

In each case, however, the stigmatised are marked as different from the normal, and this reflects a power differential between the two groups. Hughes (1996) highlights the division between 'normal' and 'abnormal' within psychology and psychiatry as disciplines, which are ultimately predicated on the identification and treatment of 'abnormals'. Indeed, as demonstrated by the third quote that is part of this chapter's epigraph, Hughes is critical of the over-emphasis on abnormality, and the lack of a grounded or accurate understanding of what normal is by psychiatry.[3] It is to the interconnections between stigma and mental illness that I now turn.

7.2.2 Mental illness and stigma

It has been noted that people with mental illness tend to face enormous and prohibitive levels of stigmatization resulting from both self-perception of stigmatizing reactions as well as actual negative reactions on the part of people when they discover or notice mental illness, and that this situation has not altered in a twenty year period (Beiser et al 1987; Kirby, 2006: 54). There is also evidence that while people with mental illness will suffer as a result of their condition; they also suffer as a result of the stigmatization they experience. Sayre presents evidence from patients, which indicates the additional impacts of stigmatization associated with diagnoses and hospitalization; these being "equal to if not greater importance than the psychiatric symptoms themselves" (Sayre, 2000: 79; 75; see also Beiser et al, 1987: 259; McCarthy et al, 1986). While this might seem to be an ironic and unfortunate aspect of medical intervention and diagnosis, others, too, note the problems associated with the diagnostic process, which leads to a mental illness label (*Labelling theory* is discussed above at length in section 3.2.2). Fabrega and Miller (1995) for example, suggest that the medicalisation of adolescent behaviour through the diagnostic labelling process actually increases the stigma faced by adolescents with mental health difficulties. This is, I argue, highly problematic, as adolescence is the period of life when most mental illnesses begin (Health Canada, 2002: 15). It has been demonstrated that the stigma associated with mental illness can and does lead to resistance on the part of both individuals and their families to seek and follow through with mental illness diagnosis and treatments (Kaplan, 2004: 572; Mechanic, 2003: 18; see also Anderson, et al 2006; Kirby, 2006; Health Canada, 2004b, 2002; Matsumoto and Juang, 2004; Mechanic, 1999). Mechanic (2007) also notes that stigma is a prohibiting barrier for people concerned with their mental health which stops them seeking mental health services (see also Mechanic and Tanner, 2007). For me, this problem highlights the disease-illness divide within biomedicine:

> An anachronistic division of the human condition into what is medical (having to do with the body) and what is nonmedical (the remainder) has given medicine too narrow a notion of its calling. Because of this division, physicians may, in concentrating on the cure of bodily disease, do things that cause the patient as a person to suffer (Cassell, 2005: 10).

What I wish to emphasize here is the key role that is played by the power differential in the relationship between physicians (who are, after all, professionally obliged to attempt to decrease human suffering) and patients; a power differential that also exists between the 'normals' and the 'abnormals' to use Hughes' (1996) words. As Weitz notes, "[s]tigma refers to the social disgrace of having a deeply discrediting attribute … . The term *stigma* does not imply that a condition *is* immoral or bad, only that it is commonly viewed this way" (2007: 180; see also Titchkosky, 2003: 142). Yet the phrasing of "commonly viewed" implies that considerable power is located with those not being labeled, but doing the labeling and, in turn, doing the stigmatizing. This power is witnessed in the ability of certain individuals to label certain behaviours and individuals as inappropriate (Weitz, 2007: 196-197). That power is involved in this relationship has been known for some thirty or so years, but to my knowledge it has yet to become a regular part of present-day mental health service practice (Offord, 1976: 125; see also Horwitz, 1979).[4] Thus, I suggest that stigma can be clearly linked to Foucault's conceptualization of bio-power, and the ability of certain groups within society to perform a "normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish" (Foucault, 1977: 184).

Stigma still exists for those attending day treatment programs, because such services are embedded in a history and a genealogy of institutionalized psychiatry, as well as present-day moral panics over (criminally) dangerous abnormal behaviours (Barnes and Mercer, 2003: 100; Wright and Moran, 2006: 3; see also Finn and Nybell, 2001; Holt and Stephenson, 2006; Morris, 2006). There is a long history of institutionalization and incarceration of people with mental illness (as I discussed in chapter three). This is still reflected today where in Ontario, for administrative purposes, mental health education facilities covered by the Section-23 remit are clustered with correctional education facilities. I suggest that this interlocking of criminal and mental illness behaviours acts to compound the justification of stigmatization on the part of 'normals.' Rhetoric around the social benefits of deinstitutionalization (as discussed above in Section 3.4) does not reflect a reduction in stigmatization for those who still are demarcated as being substantially different, labelled and precluded from taking on the status of "untarnished human beings" (Schur, 1980: 149). This difference is stark: often "patients experience **depersonalization** – a feeling that they no longer are fully human, or no longer are considered fully human by others" (Weitz, 2007: 206, author's emphasis). This depersonalization can be said to occur for young people too, as confirmed by Armstrong's discussion of the impacts that stigma has on young people who self harm. Armstrong noted that the young research participants often described themselves as experiencing a deep shame and a sense of powerlessness (2006: 57).

A further irony is that front line staff, too, are tainted by mental illness's stigma. There is clear evidence in terms of remuneration and their prestige within the biomedical profession that mental health care workers, including pediatric psychiatrists, are stained by the stigma that people they work with and for (Marks, 1999: 108). This position is reasserted by Repper and Perkins who argue that mental health staff, like people with mental illnesses, are devalued and stigmatized, because they work with stigmatized people (2003: 21). While Corrigan and Kleinlein suggest that mental health stigma can affect more than just the individual who is being stigmatized,

> the impact of stigma on a generic category called people *affected* by mental illness; although consumers of mental health services most likely experience the most harsh consequences of stigma, it also harms their family members and friends, the other stakeholders involved in any aspect of services to the group, and the public as a whole (2005: 11).

Thus, the harmful impacts of stigmatization are experienced by more than just the people with mental illness diagnoses; people who are, I suggest, structurally situated in relatively powerless positions.

This observation affirms the need for an interrelational understanding of stigma embedded in normative discourses. Bennet et al's (2003) research from New Zealand showed that young people with depression face and experience two discourses: a biomedical one, which describes depression as a disease; and a moral one that describes the young people as failures for having depression. In this case, individual bodies have failed to meet social expectations. Bury (2005) implies that there is a qualitative difference between people with serious physical illness and people with serious mental illness. This difference is apparent during 'disclosure' at work, and the social ramifications or "negative judgments" that more often come with mental illness (Bury, 2005: 16-17). Again, the locus of stigma is within failing individual bodies (and perhaps difficulties in claiming an acceptable sick role as discussed in chapter six). But I see such stigma as a social or relational product, however: an (uneven) dialogue between two parties. Yet these anthropological critiques of psychiatry are not as critical as those within the disability research field to which I now turn.

7.2.3 Disability Studies, stigma and discrimination

Within my readings of Disabilities Studies it is apparent that stigma is both a common term, and a term that is being replaced by a more accurate one – prejudice. For Saylor et al, there are significant links between stigma and "prejudice, stereotyping and labeling" (2002: 53), which if better understood and highlighted would enhance the understandings of people with disabilities (including those with mental illness). Jamison, who is both a mental health professional (2007) and a person with manic depression (1995), is adamant that people with mental illnesses face unacceptable, and at times dangerous, levels of prejudice and discrimination, the impact of which is softened by using the term stigma (Jamison, 2007). Barnes and Mercer (2003) argue coherently that negative stereotypes (or stigma) about "disabled people reinforce existing patterns of discrimination, and in some instances as with highly stigmatized groups such as those with 'mental illness', may contribute to a 'moral panic' about their inclination to commit random acts of personal violence" (Barnes and Mercer, 2003: 100). Writing on stigma associated with deafness and disability, Becker notes that "[t]he stigmatized individual must struggle with these negative attitudes and with the devalued status that accompanies them and develop strategies for handling the stigma. The individual who fails to do this cannot function adequately" (Becker, 1998: 311). While there have been some recent moves towards explicitly incorporating discrimination and prejudice into understandings of mental illness stigma, this is not a dominant perspective within stigma theory (Schnitter and McLeod, 2005; Yang et al, 2007).

Murphy et al (1998) explore the similarities between the structural and individual prejudice faced by minority groups within the United States, with that faced by people with disabilities. They note the paradox of such prejudice within economic terms. Unlike the devaluation of racialised minorities which are seen to 'subdue' the population, "the devaluation of the [sic.] disabled seems to serve no economic purpose or political interest of great moment. It is, on the face of it, largely without rhyme or reason, but it is no less virulent for all of that" (Murphy et al, 1988: 236). Following on from this position, I suggest that in part people with disabilities are vilified, discriminated against or stigmatized because they are examples of non-participants in capitalist economic frameworks – they are assumed to be unable to exchange their labour for money, unable to participate in society in appropriate or accepted ways. In this view, people with disabilities, if they do not or cannot work, represent and symbolize statuses that fundamentally undermine capitalism, thereby undermining society itself. Such people are ultimately (to adapt Mary Douglas) economic matter out of place – costing society while not contributing anything economically speaking (as I explored at the end of the previous chapter). In this way, it is perhaps the perceived threat that people with disabilities and people with mental illness "pose" that can be and is used to justify stigma, discrimination and prejudice inflicted on them.

It is essential to note that research within Disabilities Studies has critiqued the use of stigma as, like biomedical approaches to health, it individualizes and internalizes failings – as Söder argues "[t]he label ... puts the person in a category that is loaded with social meaning and preconceptions" (1992: 248). For me, *stigma*, as both a description of experience and a heuristic tool, does not highlight the socio-cultural and political-economic contexts of being defined as different.[5] Put bluntly, stigma models obscure the relational fact that the stigmatized are stigmatized by another group of people. I concur with Oliver's argument that "disabled people have not found stigma a helpful or useful concept in developing and formulating their own collective experience of disability as *social restriction*" (1990: 68, my emphasis). However, I continue to use stigma as an oppositional framework to normality in this chapter as it is used by both front line workers and young people alike.

7.2.4 Summarising stigma

To summarize, my definition of stigma follows Goffman's position that it is "the situation of the individual who is disqualified from *full* social acceptance" (Goffman, 1963: ii, emphasis added). For those client-students attending the mental health services with which I completed fieldwork, this definition appears to still largely hold true, despite changes in stigma theory and research evidence. I differ from Goffman's position by arguing that stigma, while located in the experiences of *individual bodies*, is relational in its construction through both *social* interactions between *individual bodies* and also through interactions between *individuals* and broad *body politics* discourses. I suggest that while it may be possible to overcome the disabling effect of bodily difference through normalizing adaptations, community support and legal challenges as has been documented by Becker (1998: 315), the social ramifications of difference remain in place most usually in the form of prejudicial stigma. The remainder of this chapter explores ethnographic examples of client-student and staff members conforming to and contesting stigmatization. The section that immediately follows, explores situations at *NOS* where stigma reflects individual failings and successes in relation to broader discourses. The final ethnographic section examines how normative discourses about gender and sexuality amplify the stigma experiences of client-students at *Cornerstone*.

7.3 Conformities with and contestations of stigmatised roles

Fox and Ward (2006) offer an insightful examination of the multiplicity and varied identities people perform in relation to their health that span a continuum from accepting biomedical models to resisting them entirely. This section explores three sets of data that might be considered to sit on such a continuum. First, I address systems issues, then passing as normal, and finally resisting stigma.

7.3.1 Systems issues

Attending day treatment mental health services in and of itself confirms difference by bringing into question an individual's mental health status and social capabilities, and thereby gives a potential stigma something definitive to be grounded on. As can be noted in the following *NOS* staff interview excerpt, going to a mental health service can generate stigmatizing effects:

I Do you think that the kids that come through your classroom have experienced stigma before they got there?

R As in oh you're a day treatment or as in you're a bad kid?

I Yes well (P3)

R Labelled. (P4)

I Labelled prior to arriving?

R Yes.

I And who does that? Who are the people doing the stigmatizing?

R Oh (P2) oh I think peers.

I Ok.

R Teachers. Aunts, uncles, neighbours, police, teachers. (P2) You know all that's the kit and caboodle these kids are coming with a baggage you know and how ... how its delivered to them.

I And do they experience it while they're here?

R I think at times they can. You know we've tried (P2) uh (P3) put an effort into assimilating and *(laugh)* but joining in, there's times that we need to be separate.

I Ok.

R So it's a balancing act and it's interesting how even how the schools are laid out.

Put simply, attendance at a mental health service can exacerbate stigma associated with mental health difficulties. The individualization of mental illness through biopsychiatric mechanisms, which comes with official diagnosis, can also act to amplify an assertion of individual failings. This is supported by a surge in research on the biological and genetic causes of mental illness (see Section 3.4 for more details on this). Thus attendance at a day treatment centre is not only part of the 'cure,' or resolution, or process of healing for a young person with mental illness, it also symbolizes their failings as individuals. Such failure is both in terms of academic (under)achievement, and also in terms of social abilities. This in turn impacts self-esteem. Young people who "repeatedly experience failure in their learning ... will almost certainly have a negative impact on their self-esteem" (Beverage, 1993: 11). I interpret such negative impacts on self-esteem to be an internalized refraction of social stigma associated with being mentally and behaviorally different. This perspective is supported by Söder who states that "traditional services in several ways create and confirm a status of incompetence and dependency for persons with [educational] disabilities" (1992: 249-250). This is not a chicken or egg question (lowering self-esteem or experiencing stigma); rather I wish to highlight the complex interplay of the two interlinking and interrelated factors.

In the context of the fieldwork sites, there is a further problem with regard to the mental health service itself being implicated in the stigmatizing process. It is perhaps surprising that there is little official consideration or inclusion of stigma as a cause, impact or implication of attendance at a mental health service. By this I mean that there appear to be few if any systems approaches that consider the role stigma plays for the young people whose needs are being met by the services. For example, neither the BCFPI nor CAFAS, the standardized screening, assessment and progress tools for child and youth mental health services in Ontario, explicitly address stigma as associated with mental illness symptoms or mental illness diagnosis. This is a glaring absence in light of the well-established role that stigma plays in mental illness experiences. It appears that these tools are so focused on internalized and individualized symptomatology that the social implications of mental illness are largely overlooked.

A second example of systems problems comes from the *NOS* sites, although the importance of ad hoc relationships between service and schools appears also to be the case for *Cornerstone.* As I noted, part of the *NOS* assessment and treatment program is to prepare its client-students as best as possible for return to their 'home' school. Yet there is little scope for client-students to attend regular classes prior to their full-time return; any such attendance takes place in an ad hoc manner and is based on good relationships between *NOS* teachers and teachers at the school where *NOS* is currently based. *NOS* staff are deeply aware of the stigmatising impact that can occur for client-students attending *NOS* – both in terms of peer relationships and friendships and in terms of how teachers at their home school will consider them. This systems issue is well evidenced in the following interview extract:

I there's been a documented history of clients in child and youth mental health scenarios experience almost a stigma, this is also coming out of research in Hamilton, you've hinted at this kind of different experience in the playground.

R Yes.

I Do you think the kids who come through your program experience this before they arrive? When they're there and also afterwards?

R Well I hear a lot about stigma like in terms of the anecdotal reports of families they talk a lot about that that's a common thing I guess for kids that have developed a reputation for being reactive, being the one with problems, uh being labelled by school staff. Uh I think you know to a

> large degree its real uh in the sense that uh group dynamics being what they are, uh school staffing resources being what they are in terms of you know its just human nature I guess that uh we start to attribute internal characteristics and I think within the framework of what teachers are having to deal with sometimes large classes and if they're constantly dealing with what they perceive is oppositional behaviour then they start to see that as the characteristic of a child. So um I think that's [stigma is] real. ... I guess there generally is a stigma, I mean kids taking medication in school is a stigma I've heard of kids being teased about that kind of stuff but its managed to a varying degree and it has to do with I guess the (brief pause) the general culture of the school to some degree and what's acceptable and how sort of adult oriented the kids are to some degree.

NOS is a service that assesses and then treats young people for severe mental health difficulties. Yet, as can be seen in the above quote, teachers at the home schools have considerable power to label these children in advance of their referral or intake to *NOS*. Furthermore, there is a clear internalisation of the problems into individual children's responsibility, into their individual bodies, rather than any discussion of how the educational system – the social environment – might be contributing to the poor behaviours and poor mental health. The home schools, I suggest are sites that begin the processes of psychiatrisation and medicalisation.

In the following extract, too, we see the stigma attached to the behaviours of a client-student prior to attending NOS, behaviours that are symptoms of needed therapeutic services:

I there's a documented history of clients in child and youth mental health experiencing stigma, have the kids who come here, the clients who come here experienced stigma before they arrive?

R (brief pause) because they are going to be coming into this program?

I or generally, in relation to their mental health needs, or their behaviours?

R we I would think so yeah, because their needs are very exceptional and they are identified as the 'trouble makers' the troubled kids ah (brief pause), a lot of um, a lot of suspensions in the regular classroom, they're quickly identified as the one's that are getting into trouble, and that's something that, and in our program the Principal of the school that we are in is not our Principal

I OK

R so up to a certain extent we need them to follow behaviour conduct of the school, but they are excluded from the safe schools criteria, and if they were yelling fuck, fuck, fuck up and down the hallway we would do everything we could to get them into this room and they would do that but because we've got to kind of, you know you have to try follow the rules to some extent, but are not, we do not suspend our kids and the school Principal has no authority over what we do.

There is a disconnect here. A disconnect between what are normal behavioural expectations of students attending the regular classes of the school in which *NOS* services take place, and the behavioural expectation of *NOS* client-students. In this instance, the greater leniency is essential for *NOS* client-students to be able to continue attending. But in both extracts, extracts that reflect the position of all *NOS* staff interviewed, *NOS* client-students face stigma prior to and after attending the service. As such, stigma exacerbates the social problems associated with mental illness, irregardless of the improvements to mental health and behaviour that occur because a young person has attended *NOS*, or *Cornerstone*.

7.3.2 Passing for normal

Edgerton (1967) gives a poignant account of people with mental deficits attempting to pass as 'normals' in order to resist and avoid stigmatization and discrimination. Ingold et al (1996) advocate the importance that language has on cultural forms and understandings. The clear reluctance of client-students to use medicalised language to describe their condition and their presence at *Cornerstone* is both an act of passing for normal (as Edgerton might describe it) and symbolizes the importance that language has on the cultural forms and performances of the young people at *Cornerstone*.[6] There are four examples of language choice that challenge the dominance of biomedical and biopsychiatric nomenclature, and as such are attempts to overcome the stigmatizing effects of mental illnesses on the part of client-students. Indeed, the fact that client-students *always* identify themselves as students and *never* as clients or patients, is the first example of how these young people challenge the stigma they face. Their refusal to accept the term 'client' or 'patient' is in part the reason for my use of client-student throughout this thesis, despite its awkwardness.

A second example is client-students' reluctance to use therapy or mental illness when they describe what takes place at *Cornerstone* or why they might be there. I first identified the trend of describing therapeutic outcomes, but avoiding therapy, medication or psychiatry related words (mental health / mental illness / disorder) as part of the Arts Project, and this trend continued unabated in later interviews. In response to why he might be at *Cornerstone,* one client-student said he was "having difficulties in school, basically just stopped goin' [and so] ended up coming here", another said she had "difficulties at home and (P3) at school I just, just wasn't happy. I (P4) just wasn't doin' anything" (Group interviews, May 2006). In relation to what takes place at *Cornerstone*, one client-student, near to discharge, said "well (P4) I've learned to do relaxation, woodworking, taking black and white photos, and I got a bunch of [high school] credits" (Group interview, June 2006). I interpret client-student language decisions during formal interviews as demonstrative of their capacity to resist the psychiatrisation of their presence at *Cornerstone*, and as an attempt to pass for normal. This 'passing' language choice is further confirmed through a third example – the ways in which client-students describe the service as an "alter-ed" program. Part of this process of re-naming the category of mental illness and therapeutic site is actively supported by staff, as can be seen from the following ethnographic vignette about client-students representing themselves to members of the public.

Cornerstone hosts an annual plant sale at the HHS main psychiatric hospital just before the Victoria long weekend in May. The monies raised are used to fund an end of school year trip to "Canada's Wonderland" – a destination that is typical of many Southern Ontario High Schools. In the mini-van on the way to the sale a CYW asked if any of the client-students had any concerns or questions about the day. She explained that their job would be to meet and greet members of the public – mostly health care workers at the hospital (she avoided saying that it was traditionally the psych unit) – helping them collect their pre-ordered plants, and then offering to help carry the plants to their cars. One male client-student, having been nudged by a female sitting next to him asked "what if they ask why we're not in school?" The CYW responded by asking if he wanted to know how to explain who they were; and the client-student said "yeah sure." The CYW reminded the half dozen or so client-students to remember that they controlled their own confidentiality and that if they did not want to, they did not have to disclose that *Cornerstone* was a mental health service. In fact, it would probably be better to describe themselves as being in an "alter-ed" program, or even politely say that they did not want to answer that question. She reminded the client-students that the people they would meet would be friendly and that they, the client-students, could always ask me or one of the CYWs present to give them a hand, or ask us for advice. As a follow up or debrief on the day, the CYW asked on the way back to *Cornerstone* if anyone had been asked who they were. In the end, only two client-students were asked about what *Cornerstone* was (and by implication a few of the plant purchasers had noted that the client-students were "out of place"). Both answered that *Cornerstone* was an "alter-ed" program.

In this example, I suggest that we can see an attempt to actively avoid the stigma associated with mental illness and a move towards a more normalized position, as schools are where society expects young people to be during weekdays. There is still some stigma attached, as "alter-ed" programs connote some level of difference; a level that is often negative (there appears to be much teasing amongst Canadians I know about being sent to school on a short-bus – the usual mode of transport for "alter-ed"' programs). Yet through the invocation of "alter-ed" status by mental health patients, I suggest that they have less negative connotations than mental health services.

The fourth and final example is connected to this attempt to normalize *Cornerstone* as being school-like. It comes from both interviews sections on how client-students relate to and interact with CYWs, as well as everyday interaction between CYWs and client-students. Other than the psychiatrist – who was nearly always informally described as 'The Doc,' or by name – client-students tended to differentiate *Cornerstone* staff into two categories, teachers who "help with credits", and tutors who "run the programs." Indeed CYWs tended to be addressed by their first names, but both they and the teachers encouraged the use of tutor as a title when first names were not in use – such as when asking a client-student "who's your tutor and what would they think" (usually about a selfish decision or negative behaviour).

I cannot quantify how much agency is being practiced on the part of client-students in these language decisions. It appears that client-students tended to conform to CYW language choices (for example therapeutic programming is called programming when CYWs talk to client-students). Thus, the client-students' language use might in fact be characterized as conforming to institutional demands. Furthermore, these language decisions do not actually alleviate the negative connotations of being at either a mental health services or at an "alter-ed"' school. They merely dissipate some of the stigma associated with mental health services. It is for these reasons that I have termed these actions as 'passing' rather than successful resistance to the stigmatization associated with mental illness.

7.3.3 Resisting stigma

Goffman was correct in his text on stigma. Society does "establish … means of categorizing persons" (1990: 11), and in Canada one key way is people's educational status. The Ontario High School Diploma is a major educational marker of success or failure for young people in the Province. Client-students, as they regain more control over their mental illness and spend increasing amounts of time and effort focusing on their studies at *Cornerstone*, resist the negative politic-social-individual triad of impacts associated with having a mental illness that also impacts on their educational progress. In succeeding in the classroom by gaining high school credits in a range of subjects, client-students move towards claiming a 'normal' status and in a way resist the stigmatization associated with the period of their difference. Through these educational activities, the staff at *Cornerstone* – both teachers and CYW's – advocate that teens should and can strive to be 'normal' in spite of their mental health difficulties. Thus, one key arena where *Cornerstone* client-students resist stigma is in being able to perform successfully 'normal' adolescent roles. As with the passing discussion above, school is a key signifier of such roles. It is in the two classrooms and with work that leads to credits that such normality can be clearly achieved. The teachers and tutors do much to facilitate these processes. Here, I will focus on the ways classroom activities assist with enabling client-students to resist stigma and perform more 'normal' roles.

The following ethnographic example is typical of what took place as a client-student started in the humanities classroom. Once the teacher, *Michael,* noted the arrival of the new client-student, the teacher asked them to come to the front desk so they can have a chat. Introductions were made, *Michael* stated that the work is to be done on a "relaxed basis; you'll work at own pace but do ask if you need help." *Michael* continued by saying that he would "step in on a particular task, if it looks difficult or you might need some extra info to get you going." *Michael* said that they would start with English, and asked "what English did you last do." The student suggested it was probably Grade 9, but they were "not sure if it was applied or academic [stream]." *Michael* responded that they would "start you on grade 10 academic." This initially shocked the new client-student, but *Michael* said that there was "no point in not being stretched, we'll begin you on the academic stream and it has common components and if we need to we'll just change the course code." *Michael* took out a large binder and said that they would make a copy for the client-student. It appeared to contain the whole credit's curriculum, and as *Michael* left the room to photocopy it, the client-student seemed a little surprised. However, when *Michael* returned he passed over just a small and specific section from the curriculum, and suggested that this was so that the client-student had lots of small tasks to complete. The client-student calmed and began reading the work. Within that class period, the client-student had completed the first assignment, handed it in to be graded with a smile, and started on the next piece. This example illustrates the importance of easing client-students into success, and also the cooperation between the mental health and education professionals at *Cornerstone*. In this instance, the staff knew that the client-student had not been in school for nearly four semesters and loathed math – hence started them on English in the humanities class.

Success in their educational endeavors is a key way for client-students to resist the stigma of not attending regular school. Client-students are all too aware that if they do not spend time doing credits then they are not participating in a process that is 'normal' for adolescents. Their successes not only mean that when they return to regular school they will have progressed educationally, they also mean that their participation in therapy has concrete measurable outcomes – CYW's regularly praise client-students' classroom successes, especially in relation to pre-*Cornerstone* difficulties. In this way, client-students' educational success is a key way for them to resist the discourse that individuals with mental health difficulties are automatically failures, as discussed earlier in this chapter.

Above I noted that a client-student expressed concern over the stream, and by implication, the vastness of the credit that they would work on. Client-students tend not to be told exactly how many tasks or hours of work they have to complete before achieving the credit. Indeed, the teachers encourage a short-term work focus. In other words, client-students focus on day-to-day progress and successes, and know that eventually they will get the credit. For example, in a math/science class in early February, one student, who was somewhat distracted with the new school semester having started, but still needing to work on last semester's math credit asked the teacher "am I near the end?" The teacher responded by saying "*George*, that's not a Zen way to look at the credit. You should focus on this chunk of it." The teacher went on to explain to both *George* and the class in general that he thought *George* (and by implication all of the client-students) would work too quickly to learn much if he were close to the end and work too slowly if it were a long way off. *George* asked again "so am I close?" and the teacher replied with a smile "you're close-ish, and your work is great so keep going."

An area of therapeutic programming that can also be used as part of a physical education credit are the bi-weekly trips to the local YMCA, and I participated in the Friday afternoon sessions for just over one semester. This program is facilitated by both CYWs and a teacher and usually includes a period of semi-supervised aerobic and weights activity, which is often followed by a 3-on-3 or 4-on-4 game of basketball. I use the phrase semi-supervised as the client-students are expected to organize their own activities at the Y, and are joined by staff members who encourage them or give them assistance with the various machines. The day before my first participation in this program, I spoke to one CYW about what I should expect – having never been to this Y or played any basketball. The CYW responded by laughingly saying I should "bring clothes to sweat in," and more seriously that there were "no worries if I was no good at basketball, [but I should] just give it a good go." The CYW then went on to say that really the YMCA program is to "help them [client-students] learn life can be fun." The CYW conveyed that it was essential that I participate fully, to experiment with the various activities, and show the client-students that I was not afraid of failing. The visit the next day was also the first time for about half of the client-students in the program. One CYW on the journey to the Y reminded us all to be respectful of the other people there, and not to stare or be rude. The teacher then suggested that the new ones would be expected to try everything and that the staff (CYWs and teacher) would help show them around, and assist them with the machines.

Later, as we played our basketball game, every attempt, and each supportive action or word, in addition to every basket or block, were celebrated and praised by the participating and watching staff members. In the changing room, the teacher said it was "good to get their hearts pumping, and laughing and sweating at the same time." The teacher reiterated to me what the CYW had said the previous day – that it was important for client-students to have fun. Over time, with our repeated visits, both Y staff and regulars would nod approval at the client-students and the staff as they worked on their exercises. That this all occurs in a public space not only boosts client-students mental health, but is also an occasion that client-students, with the support of staff, actively resist the stigma of mental illness: they behave just like anyone else at the Y, working out to be fitter and healthier.

It also appears to be quite 'normal' for client-students to want to avoid assignments. One example of this is when they are not being supervised by their regular class teachers, such as when the teacher attends a regular Section-23 staff meeting. This avoidance is amplified further when their lead tutor is not in the building. On one occasion, a client-student justified their lack of work to the class supervising CYW by saying that there is "no police today," and that "they could take it slow." They soon said it was "good to take it easy once in a while." Later that afternoon in the games room at break, the same CYW teased this client-student about their ability to focus on their game of pool, but not on their math's assignment: "I bet *Douglas* and *Jeremy* would be real interested to know." The CYW continued by jokingly proposing to "tell on you." The client-student responded by promising to work better after the break.

The teasing was repeated in the second half of the math's class after break. If there was any hint of the client-student being off task the CYW would repeat in a whiney voice their earlier claim that "I'm going to tell on you," the client-student responded by saying with a smile "shut up, I am working; look here's how much I've done." Yet within this example we see an interesting interplay in the relationships between CYW's and client-students. It is the latter group who have control over their work-pace, and they also know what can be expected of them during an afternoon's class – even in the absence of their "police." Yet in the absence of a teacher, CYWs still offer a watchful eye over these activities. The CYW/teacher and client-student relationships are playful, but still encourage productivity.

Thus, while client-students know and appreciate the boost to their self-esteem that comes from achieving credits, they also see refraining from school work as a typical adolescent behaviour – being off task was not limited to the above vignette. Stigma can therefore be resisted by performing roles that are normal for high-school aged young people. Such resistance can take the form of both choosing to *and* choosing not to work on credits. Through the post-teasing response, we also see the client-student conforming to the demands that the teacher and the tutors make on them; they should be achieving credits and working thoughtfully towards them. Clearly there is informality to the relationships between staff and client-student (as discussed above in section 6.6); an informality that I imagine would not be usual in mainstream schools, but the supportive nature of these personalized relationships – assisted by small class sizes – is noted by *Cornerstone* staff as being essential to the client-students' mental health improvements.

In all but one interview with staff, the issue of building trust was mentioned in terms of the therapeutic milieu, getting client-students to be able to laugh and cope with teasing, and also the importance of forming a therapeutic relationship. The therapeutic relationship is one where

> you [as a staff member] have to be so conscious of your interactions and based on your relationships models too, establishing trust and respect with these kids establishing (P3) a healthy therapeutic relationship with these kids … the kids understand that when they come in and we're quite open with that around the kids too "you know we really like you and that, but we're not your buddy" you know that kinda thing, more "we're here to help you" (Staff interview, January 2006; "air quotes" given by interviewee).

Such trusting relationships are therefore key to therapeutic processes at *Cornerstone*. Maintaining trusting relationships, as well as achieving credits, is a marker of therapeutic recovery, with credits being a concrete way to measure behaviour that is normal for high-school aged young people. Relationship formation, as I argued in the *rites de passage* chapter, is an indicator of client-students becoming (mentally) healthier individuals, and relationship formation also highlights the sociality of therapeutic processes at *Cornerstone.* This example illustrates how client-students deny the 'normals' the power to stigmatize, whilst at the same time they take on and perform normal roles.

7.4 Stigma, gender and sexuality

Before I conclude this chapter, I will comment on one further aspect of the relationship between mental illness and stigma: that of the gendered patterns within fieldwork data. In chapter three, which outlined the broad contexts that form *body politic* frames on mental health and mental illness, I argued that there is evidence of female adults in Canada having lower quality mental health than males – in terms of number, proportion to population, and severity of mental illness. There is clear recent longitudinal evidence that young females in Canada fare more poorly on a range of health related indicators – including those linked to poor mental health – than young Canadian males (Health Canada, 2004a, 2004b; Statistics Canada, 2003; also see section 3.2.4 above for more details). While the ethnographic details outlined below relate the interaction of gender and low mental health at two specific sites, I would like to comment on how this is linked to the broader patterns of gendered determinants of mental health within Canada generally. To do so, I contextualise my ethnographic analysis of two connected issues, that of gender and sexuality, by first addressing the content of the latest Federal report on young Canadians' health (Health Canada, 2004b).

7.4.1 Gendered service uptake

Health Canada (2004b) reports on the third implementation of the Health Behaviour of School-Aged Children survey of over 7000 school attendees over five grades (Health Canada, 2004b: xv). The statistical analysis presented in this report demonstrates that, aside from socioeconomic inequalities (linked to household income and parental / familial relationships), gender appears to be the strongest determinant of the quality of adolescent life. The report concludes that "gender is a strong determinant of many aspects of adolescent life: physical and emotional health; satisfaction with school and home; healthy living patterns and bullying and injuries" (Health Canada, 2004b: 121).

One chapter in the report is entitled "Emotional Health", but I suggest that it really deals with indicators of *mental health* or wellbeing (perhaps the language choice is part of an attempt to de-stigmatise these issues).[7] The chapter's introduction highlights the need to address emotional health because of the economic (but interestingly not personal) costs of mental illness.[8] This "Emotional Health" chapter discusses results from survey questions that attempt to measure emotional health through both symptomatic and global questions (Health Canada, 2004b: 110). For all four of the emotional health indicators detailed – headaches, backaches, feeling depressed or low, feeling irritable or in a bad mood – the percentages of females who reported these symptoms was greater than males regardless of age (Health Canada, 2004b: 111-114).[9] In addition, for both global indicators (life satisfaction scale and perceived health), males scored higher than females.

When the symptom indicators were compared in relation to those of general life satisfaction, females fared worse than males. That is, even female respondents who gave their satisfaction with life as '10 out of 10,' had higher scores for the mean number of reported psychosomatic symptoms than did male respondents who also gave their satisfaction with life as '10 out of 10' (Health Canada, 2004b: 117). This gendered pattern was repeated for all satisfaction with life ratings. In fact, the report suggests that,

> regardless of life satisfaction, girls experienced more emotional health complaints. The steep increase in health complaints for girls along the life satisfaction scale indicates that psychosomatic symptoms may be a better means of distinguishing girls who are at risk for emotional health problems than is a general life satisfaction scale (Health Canada, 2004b: 117).

In presenting these recent statistics that show young Canadian females as having lower levels of emotional (read mental) health than males, I am attempting to link the adult gendered patterns in mental health and mental illness with apparently gendered patterns in adolescent mental health and mental illness witnessed in my ethnographic fieldwork. That is, what we are faced with for adults (in magnitude and costs) appears to begin during childhood and adolescence. Yet I wish to move beyond a merely descriptive comparison – what do we make of these patterns, how do these *individual body* issues link to and with broader *body politic* frameworks? Is the predominance of female client-students (70:30 ♀:♂ ratio) at *Cornerstone* and the predominance of male client-students

(5:95 ♀:♂ ratio) at *NOS* a reflection of gendered behaviour expectations, expectations that help to form the essentialized age-based categories that I describe above in section 3.3? There is clearly a need for further research on the potential links between the statistical representation of gender differences amongst young Canadians and the trends in the ethnographic situations that I have analysed. What follows are my thoughts on this issue.

It could be argued that the two services serve two distinctly different sorts of mental health needs – predominantly internalising and predominantly externalising – which accounts for the gendered patterns I have described. It might also be said that these numbers do not reflect the usual ratios as it is merely an ethnographic snap-shot. In response to such questions around reliability, I acknowledge that I am of course assuming that the mental health services I have worked with are somewhat representative of mental health services in Ontario. I also repeat the fact that Health Canada (2004b), Kirby (2006) and as well as data from my interviews with *Cornerstone* and *NOS* staff confirm the general historical trend of *Cornerstone* assisting more young women, and *NOS* assisting more young boys.[10] I also ask why it is that younger males act out to such an extent that they need additional and segregated resources in numbers so much higher numbers than younger females? *NOS* offers a universally accessible program; with few if any supposed barriers to potential client-students who are female. So why are so few females acting out in the city's schools (or why are so few being identified)? This is, I argue, linked to Canadian social norms around females being passive and males being active. There are clear differences in presenting behaviours and thereby diagnoses, but interestingly not in resisting stigmatised roles. Young females are far more likely to present internalising disorders and young males are far more likely to present externalising ones (Aalsma and Lapsley, 2001; Casper et al, 1996; Chattha, 2004), but both males and females refer to the negative impacts of stigma, and react to it in similar ways.

I suggest that what we witness in the ethnographic data, adolescent statistics (Health Canada, 2004b) and adult statistics (Health Canada, 2004a; Government of Canada, 2006), might be a reflection of a clear and continuing gender imbalance within Canadian society. As a Government of Canada report on mental health and mental illness notes in relation to adults,

> [g]ender difference in the symptoms that are associated with depression may also contribute to the difference in prevalence. While women express the more 'classical' symptoms of feelings of worthlessness and helplessness, and persistent sad moods, men are more likely to be irritable, angry and discouraged when depressed. As a result depression may not easily be as easily recognized in men. In addition, women are more likely than men to seek help from health professionals (Government of Canada, 2006: 60).

Is the prevalence difference noted here evidence of a biologically based difference between the sexes – effectively making depression a different disease for women and men? Or rather, is it evidence of the culturally constructed difference between the genders that in turns impacts gender performance? Both Goodwin (1996) and Thorne

(1993) provide evidence of the gendered talk and cultural performance of young people; performances that are explicitly tied to norms and expectations. Butler's (1993) work demonstrates the multitude of negative impacts of socially located gender expectations on young women (see also Benhabib [1992]). In addition, Butler argues that gender is clearly performative (2004: 218), and that gender is therefore re-created in everyday acts (such as depression symptomatology):

> What this means is that through the practice of gender performativity, we not only see how the norms that govern reality are cited but grasp one of the mechanisms by which reality is reproduced and altered in the course of that reproduction (Butler, 2004: 218).

One key area of gender performativity can be seen in *Cornerstone's* client-students' relationships with their body shape and size. Turner agues that "the body seems thrust into ever-increasing prominence as the arena of social conflicts and repressive controls, as well as some of the most liberating aspects of contemporary culture and social life" (Turner, 1994: 27), and for some female client-students at *Cornerstone* their bodies are certainly arenas of conflict and repressive control.

By this I mean that during my time at *Cornerstone* only one male client-student had issues with clinical obesity, and none, to my knowledge had identified eating disorders. No males commented on their body or their body image as being a potential source of anxiety or stress during interviews. Male client-students did not seem to be pre-occupied with their body image during everyday interactions with their peers or the staff in terms of commenting on their clothing or hairstyle unless it had drastically changed overnight or over the weekend. However, roughly one in five of female client-students had problems with being either over or under weight for their age and height. During my interviews, nearly half of all females mentioned that their appearance or body size was a source of concern, and during everyday interactions, the female client-students would regularly comment on how they were looking, how much they had eaten or not eaten, as well as how important it was to look good (both in terms of physicality and also in terms of clothing and make-up). These gendered patterns reflect structural level (i.e. *body politic*) frames that influence individual body actions, justifying apparently internalised sex differences within gendered categories, and supporting the continuance of gender inequality within Canadian society. Perhaps in these trends is a link between mental illness and forms of social control, and the social control outlined in Horwitz's (1982) now seminal book.

7.4.2 Sexuality and stigma issues at *Cornerstone*

A second, and perhaps more sensitive area of fieldwork observations, is the fact that all of those client-student at *Cornerstone* who, in either everyday interactions or as part of formal interviews, self-identified as having non-heterosexual sexuality, said that people's reactions to them greatly amplified their low mental health and low self-esteem. Admittedly this group is relatively small – just eight or nine individuals during my time at *Cornerstone*, yet it speaks to the relationship between stigma and normality that reflects the underpinning of these situations: the power differential between those who consider themselves "normals", and those who are considered by this powerful group to be "abnormal." [11] The client-students who express gender or sexual orientations outside of Canadian heteronormative frameworks all stated that they had faced considerable bullying at their regular schools and that this bullying was a significant contributing factor to their unwillingness to attend. In other words, such bullying is a significant factor in their "dropping out," which becomes part of their mental illness symptomatology. All interviewees who identified as non-heterosexual also made direct links between such heterosexist bullying and their depression and / or anxiety.

The existence of stigma (and prejudice and discrimination) associated with homosexual, lesbian, bisexual, or transgendered self identity and performance is well evidenced in Canada (O'Brien, 2003). I suggest that the interplay between these young people's sexual identity and the negative implications they face is a clear example of the relational aspect of the *individual-social-politic* bodies triad. Their mental illness has been contributed to, not by their sexuality, but by people's (their peers), institutions' (schools and teachers) and discourses (heterosexist norms) interactions with them, their self-perception and performance. Thus there are multiple '*body*' layers that make these client-students suffer for being somehow (unacceptably) different. In light of my above comments on acts of resistance again mental illness stigmatisation on the part of young people, I suggest that the non-attendance or "dropping out" of regular school by non-heterosexual client-students before they attended *Cornerstone* should be considered acts of resistance on their part.[12] They are resisting the stigma, discrimination and bullying by using the only real power they have – to decide whether or not to attend school. These interactions and decisions then contribute to their overarching mental illness. I suggest that despite the future ramifications of missing school, this is a logical response on the part of the individual, as it removes them from a source of immediate suffering.

This is clearly a highly sensitive issue, not least because of society's expectation that young people should not be sexually active, and certainly should not be cognizant of their own homosexual, lesbian, bisexual or transgender identity (Pilon, 2001; Hurley, 2007).[13] It is also a sensitive issue because it is a clear site of discrimination; discrimination that is masked by generalized stigma associated with mental illness. Such bullying might be more easily justified by the stigmatizing groups as a response to the stigmatized's "weird behaviour" (behaviours that form part of a mental illness symptomatology), rather than as a response to their "weird sexuality."

It should be noted that staff at *Cornerstone* are very supportive of these client-students, and critical of any heterosexist behaviour on the part of other client-students – likening their needs for support and acceptance to that of any others within the Therapeutic Community in general. However, apart from two CYW's at *Cornerstone,* there is little vocalisation of critical thought around why schools cannot cope structurally or systemically with heterosexism. I also wonder if it is even within *Cornerstone's* mandate to comment on this pattern that reflects heteronormative inequalities. Both teachers and CYW's are all too aware of the "brutal hellholes" that are certain high schools within the city. Yet, other than to ask social workers based at the particular high schools to be on the look-out for the victims of this kind of bullying, *Cornerstone* staff as professionals are powerless to change the attitudes or approaches at them.

Upon discharge, *Cornerstone* directs most of the client-students, irregardless of their sexuality, to one or two schools that are known to staff as being more supportive than others within the city. Both CYWs and Teachers said that these are schools that have Vice-Principals that the *Cornerstone* teachers have a good professional track record with. As one CYW stated, these are Vice-Principals who "fundamentally understand the needs of our kids." It is not my place to comment or criticise the staff at *Cornerstone* who are attempting to ameliorate the effects of heterosexist approaches to schooling as apparently advocated (or at least overlooked) by the HWDSB – this is in spite of the work of the Safe Schools Action Team (Ontario, 2006).[14] Nevertheless, it is clear to me that stigma based in heterosexism amplifies the stigma associated with mental illness that *Cornerstone* client-students experience.

7.5 Concluding Comments

One should not underestimate the role that stigmatization has on the daily experiences of young research participants, and indeed the staff. I am not convinced that the system itself does everything possible to mitigate the negative social impacts of diagnosis or treatment, especially where these services are segregated from 'regular' schooling. Furthermore, the situation is not helped by the fact that the services examined through my research have education monies that are supervised in conjunction with those educational services in correctional facilities, thus clustering young people with mental illnesses with people who break laws (see Rhodes [2000] for an insightful investigation of the implications of mental health services and diagnoses in prison settings). In this simple administrative process, people with mental illnesses are made analogous to criminals, and as such are represented as serious transgressors of societal values and rules. In many ways this is the case – they are not able to cope with the expectations of Ontario's school system and as such have transgressed social rules. Yet, and this is especially the case of the client-students at *Cornerstone* who are questioning their sexuality, the system does little to protect or support young people from the discriminatory stigmatizing actions – intentional or otherwise – of both staff and peers at their home schools.

A substantial de-stigma or anti-stigma campaign would, in theory, decrease the *social* and *politic* influence on such suffering. There are, however, many difficulties with de-stigma campaigns, despite their best intentions. While there is good evidence that social support can decrease the negative impacts of stigma on people with mental illnesses (Mueller et al, 2006), there are difficulties with re-locating mental illness outside of individual bodies (i.e. lessening the implications of biomedicalisation of behaviour), rather than increasing contact and good quality interactions between 'normal' and 'abnormal' individuals, groups and communities (Read and Harré, 2001). Furthermore, commenting on attempts from the U.S., Brown and Bradley (2002) acknowledge the considerable difficulties with and inefficacy of many stigma reduction campaigns, despite the known need to reduce stigma (see also DHHS, 2001: 413). While Jamison argues that to increase research and interest in an illness "is to some extent to destigmaitize it" (2007: 534; see also Huxley, 2001: 119), much biomedical and bio-psychiatric research fails to account for the social and political contexts of stigma. Merely increasing biomedical and bio-psychiatric research in these areas would only reproduce the current systemic failings and fail to improve the current dilatation.[15] In addition, I suggest that the failings of previous de-stigma campaigns appear to be due to the over-reliance on biomedical-dominated discussions about mental illness being located within specific malfunctioning body parts – usually within misfiring brains (Bennett et al, 2003: 298). Their failings might also be due to the fact that, as Mary Douglas (1990) notes, identifying and noting difference is key to human society.

When investigating a rapid increase in prevalence of schizophrenia in rural Ireland in the late 1970's Scheper-Hughes concludes that "Schizophrenia is one of the many expressions of the human condition. Writ large, it is the translation of social ills into private troubles" (Scheper-Hughes, 1979: 195). I am not arguing that all of the mental illnesses witnessed at *Cornerstone* and *NOS* are exactly the same; however, there do appear to be multiple social ills reflected in the stigmatization that they face, stigma that is then internalized and individualized for and by the young people attending these mental health services. Moreover, these multiple social ills negatively impact the mental health of the client-students.

In the end, and after much reflection, I would recommend a combination of de-stigma campaigns that focused on the *social* and politic *levels* (or rather the relational contributions to discrimination) in conjunction with the provision of more culturally sensitive mental health services, and an education system that has social inclusion as part of practice and not just as rhetoric. This multi-faceted approach might prove an expensive one, but I believe it would be more effective than implementing any one of its components. Furthermore, a more holistic approach that broached systems-wide changes would eventually, theoretically, lead to less expenditure at the point of service provision because fewer students would manifest “dropping out” and “acting out” resistance behaviours that are the outcomes of systemic discrimination and power differentials.

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[1] Bloom (2001), Lekas et al (2006), Littleton (2004), Parker and Aggleton (2003), and Pearson (2005) all offer more recent examination of the interplay between AIDS and stigma, linking individuals' illness experiences to social reactions and discrimination.

[2] In the early years knowledge about HIV/AIDS, the four H groups were identified as high risk populations, and were attributed with questionable morals, which was seen as a partial reason for their difficulties.

[3] It would appear that Hughes' complaint about the predominance of abnormality within both psychiatry and psychology is well founded, as both disciplines can be characterised as overlooking the social construction of mental illnesses. For example, Wicks-Nelson and Israel's (2000) textbook on childhood behavioural disorders does not address stigma, prejudice, or negative social implications of being labelled with a mental illness. There are just two pages on labelling in a text more than four hundred pages long (Wicks-Nelson and Israel, 2000: 100-101).

[4] Perese (2007) goes further in highlighting the power differential within these relationships, by providing evidence of the intersection of stigma, poverty and victimisation on people with mental illnesses, and while all three should be explicitly considered as part of psychiatric care plans for individuals with mental illnesses.

[5] Frank's (2005) piece argues for the necessity to recognize and support people through illness rather than demand brave faces and strength. Key to Frank's position is the need for medical practitioners, and society, to remove the rhetoric around "negative emotions" and replace it with recognition of the illness experience that has to be lived (cf Frank, 2005: 30). In this way I suggest that Frank moves beyond a purely biomedical approach towards an illness experience one.

[6] In a way, I am following Ochs who argues that a "focus in language practices as resources for socialising social and cultural competence links language socialisation research to post-structuralist paradigms that portray *social structures as outcomes of social practice* " (Ochs 1996: 408).

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[7] There is growing literature in the social sciences calling for systematic investigation of emotions (indeed Scheper-Hughes and Lock's prolegomenon suggest this area would be a fruitful location for understanding bodies). Turner and Stets (2005) offer a fairly comprehensive survey of the sociological theorizing on emotions, yet they do not explicitly address the implication of emotional or mental states that are outside, or the role psychology and psychiatry play in identifying and regulating such emotions. In Turner and Stets text, we see a separation of emotional and mental well-being that is, I would suggest, a false division.

[8] The report reconfirms the high financial cost of mental illness in Canada: "A recent report indicated that $14.4 billion is spent annually on treating mental illness in Canada ... with this amount expected to increase to the point that mental illness will represent the leading health cost in the country by 2020" (Health Canada, 2004b: 109; citing Joubert and Stephens, 2001 and Canadian Psychiatric Association, 2001).

[9] It might appear anomalous for headaches and backs to be used as indicators in this survey. However, heads (and backs) appear to be the physical location of stress and become a symptom used in North America to connote stress – like German complaints about their stomachs or French complaints about livers. It is surprising to me that self-esteem is not explicitly used as an indicator of emotional health in this report. Rather, self-esteem is used as an indicator of the quality of multiple overarching determinants such as overall health, life situation, parental/familial relationships, peer relationships, and school satisfaction.

[10] I would also recommend Davis who argues that, "Fairly consistent gender differences have also been seen; for example, depression, eating disorders, and borderline personality disorder are all diagnosed more frequently in women. These differences may reflect the differential impact of socio-cultural factors as well as gender-specific patterns in seeking help" (Davis, 2006: 9, citing Morrow, 2003). A further response to questions about reliability of the ratios I present is why are epidemiological-level data on who is accessing which mental health services in Ontario not available?

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[11] Even though such a word is abhorrent, there is a clear case within psychology that abnormal retains much currency and value within University facilities – i.e. course texts that use Abnormal Psychology in their titles (McKay, 2008; Oltmanns et al, 2002).

[12] The most extreme mechanism of resisting and avoiding the stigma attached to mental illnesses is in fact resisting the diagnosis itself (Corrigan et al, 2005: 363).

[13] Admittedly, the legal statute only differentiates between sexual intercourse (presumed vaginal) and anal intercourse, and thus only differentiates between hetero- and homo-sexual activity in rather blunt ways, therefore overlooking lesbian, bisexual and transgendered sexual activity. However, such sex acts are treated differently under the Canadian *Criminal Code*:

> The *Criminal Code* does not criminalize consensual sexual activity with or between persons 14 or over, unless it takes place in a relationship of trust or dependency, in which case sexual activity with persons over 14 but under 18 can constitute an offence, not withstanding their consent. … The exception, of course, is anal intercourse, to which unmarried persons under 18 cannot legally consent, although both the Ontario Court of Appeal and the Quebec Court of Appeal have struck down the relevant section of the *Criminal Code*. (Pilon: 2001: 3-4)

A more recent report confirms that the criminalization of anal intercourse, as it remains illegal unless the participants are married (Hurley, 2007: 23).

[14] The difficulties faced by Canadian schools is well recognized: Canadian public schools today "struggle to respond to the challenges posed by changes to Canadian society … because of the centrality of public schooling in the transmission of core Canadian values, the failure of public schooling puts Canada at risk" (Ungerleider and Burns, 2004: 139). However, in general, schools have not been responding well to 'minority' needs, and some would claim have been exacerbating the problem (Dei et al, 2002; Richmond and Saloojee, 2005; Shera, 2003).

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[15] I would argue that in-depth anthropologically orientated ethnographic can be a productive addition and alternative to such focused research.

8. Reflections and Conclusions on Fieldwork and Thesis

8.0 Chapter's Aims

With this reflexive and interpretive concluding chapter, I aim to achieve two tasks. First, I address how my experiences and expertise might be within a *Canadian* medical anthropology background. Second, I evaluate and reflect on my use of Scheper-Hughes and Lock's prolegomenon, and comment on its currency some twenty years after its initial publication. The first task is essential, as I feel my work reflects clearly the interdisciplinarity that Inhorn highlighted as President of the Society for Medical Anthropology:

> the cutting edges of our field [medical anthropology] are now found 'at the intersections' of many other disciplines. With our solid foundation in place, medical anthropology is now expanding outward and interacting in many productive ways across disciplinary boundaries (Inhorn, 2007: 249).

My work reflects such interdisciplinarity by its fieldwork and academic locations, as it is at the margins of anthropology, sociology of health and illness, and education, as well as psychiatry and psychology and disabilities studies. As such, I suggest that my research typifies medical anthropology that is "at the intersections." But Inhorn represents a society located primarily in the US; so where does that leave my research within Canadian approaches to health and illness? This is a particularly apt question to reflect on, as my research has a non-traditional locale within the Canadian anthropology canon (i.e. not with First Nations or Arctic communities). While there is a medical and applied anthropology literature in Canada that address mental health and mental illness, it tends to focus on adults and Aboriginal adults in particular (Waldram, 2004; Kirmayer et al, 2003; Adelson, 2000). As an anthropologist working primarily with young people and with institutions (rather than with a specific cultural group), it therefore seems necessary to situate my fieldwork experience by discussing how my work may or may not fit with *Canadian* anthropology approaches to health and illness.[1] With regards to the second task, it is necessary for me to comment and reflect on the three bodies metaphor, and clarify my use of it. I am not certain that its use makes my work particularly Canadian, although Margaret Lock is one of the renowned anthropologists in Canada. Put simply, I have used Scheper-Hughes and Lock's position as a heuristic device, as a way of considering a kaleidoscope of theory, rather than trying to re-apply it in any strict way. In light of my divergent approach, it is critical, if not essential, that I comment on my adaptation and (perhaps mis)use of it.

8.1 Reflections on research – is it a Canadian anthropology endeavour?

My fieldwork experience at *Cornerstone* lasted from January 2005 to July 2006, while my fieldwork with the *NOS* lasted six weeks covering three months (August and October 2005, and March 2006). As was outlined in chapter 2, I initially worked as the qualitative researcher on a mixed methods project that investigated the Role of the Arts Programs offered by *Cornerstone*, rather than as a fully participant observing anthropologist. At that time, and as fieldwork "proper" began, I considered myself aligned with the cultural camp of anthropology, more interested in enculturation into Canadian society and how this connected to young people's lived experiences of a Canadian Childhood and Adolescence. But as I met more staff at the Hospital and other mental health professionals I was introduced as a medical anthropologist. At one point, I attended an external review and was introduced as "*Cornerstone's* very own Medical Anthropologist" (Fieldwork notes July 2005). It has become a title I now use regularly when I meet health-care professionals. But I am not sure either I, or the staff, were aware of my gradual shift from cultural to medical anthropologist. For the staff, my research was about the processes of treatment and recovery rather than my initial concerns about what it means to be a young person dealing with mental health difficulties, day treatment, or how such institutional experiences impact on Childhood and Adolescence as social categories.

On reflection, I propose that my own language and self presentation have shifted to conform to expectations hospital staff have of me – initial questions by *Cornerstone* staff (and latterly from hospital management, mental health workers and Public Health practitioners) included "what use can this anthropologist be to us? what are anthropological and qualitative methods? how are the results replicable, reliable and valid?" To some extent, this shifting performance is not overly problematic. I have to perform a certain role if I wish to gain a post-doctorate position or permanent job as an academic or researcher. But like the subtle ironies described and analyzed in chapter four, there appears to be a complexity in my conforming to role expectations – more on this below.

I would also suggest that there is great need to better understand how policy and practice variations impact on therapeutic outcomes, and how client-student experiences and understandings impact on their therapy. A need that can be met by a qualitative anthropology approach. I would suggest that I have gone through what is probably a 'normal' anthropological rite of passage – being enculturated into a professional role of participant observer and becoming part of a community, which I turn to next.

I am not a health professional, and for insurance and liability reasons my presence at *Cornerstone* doing anthropological fieldwork had to be formalized within the possible roles available at the Hospital. Thus, I had to become an official Volunteer. However, the anthropological role of participant observer goes beyond the normal descriptions of volunteer work undertaken within Hamilton Health Sciences – usually shop clerk, reader / visitor, information desk attendant. So *Esme,* the lead Child and Youth Worker liaised with Volunteer services, and Volunteer Services then wrote a specific volunteer role for me – no one had completed this kind of research previously within Hamilton Health Sciences. Volunteer services had to, in turn, convince the Risk Management department that it was appropriate for a volunteer to undertake such a role, and furthermore that I had the appropriate skills and qualifications. As part of this process, I also had to sign a waiver confirming I would not undertake any tasks that were the responsibilities of unionized jobs.

Having been interviewed and vetted by Volunteer Services I was issued with an official volunteer identity card, and then the negotiation over the 'lovely' green smocks began. All hospital volunteers are mandated to wear an 'institutional green' Volunteer vest – clearly identifying them as non-medical staff. However, *Cornerstone* is an off site, or community-based, program and is located downtown. I raised the issue of the smock at the next staff meeting I attended – and was roundly mocked – "you can wear it but we'll tease you until you stop wearing it" said one staff member laughing (Male CYW, Fieldwork notes April 2005). The staff consensus was that they wanted the kids to feel as normal as possible, so reminding them that they were in a hospital in that way would just not be appropriate (Fieldwork notes, April 2005). *Esme* had to officially 'write-off' my non-wearing of the smock to both Volunteer Services and Risk Management. In doing so, she agreed "officially" to have weekly supervisions with me. This was something I had requested anyway as part of my participant observations, in order to maintain ongoing ethical research activity, so my volunteer / researcher role was highly supervised (and rightly so).[2] Yet I suggest that my position was not as well defined as Volunteer Resources or Risk Management might have envisioned, which can be seen through how staff and youth viewed me, as discussed in the example in the Methods chapter.

That example suggests that quite quickly during my fieldwork I came to be considered and treated like any other adult at *Cornerstone*. This position is confirmed through a variety of other fieldwork sources (such as interviews with both staff and client-students, during informal daily activity and conversations; as well as during seasonal celebrations and the big goodbye at the end of the summer term). It is through these instances of 'acceptance' and my outward 'performance' in general at *Cornerstone* that we witness my enculturation into a successful participant observer role, which in relation to my theorizing in chapter four can be seen as my internalization of durable dispositions *hexis corporeally* that make up a *habitus* necessitated by such a position. Through these examples I suggest that I have successfully embodied a professional role of participant observer. But have I become a Canadian Anthropologist?

As I approach the end of my Ph.D. I am developing a sense that I might be becoming 'Canadian anthropologist' but at the same time I feel marginal to the identity. Clearly I am an anthropologist who is not a 'Canadian', I moved to Canada in 2002, but why might I want to self-identify as a Canadian Anthropologist and why might I feel marginal to this title and associated discourse now? These feelings motivated me enough to co-organize a session at the annual conference of the Canadian Anthropology Society / Sociėtė Canadienne d'anthropologie (CASCA) (Stride-Darnley and Sandford, 2007), an association predominantly for 'academic' anthropologists. During my Ph.D., I have attended a range of academic and professional conferences including anthropology focused ones, where I met an array of Canadian and non-Canadian anthropologists. In the informal chats discussing research and fieldwork I faced a slew of repeatedly asked questions. Who were 'my people'? Where was I working? What is the cultural background of 'my people'? So is my work actually anthropology or is it sociology? I also met with many people who wear something that reflects their anthropology fieldwork – clothing, jewelry, even tattoos – perhaps to be seen as badges of honour for successfully negotiating the anthropology fieldwork rite of passage. I will admit that within nine months of fieldwork I too had badges of office: like nearly all of the male members of staff who still had hair I grew mine long and shaggy; like five of the eleven staff members I wore very regularly a newly-purchased pair of old-style converse trainers. But these are not markers of an identifiable cultural or ethnic group; merely, perhaps markers of "Canadian" culture. It is at a number of academic conferences that the need to justify myself and perform an identity becomes concretized. On these occasions, I have to situate myself in reference to discourses that tend to focus on Indigenous and other globally marginalized peoples. I highlight the marginality of the people I have worked with (in line with my discussions in the introductory chapter), and tend to situate my presentations within specific 'pure' anthropology and /or theory perspectives (foregrounding the *academic* rather than *applied* merits of my work).

In these reflections, I am not arguing for the need for a singular definition, remit or parameter for what Canadian Anthropology or Canadian Medical Anthropology is or should be (it is definitely not just a McMaster/Warry influenced *praxis* approach). Rather, I am calling for a widening up of the scope of Canadian Anthropology to include an increased awareness of, and support for research that is marginal to Canadian Anthropology, and not just support for anthropology of distant and marginal populations. This is because it is at CASCA that I, someone who wishes to self-identify as a Canadian Anthropologist, regularly feel isolated at what is nominally my "home" academic conference. When meeting other anthropologists, like when meeting health care professionals, I feel a pull towards the 'medical anthropologist' title, or better still the title "anthropologist of health and illness." However, this title when combined with my research focus does not seem to satisfy anthropologists' seemingly insurmountable need to associate anthropologists with "a people, "a culture," or "a community."

My thinking about my anthropological identity began in 2001/2002, when I was completing an MA honours degree in Social Anthropology at the University of St Andrew's, Scotland. Reflecting on my time there I have come to recognize St Andrews anthropology as typically being 'Jungle' or 'exotic' anthropology; where 'proper' anthropology research would include a minimum of eighteen months in locations that were at least stylized as highly isolated, with 'preliterate' cultural groups that are vulnerable to the encroachment of modernization, such as the cultures and peoples of

Amazonia or Africa. The senior professors were indeed venerated elders, but who had only returned to 'their people' as a brief pre-retirement swansong.

This did not seem to sit well with my (perhaps idealized) neo-Marxist and critical perspectives. I came to Canada, and to McMaster, because of a more practical approach – for training in *praxis* and applied anthropology in particular – and because of a realization that anthropology as a discipline has responsibilities to the people(s) we do anthropology *with*, rather than *on*. I admit that I might be perceived as throwing stones in a glass house. Like some of the St Andrew's professors, it is unlikely that I am going to spend my anthropological career doing research with the adolescents who attended *Cornerstone* during their adult lives. I am, however, giving back to the institution so that systems can be improved – intake, retention, and discharge – so that the therapeutic processes can be more successful and be accessible to more young people within the catchment areas that *Cornerstone* and *NOS* serve.

In answer to some of the practical paradoxes I have noted throughout this dissertation (i.e. apparent heterosexist discrimination contributing to mental illness progression, and return to that heterosexist environment as 'success') and further to my conclusions in chapter six and seven, I have pondered on what recommendations to services and administrators I would make in my attempts to achieve *praxis*. Increasing the number of child and youth mental health services (or places at them) within Ontario and Canada would, in theory, improve the *individual* level suffering. Yet this would not necessarily address the apparently systemic reasons for their needing to access such services. For me, this is an important area of reflection and generates three highly difficult questions, both in terms of my "evaluation" of mental health services in Ontario and also in terms of the service providers and educational administrators who are trying to meet (under)met needs and improve service delivery. First, if some young people do not have the capabilities to participate in mainstream schools, and need treatment to counteract their deficits, but the segregated process appears to merely amplify the stigma that these young people face in connection with their apparent deficits, how best are their needs to be met? Second, if the mental health services have increasing wait lists and need more funding to meet the needs of young Ontarians, and indeed young Canadians generally, is the money better spent decreasing stigma or increasing service availability? This is especially pertinent in light of chapter six's discussions about the potential for racism prohibiting access to services and Ontario's and Canada's increasing ethnic and cultural diversity. Third, is it the system or the individuals that are failing? For me the system is at least partially responsible for the failings, and at the same time through psychiatrisation and medicalisation the system relocates blame onto individuals. Therefore, what systems and systemic changes are necessary to improve mental health of young Canadians and mental health services?

As noted in my discussion of de-stigma campaigns in the conclusion to chapter seven, there are a myriad of difficulties with attempting to implement single-focus change to mental health systems. In the end, and after much reflection, I would return to an approach that includes a focus on *social* and *politic* levels (or rather the relational contributions to discrimination) in conjunction with the provision of more culturally sensitive mental health services, and an education system that has social inclusion as part of practice and not just as rhetoric. My recommendation of such a multi-faceted, more holistic approach, would likely face resistance from some policy makers and practitioners, because it challenges biomedicine's and bio-psychiatry's predominant focus on individuals (with their internalized malfunctions), and because it likely would prove to be an expensive approach. However, in my evaluation such an approach would be more effective than implementing any one of its components. Additionally, a more holistic approach that broached systemic changes would eventually, theoretically, lead to less future expenditure at the point of service provision because fewer students would manifest "dropping out" and "acting out" resistance behaviours that are the outcomes of systemic discrimination and power differentials. A holistic approach would, theoretically, reduce the need to change the status of young Canadians from students to client-students.

Yet I have come to realize that there are problems inherent in this 'applied' process – at best I can achieve systems change, and systems improvements, but I cannot (at this point in time) demonstratively effect systemic or structural change. Systemic change is a pressing matter especially in light of my discussions relating to the raced and gendered patterns in access to, attendance at, and success with mental health services in Ontario. Perhaps it is a more pressing matter than effecting systems change. Lavis (2003) demonstrates the difficulties in transferring non-medical knowledge about health to health and economic policy makers within Canada, and while Lavis primarily discusses Public Health determinants of health approaches, I would include the anthropology of health and illness within the non-medical knowledge category. As such, there are similarities between the difficulties applied anthropological researchers face and the difficulties faced by researchers who attempt to transfer evidenced-based best practice into both front-line and policy arenas. Lavis et al (2003a) discuss how presenting "ideas" rather than data appears to most influence policy makers (2003a: 224), which is something I have focused on with my executive summaries. Moreover, it is essential that "take-home" messages from research are simple and that "they are appropriate to the decision-making environments to which they are directed" (Lavis et al 2003a: 224). Again, this is something I have attempted to achieve through the incorporation of research questions from front-line staff and administrators in addition to my more anthropologically orientated ones.[3] I have not yet been able to assess the impact of research for the service providers, because such measurements were not explicitly part of my Ph.D. proposal.[4] In any case, it remains clear that I can only aspire to systems changes rather than systemic or structural changes.

This is where I perceive the inscription of a complex and ironic interplay onto my role as an anthropologist, which I briefly mentioned above. On the one hand, I am supporting and, in a small way, hopefully improving a system that works with the young clients' desire to 'fit in' and to progress; to undergo a naturalized self-disciplining process. On the other hand, there is no scope within the system to critically question the societal norms that frame what characteristics are needed in order to 'fit in'. A further irony is that the client's 'progress' makes them, and the staff and services involved, feel good about themselves – justified as people or institutions. A third layer of irony is that the applied component of my research – indeed a necessary component of negotiating entry to this field – has generated self-questioning. As has been evidenced throughout my thesis, I draw heavily on critical medical anthropological, feminist and various post-theories, which in general question the normalization and individualization of social status and inequality (Butler, 1991).

Despite that, I know that I am conforming to societal expectations through my academic work, and I am contributing to the institutionalization and medicalisation of problems that are both socially located, and at the same time can do nothing to alleviate the root causes of the inequalities. I feel insidious about being overtly critical of the specific services I have worked with (because of the apparent growth that I have witnessed – the young people are not asking much from life [to be able to get on public buses without a panic attack for example]), but however insidious I might feel about critiquing the mental health services and the staff with whom I have worked, application and knowledge transfer is important to my research approach. Indeed such attempts at research that is socially valuable is a key component of Canadian anthropology approaches, as witnessed by CASCA's Weaver-Tremblay annual award in Applied Anthropology. Where social suffering takes place, anthropologists have a responsibility to not only account for it in terms of 'pure' ethnography, but also to attempt to ameliorate it in terms of application – and, while this thesis might be seen as more closely aligned with 'pure' anthropology rather than 'applied' anthropology, I have attempted to converge the two through *praxis*.

8.2 *Three* Dialogic *bodies* – Revisiting a prolegomenon twenty years on

In response to the elevated position of theory within 'pure' anthropology, and the normative implications this has within our discipline, I have presented a highly theoretical thesis. This is despite the applied proclivities of my work.[5] I begin this final concluding section by briefly revisiting the content of Scheper-Hughes and Lock's (1987) seminal prolegomenon, as I wish to clarify two main points before I summarize my use of theory to analyze and understand the therapeutic practices at the two fieldwork sites.

First, Scheper-Hughes and Lock propose to shift Medical Anthropology from 'traditional' fields of enquiry that focus solely on Indigenous belief and practices about illness cross-culturally to legitimatise the study of western biomedical practice in and of itself. Scheper-Hughes and Lock's (1987) stance acknowledges that just as with "alternative," or "traditional" healing practices, biomedicine's "knowledge relating to the body, health, and illness is culturally constructed, negotiated, and renegotiated in a dynamic process through time and space" (Lock and Scheper-Hughes, 1996, 49). My dissertation research could be seen as a reaction or response to their proposal, as it is solely based on biomedical, and what I have described as biopsychiatric, practices rather than Indigenous, alternative, or traditional ones.

Secondly, Lock and Scheper-Hughes (1996) argue that the shift towards analysing biomedical practices could be achieved through the examination of three culturally constructed bodies, which they consider to epitomise 'best-practices' for Medical Anthropology, and has subsequently encouraged many researchers to focus on one of the *three bodies*. I, like many other medical anthropologists, very much appreciate their canonical work, but it seems to me that one aspect is lacking from their prolegomenon – the benefits of explicitly considering the interactions between these *body* levels. In this thesis, I have provided ethnographic evidence to support my argument that while these three views of the body – *individual*, *social* and *politic* – are useful as single perspectives, there are benefits to analyzing the interactions within and between all three.

By this I mean that there appears to be a relational or dialogic aspect to each *body*, and that these relational aspects became apparent during both the fieldwork itself and the subsequent analysis of the associated data. In my analysis and interpretation of the data, there appears to be clear interaction between phenomenological, symbolic, and broader political-economic levels witnessed within bodily performance and daily occurrences at the fieldwork sites of psychiatric mental health day treatment services in Ontario. Perhaps in this interpretation and use I am suggesting that their prolegomenon itself has become an appropriate analytic concept and tool (to paraphrase their words), something their article initially searched for: "This article is descriptive and diagnostic. Its goal is both the definition of an important domain for anthropological inquiry and an initial search for appropriate concepts and analytic tools" (Scheper-Hughes and Lock, 1987: 7).

I have argued and demonstrated that Canadian mental health services as represented by my two fieldwork sites are framed by an abundance of overarching *body politic* discourses. I have discussed how biomedical diagnoses and evidence-based treatments, educational concepts of skills, progress and achievements, social expectations of what young people should be doing and feeling, all come to influence the daily interactions and events at these fieldwork sites. Furthermore, as evidenced in chapter four which viewed fieldwork data utilising Bourdieu's and Foucault's theoretical insights, key therapeutic discourses – the therapeutic community model and cognitive behavioural therapy, such as relaxation – are deeply embedded within biomedical practices and are linked to the role mental health services have in (re)creating healthy working people within Canadian society. In chapter five, my exploration of *confined agency* expands on the *body politic* aspects that frame adultist conceptualisations of young people; conceptualisations ascribed to them as a result of their position within the social categories of Childhood and Adolescence conceptualisations that consider young people's capacity and abilities to be limited, thereby overlooking the roles young people play in creating and acting within their own social worlds. By advocating the relevance of *confined agency* within the fieldwork sites, I challenge the notion that children and adolescents lack agency entirely. In this fifth chapter I also discussed how the agency of mental health services, CYWs, and other involved adults are all also framed by broad *body politic* factors such as funding formulas, policy decisions, and biomedical discourses in their attempts to ameliorate client-students' mental illnesses.

Even within the two chapters that address more explicitly the importance of various *bodies politic* discourses there are, I suggest, clear examples of the *sociality* of practices at the fieldwork sites. That is to say, there are clear interactions between the individual-social-politic levels within the ethnographic details I presented. I will give two very brief examples here to clarify my point. My discussion of *Cornerstone's* Relaxation program argued that individual body level skills were inculcated in individual bodies. At the same time, the Relaxation program is also an example of the shared sociality of treatment – noted in particular through the breathing practices. Initial analysis might suggest that it seems to be an individual body process, yet the control over stresses in turn enables client-students to perform more 'normal' social roles and potentially overcome the stigmatization they have faced because of their mental illness. The example of *David's* knowledge of his societal position that I gave as part of chapter five's conclusion also clearly demonstrates the relational sociality of mental health services delivery. *David's* responses to my questions reveal a child-adult-expectation dynamic, and that he is cognizant of this dynamic interaction.

I suggest that it is, however, in the chapters that address stigma and *rites de passage* that we witness the interweaving of individual-social-politic triad most transparently. Abutting the services' attempts to ameliorate client-students' mental illness is the stigmatisation faced and resisted by the client-students. Stigma is painfully felt by individual client-students, but it is socially located because it is always relational – *other* people discriminate against *them*. Yet, ironically, stigma also acts to generate conformity from the population – client-students are cognizant that they are somehow different as a result of their pathologised illness, and in nearly all of my interviews with client-students they mentioned their desire to "fit in," or to be able to do 'regular' things. In other words, they want to try to conform to 'normal' roles. Despite efforts to minimize and resist stigma on the part of staff and client-students, by expressing the desire to "fit in" we see the power of "normality" and stigma to inspire conformity. Moreover, while on the one hand the desire to 'fit in' can be seen as resistance to the disabling effects of their mental ill health, on the other hand the compliance to medical processes and social regimes means that the focus is on individuals as the site of disease rather than on the social determinants that contributes to illness and disability. It is here we see the internalization of mental illness through systems of bio-power.

NOS and *Cornerstone* are in a way services that focus on relational bodies, which is argued throughout chapter six. Through my use of liminality and *rites de passage* to describe the mental health service settings, I have argued that what is witnessed in the provision of mental health services are State reactions to the presumed 'danger' that young people with mental illness pose. In a more positive light, the mental health services could also be considered as therapeutic sites of potential, as arenas of becomings, akin perhaps to a chrysalis, which protects and nourishes a caterpillar prior to its transition into a flourishing butterfly. In the words of one staff member, "What we deal with are weeds who grow in the cracks in the system and help them turn into flowers and trees" (Staff Member interview, March 2005).

Key to the transition of individual client-students attending the mental health services is the development and acquisition of knowledge about and a relationship with one's own body, knowledge of one's own anxieties and stresses, in addition to building healthy relationships with other people. These are all integral prerequisites for client-students to accomplish prior to returning to more 'normal' institutional locations, such as 'regular' schooling. It is not a huge leap of logic to propose that these relational bodies can be framed within broader socio-economic and political bodies, which designate behaviours as normal and abnormal, and bodily reactions as pathological or regular.

There is, I have maintained, a relational and dialogical aspect to the interaction between the individual and politic body levels; interaction situated in the sociality of everyday practices at mental health services. My position here is linked to Hurrelmann's assertion that,

> [t]he everyday activity of adolescents is decisively characterized by an adjustment to the specific institutions that are standard for their age group. Each of the institutions imposes demands within the framework of its own system-specific conditions and acts according to the patterns of its own functional structures.
> (Hurrelmann, 1996: 55)

I do differ from the totality to the institutional imposition that typifies Hurrelmann's position. As with my argument concerning *confined agency* in chapter five, the relational and dialogic aspects are very much framed by adult discourses and institutional settings; nevertheless, young people do play key roles in their therapeutic recovery.

Here I diverge from the definition of Scheper-Hughes and Lock's *social body.* My use of *social* is not a symbolic representation, a *body* that is good to think about nature, culture and social structure with. Rather, my interpretation considers the *social body* to be understood and witnessed in interactions and dialogues. I consider how client-students represent themselves to friends and colleagues, other clients, the 'outside' world; and also how the outside world views these bodies and their 'sick' minds. I have argued that the sociality of *social bodies* of *Cornerstone* and *NOS* as fieldwork sites is integral to client-student's recovery and preparation for return to normal roles – in this sense, individually constructed bodies are interacting with other individually constructed bodies (and their multiple subject positions). These *individual bodies* and *social bodies* are then, in turn, influenced by broader *body politics* that demand conformity to normative forms of behaviour from young people in Canadian society.

I have attempted to emulate Scheper-Hughes and Lock's tripartite approach to structure my thesis. Yet as the writing has progressed, the distinct division between the *individual-social-politic* bodies has not reflected the multifaceted fieldwork contexts, and so I have moved away from a definitive tripartite structure. Notwithstanding the obvious merits of each single approach to understanding 'the body,' I hope that my complex analysis of all three bodies provides analytic strength to the thesis. In terms of my analysis and interpretation of the ethnographic data the *prolegomenon's* distinct divisions between *individual-social-politic* bodies are more useful as rhetorical tools, frameworks, or structures – "perspectives from which the body may be viewed" (Scheper-Hughes and

Lock, 1987: 6) – than as an accurate theoretical description of on the ground events at the two fieldwork sites. I suggest that there is a need for a relational analysis of the *individual-social-politic bodies* that Scheper-Hughes and Lock's prolegomenon implies, but does not explicitly state.

This is because there is more than one individual, structure, or policy at play within Ontario's mental health system. Examining how each body (person, structure or policy) interacts with and influences the other bodies is necessary if a contextual or deep understanding is to be achieved. It is in the combination of *individual-social-politic bodies* that provide for successful therapeutic outcomes for client-students accessing these services. Despite the potential criticisms directed at how success is measured, or criticisms directed at the services as being tools of bio-power in their supporting of normative frameworks, from the perspective of the client-students the services are successful and, to a greater or lesser extent, normalcy is regained. The services work to give client-students agency by removing them from society, and provide a therapeutic space that is transformative and safe. The services work by inculcating skills necessary for performing 'normal' tasks and behaviours. The services work by combining therapeutic and educational goals (in response to societal expectations) so that client-students maintain and even improve their academic standing. Such agency, inculcation and educational progress, works at both a body and social level and can then be used to confront and combat the social stigma the young people face as a result of their mental illness and social isolation. I admit that my particular use of the *individual-social-politic* bodies may very well have overstretched their intended use as "three separate and overlapping units of analysis, but also three different theoretical approaches and epistemologies" (Scheper-Hughes and Lock, 1987: 8) designed to problematise the body so that medical anthropology does not "fall prey to the biological fallacy and related assumptions that are paradigmatic to biomedicine" (Scheper-Hughes and Lock, 1987: 6). However, in this thesis I have highlighted the usefulness in "overlapping" aspects of each *body* as evidence of the prolegomenon's pertinent currency as an analytic tool.

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[1] Indeed in noting the need to distinguish Canadian-ness from American-ness am I performing the ultimate shibboleth of Canadian identity?

[2] Like all other adults (front line workers and CYW students) at *Cornerstone* I was supervised on a weekly basis by *Esme*, further I was supervised monthly by Volunteer Resources, and I submitted regular up-dates to my university supervisory committee as well as having more formal reviews every six months. I have also undergone an extensive review by the Hospital/ University's Research Ethics Boards, which has been re-reviewed at the 12 and 24 month stage.

[3] Boudreau (1998) notes the peculiar difficulties in research-policy mental health partnerships. These attempts at "interdisciplinary" partnerships in Quebec have not worked due to "highly entrenched hierarchization of professions and a constraining judiciarization if work relations" (Boudreau, 1998: 508).

[4] Lavis et al (2003b) argue that such post research measurement is necessary for health based research and could, if not should, be incorporated into Canadian (and by implication U.S.) health funding bodies as a standard aspect of evaluating research funding applications. That is, knowledge transfer should become integral to research funding – a trend that recent developments at Canadian Institutes of Health Research seem to confirm.

[5] In light of the above discussion on my role as an anthropologist, the ironies of this are not lost on me.

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10. Appendices

10.1 Young people interview protocols

INTRODUCTORY QUESTIONS:

How do you describe yourselves?

What word or words do you think staff would you use to describe the kids that come here (formal / informal)?

What are your reasons for being here? How would you describe your understandings of your own diagnoses? How well were they explained to you?

What explanation do you give for attending Cornerstone?

Can you describe your history? – how did you find out about Cornerstone, can you describe your entry into Cornerstone? What has your time here been like?

ISSUES:

Have you experienced stigma in relation to the reasons for your being here? Before you came? While you've been here?

Can you give me a brief description of what Cornerstone is / does?

What takes place here? Could you describe what classes you've been in? Do they count?

What are the main therapeutic activities here? Are they different from therapies kids have access to?

FU: Is their a underlying therapeutic concept?

What role does humour play in the therapeutic processes here

FU: Can you give an example

How does Cornerstone negotiate its role as edu and therapy site.

How have you interacted with both?

How do staff deal with both?

How is discipline maintained? Is this an issue?

How are friendships formed here? Who are your friends (from Cornerstone/outside Cornerstone) FU?: How does love, lust, hormones, identifying sexuality, gender ?

CORNERSTONE WITHIN HOSPITAL:

What role does the Hospital play for Cornerstone
Do you see the place being connected to McMaster Children's Hospital?
Who works here? What skills do they have?

MOVING ON:
Can you think of any examples of students starting here but not staying for very long?
What happens if you don't like it here?
How does the decision to move on take place?
How have you measured your improvements?
What is the process of therapeutic recovery?
How does the move take place?
(NOTE TO SELF: do they client-students use discharge?)
Have your goals on entry influenced your leaving process?
What role does kid's choice really play in the service and the therapy?
What happens to those kids who choose not to get help – having gone through the extensive intake process?

FINAL PHASE Questions:
If you were in charge or could press an issue to those in charge what would your action be / message be?
Do you feel listened to? Like your opinion counts? Are you valued?
Many / all of the staff here are very experienced … does the age difference influence interaction with the kids? If so how?

Knowing that this research is about child and youth mental health policy / provision and therapeutic processes is their anything else you would like to add?

10.2 Adult interview protocols

Can you give me you elevator speech describing your job/role here and also what Cornerstone is / does?
What word or words would you use to describe the kids that come here (formal / informal)?
How would kids here describe themselves?

Stigma in child and youth mental health – does it occur to / with the students here
Do you think it occurs to them before they arrive / after?

What are the main therapeutic activities here? Are they different from therapies kids have access to?
Is their a underlying therapeutic concept

If asked what explanation would students give as reasons for them being here?
How do you understand their diagnoses? Are their specialists between the CYW's
How would you characterise students understanding of their diagnoses
What role does humour play in the therapeutic processes here
FU: Can you give an example

How do 'regular' teen growth experiences play out at Cornerstone – love, lust, hormones, identifying sexuality, gender
How would the kids describe their histories?

CORNERSTONE WITHIN HOSPITAL:
Role of administration in the centre
How would you describe recent events (sale / re-organisation)?
FU Have their been positive / negative changes

How have things changed during your time here.

THERAPY / EDUCATION DUAL ROLE:

How does Cornerstone negotiate its role as edu and therapy site.

How do you as a staff member interact with both?

How do client-students deal with both.

How is discipline maintained? Is this an issue?

FINAL PHASES:

How do you measure recovery / improvement?

Transition – can you describe typical processes of discharge from Cornerstone

How do the kids understand end-goals

Recently some clients have been discharged for non-attendance. Much of the discussion was around 'ready to make the choice to come' have to make a positive decision to attend (as well as attempted to deal with extenuating circumstances).

So two-part question:

What role does kid's choice really play in the service and the therapy?

What happens to those kids who choose not to get help – having gone through the extensive intake process?

If you were in charge or could press an issue to those in charge what would your action be / message be?

Do you feel listened to? Like your opinion counts? Are you valued?

Many / all of the staff here are very experienced … does the age difference influence interaction with the kids? If so how?

Do student CYW get training? How do they get incorporated?

What is the process of therapeutic recovery?

Knowing that this research is about child and youth mental health policy / provision and therapeutic processes is their anything else you would like to add?