Childism, Intersectionality and the Rights of the Child

The Myth of a Happy Childhood

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Chapter 5

Childism and ableism intersecting

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5 Childism and ableism intersecting

On a perceived lack of abilities

Ableism[1] intersects with childism through discriminatory and prejudiced discourses. Childism encompasses ableist discrimination and social prejudice against children related to their perceived lack of abilities. Childism accordingly distinguishes people by their lack of adult abilities and as inferior to adults with such abilities. On this basis, children are assigned or denied certain perceived abilities, skills, or character traits, for example, assigned traits of compulsivity, obnoxiousness, or disobedience and denied character traits of rationality, generosity, or empathy. In childist societies, children who are perceived as lacking these abilities are viewed as less valuable, or even less than human.

Drawing on critical disability studies, this chapter explores ableist attitudes found in childism. By understanding ableism, we gain crucial knowledge about childism in how prejudices against people with disabilities and against children are based on ideas about a 'norm' and about 'ableness.' 'Ableness' is here linked to ideas of being 'able-bodied,' having 'ability,' to normalcy, normality, competence, reason, aptitude, and capability.

In critical disability studies, social, cultural, and political perspectives are used to disclose how disability is maintained through discriminatory discourses, practices, and physical hindrances in society (Mackelprang and Salsgiver 2016). While a medical understanding of disability focuses on how to enable the child with disabilities to function within the current system, a social, cultural, or political understanding focuses on how to re-shape current practices into inclusive ones for all.

Anti-ableist and anti-childist lenses question prejudices adults hold about children's perceived lack of abilities while recognizing how children's dependency is partly socially constructed and their lack of freedom and rights not only a 'natural order' but a political question as well. In this chapter, I explore social environmental aspects of discrimination in relation to disability and age that calls for more progressive legislation on substantive equality. Further, questions about whether anti-childist lenses could be employed on adult bias in defining deviations from 'normality' in childhood and on dominant medical explanation-models to children's behavior will be raised. What forms of adult biases inform our understanding of children and their behavior in terms of what we define as the 'norm'?

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5.1 ‘Reasonable’ adjustments?

In critical disability studies, challenges faced by individuals with disabilities are examined, not primarily through a medical perspective but through social and political perspectives on discrimination, shifting the focus away from explanations about deficiencies on the individual level to the social, political, and legal hindrances in society that lead to discrimination. Progressive legislation against disability discrimination places the responsibility for adjustments on societal actors to prevent inequality arising from prejudice. A provision, in section 15(1) of the UK Equality Act, states that a disabled person is discriminated ‘if treated unfavorably because of something arising in consequence of their disability and if the treatment cannot be shown to be a proportionate means of achieving a legitimate aim’ (Chap. 2, Part 2, UK Equality Act 2010). There is thus a duty according to the Equality Act to ‘make reasonable adjustments for disabled people,’ which is a cornerstone of their protection (Hepple 2010, 73). ‘The duty arises where a disabled person is put at a “substantial disadvantage in comparison with persons who are not disabled” by a provision, criterion or practice’ (2010, 73). The duty to make adjustments in order to avoid disadvantages being conferred unto disabled individuals may consist of (1) changes in the ways things are done toward more-inclusive and diversity-accommodative ways, (2) changes in the built environment, and (3) changes in the provision of auxiliary aids, for example, text messaging, taped texts, audio recordings, and large print materials.

As children are generally perceived as lacking abilities according to adult normativity, this legislation is important to look at more broadly in relation to the rights of the child. How could a similar duty to make reasonable adjustments for all children be formulated into laws on substantive age equality, to avoid disadvantaging children in comparison to an ‘able-bodied’ adult?

Relative disadvantage is ingrained in childist societies to the point whereby suggesting that there exists a lack of adjustment which in turn creates discrimination against all small children may be seen through an adult perspective as unreasonable.

As with discrimination against individuals who are viewed as disabled in society, children in their early years generally face physical obstacles due to their small size and limited physical ability relative to adults. Tables and chairs are generally constructed to match the adult norm, hindering children’s access to common spaces. Refrigerators are placed out of reach for people smaller than the adult norm, adding to children’s dependency on adults. Food necessary for survival is generally placed out of reach of children, who jeopardize being punished for trying to overcome physical obstacles when hungry. Houses, apartments, and kitchens have been constructed through adult normativity and ableist normativity causing children (and persons who deviate from the adult and abled bodily norm) a huge problem in resisting these disadvantages. Much more is demanded of infants if they are to overcome the physical barriers created against their autonomy—they have to use strength and balance in order to climb, reach, and stretch for the most basic rights that abled adults take for granted to be within their comfortable reach—to fetch a glass of water.

If age discrimination was made applicable to children in the UK Equality Act—and in similar legislation in other countries—adults would not be allowed to discriminate against children by treating them unfavorably because of something arising in consequence of their bodily size and/or their perceived disabilities in younger years if adults cannot demonstrate that a specific treatment of children is a proportionate means of achieving a legitimate aim. All the abovementioned examples of hindrances against smaller children's ability to reach and fetch things that are placed out of reach in the physical environment could be regarded as proportionate to achieve child safety. The argument about adult normativity in the construction of homes, school buildings, and other public environments is not intended to motivate rebuilding or refurnishing of these spaces but serves to provoke new questions about legitimate aims with the socially constructed current limitations.

The way that buses, schools, parks, apartments, and society at large could be modified if children's abilities and needs were taken into consideration could generate public spaces that enable new and unforeseen creative possibilities for both adults and children. Adult and ableist normativity have created physical barriers and unequal conditions for variety-abled persons including children so that the hindrances that are socially constructed and how society is organized have become viewed as 'normal' whereas diversity in terms of abilities and bodies have been regarded as deficits instead of positive variety.

More child-equitable studies on different conceptions of protection are necessary to inform discussions about when hindrances posed to children in the social environment should be regarded as discrimination and when not. For example, in buses, safety belts are constructed for the adult body, creating a situation in which a body smaller than the adult norm faces the endangerment of being strangled in the event of a crash. Belts are not designed in proportion to the body mass of children, and so may become a hazard in themselves. On public transport, handles are placed so that adults may support themselves while walking up and down the stairs. Small children, on the other hand, are left without the choice to support themselves with handles, with the stairs themselves also being created at a height for adults and thus demanding more exertion from the child to climb and descend. It is thus assumed that children are always supported by an adult guardian. An anti-childist lens on how the public space has been designed could target the socially constructed dependence of children on adults and how this dependence is maintained through physical barriers in a society shaped for the normative able-bodied adult.

Being smaller and lighter than the adult norm does not naturally have to imply a perceived disability or a constant dependence of children on adults. Physical size—being smaller than the adult norm—can from an anti-childist lens be studied as including abilities that generate unique possibilities, rather than posing problems for the individual. What are the ways in which structural discrimination against children denies them the opportunity to demonstrate their abilities? This question begs empirical child-centered investigations.

Discriminatory practices toward children with disabilities should be acknowledged as rights abuses that arise from interlocking oppressive prejudicial systems of ableism and childism. Children with disabilities may suffer from intersectional invisibility as marginalized within the disability community. Adult disability movement has raised questions concerning discrimination-facing adults with disabilities on the right to housing, for example, but the political invisibility of children with disabilities and racialized children with disabilities, risks silencing their specific political concerns. Non-governmental organization (NGO) protests against discrimination of the disabled include early examples such as 'the Independent Living Movement in North America, the Swedish Self Advocacy Movement and the Union of Physically Impaired Against Segregation (UPIAS) in Britain' (Traustadóttir 2009, 6). Such movements question the prejudices and discriminatory practices inflicted on individuals with disabilities that hinder their right to self-advocacy, independent living, and accessible housing. The variety in abilities of children and adults calls for non-discrimination in human rights frameworks by addressing conditions that create social inequality.

The comparable disadvantages that children face in the public space need to be conceptualized by small children themselves based on their experience of being hindered to identify the ways in which societies can make reasonable adjustments toward substantive age equality. Children labeled 'disabled' are the ones to be heard on how they define their abilities so that any perceived need for such labels derives from children's own experiences of discrimination and exclusion. The importance of 'an ethical research design that seeks to position the voice and experiences of disabled children at the center of the inquiry' is put forward in the *Palgrave Handbook of Disabled Children's Childhood Studies* (Runswick-Cole, Curran, and Liddiard 2018, xxiii). Building on the narratives of children with disabilities about their childhood and experiences furthers critical inquiry of how children with disability risk being maltreated, discriminated against, and made invisible through institutionalization.

In order to question and challenge adult bias, ableist normativity, and adult normativity, people who are assigned or denied abilities and character traits ought to be able to dispute or be part of reformulating these presumed categories and classifications through their own experiences. The right to voice one's abilities, rights, and needs in the first person—instead of through an adult and abled biased language—is important in opposing discriminatory discourses.

For administrative and allocative purposes?

Disability can, as noted, be seen as a social and cultural construction, referring to, as Branson and Miller suggest,

> [A] category that able-bodied people assume is embodied but that remains vague and undefined; a collection of people who are defined as disabled by others for administrative purposes such as housing, education and social services; and as a collection of people who identify as disabled by suffering the same marginalization and oppression.
>
> (Branson and Miller 2002, xiii)

Any set definition of what is regarded as a disability says something about the systems in place that conditions what kind of abilities should be assimilated, into what kind of norm and at what cost. Schools as a societal institution, for example, represent a public domain in which children with disabilities might face discrimination and marginalization in attaining their right to education in terms of access and quality. The norm in societal institutions sets conditions for 'normalcy' and the need for 'special education.' Pedagogical methods that facilitate communication and listening for all when integrated in the whole school organization, such as using sign languages and visual materials, transform 'special education' targeting a few to 'education for all' regardless of diverse abilities.

Fixating only on certain abilities which the majority is supposed to master—like oral speech and listening attentively by ear—disregards other abilities that both teachers and children could benefit learning from. Key examples are sign language and being attentive to senses other than hearing. Not all children find total silence the best environment for concentration. Not all children think best while sitting still. There might be unforeseen gains in placing education outdoors in the nature, for example, and by supporting collaborative curiosity among peers instead of the dominant focus on classroom education with individual instruction. The in-group diversity among children can become an opportunity for learning and creativity when classroom and school environments are refurbished and progressively designed.

> Western concepts of childhood have defined disabled children against child development 'norms' and have provided the rationale for segregated or 'special' welfare and education provisions.
>
> (Runswick-Cole, Curran, and Liddiard 2018, xxi)

Although contested, children are by the general adult community compared to 'normal' development stages and different curves, for example, for 'boys' and 'girls,' on what abilities adults expect at certain ages. Adulthood is defined as the ideal toward which children develop. Adults in western contexts are the ones who have defined a desirable 'norm' for children's development, a developmental curve, and intelligence curves from adult and abled biases about the 'ideal child' who follows a predicted age-development toward adulthood. Are we disregarding diverse knowledges in educational spaces when the pedagogical focus moves away from providing inspiring learning opportunities, and rather minimizes this kind of experience by demanding all children to learn and act in a certain way and by fitting children viewed as deviating from the norm into a structure that upholds the 'norm'? Behavioristic ideas in education serve such purposes, of estimating input and output from educational instructions that reinforce ideas about ideal child behavior and academic results.

5.2 Ableist normativity

Prejudice against children with disabilities—of regarding them as less able to communicate their feelings, needs, and rights—can lead to discriminatory practices of not letting children with disabilities being heard on issues that affect them, on the treatment and support needed, or on the relational distress connected to a diagnosis. Problem-formulations and solutions to these are thus in the hands of adult professionals, who, in ideal situations, act cooperatively with the child in focus and in prejudice-free ways toward children with disabilities. Professionals working with children with disabilities may have different perspectives to discern a child's best interests that may conflict. Due to intersectional invisibility leading to epistemic injustices, a child with disabilities risks not being listened to or being taken seriously in what they try to communicate. The focus here is on the non-ideal circumstances where prejudice and intersectional discrimination stemming from ableism and childism intersect, leading to a child's own narrative being overlooked or ignored by guardians or professionals causing epistemic injustice. Prejudice against children who are seen as deviating in different ways from the norm (deviations from androcentrism, heteronormativity, and adultcentrism) informs social judgments about children's capacity.

A descriptive language of a child's behavior and symptoms without listening to the child says less about its actual causes. Certain observable behavior may not re-appear in different environments or under different circumstances. Here, medical, social, relational, and socio-political explanation-models provide conflicting perspectives. Applying medical language to describe social and cognitive conditions according to a 'normal' development curve of socialization and learning assists professionals to determine the kind of treatment that could relieve the child with present challenges. The increase in diagnosis in childhood is a well-intentioned intervention in children's lives to help them 'function' and 'develop along their peers' but there are limits to the extent to which neuropsychiatric disorders can provide all-encompassing and enduring explanations for individual symptoms and behavioral patterns and the extent to which genetics and functions can be related to emotions, learning, and identity. The definition of a 'mental disorder' in psychiatric classifications during childhood is set by western normative ideas of what constitute the 'ideal child' with 'ideal functions' against those deemed to be 'unwanted.' With new ways of measuring the norm of ideal functions in children, it has become easier to label more children and youths through a medical perspective that classifies undesirable deviations from the norm of a perceived ideal. For example, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), in its fifth edition, introduced a definition of 'Global Development Delay,' a phenomenon which 'applies to individuals who are unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing' (American Psychiatric Association 2013, 41). The international focus on standardized and systemic assessments of pupils feed increased academic demands on children and additional measurements of the ideal and 'normal child.'

Robert E. Kendell, psychiatric expert on the classification of mental disorders, questions the certainty with which we can define disorders as failures of evolutionarily designed functions or as biological disadvantages (two of the criteria for disorders).

> Too little is known about the evolution of most of the higher cerebral functions whose malfunctioning presumably underlies most mental disorders; mood states such as anxiety and depression may have evolved as biologically adaptive responses to danger or loss rather than being failures of evolutionarily designed functions; and several important cognitive abilities, such as reading and calculating, have been acquired too recently to be plausibly regarded as natural functions designed by evolution.
>
> (Kendell 2002, 112)

'Dysfunctions' can, according to Kendell, in principle be defined without reference to either evolution or biological disadvantages. If these two biological criteria would be rejected, then 'a wide range of purely social disabilities' of 'uncooperative behavior' could be regarded as mental disorders (Kendell 2002, 112). If mental disorders cannot with certainty be regarded as biological disadvantages, the socio-political aspects of diagnosis play a large role in determining deviations from the norm and in delineating what is to be regarded as unwanted behavior warranting treatment.

If all children had the accessible right to support and resources for quality education in child-equitable environments, would they need to be pathologized for not being accommodative according to ableist and adult normativity? This question aims to stimulate discussions on adult neglect to invest in childhood and the possible effects of deprioritizing children's rights while asking of them to accommodate to adult norms and standards, not to question the existence of the categorizations of mental disorders.

The normative and value-judgment aspects of defining disorders become even more visible through socio-political criteria. By acknowledging how childism plays out in the medical psychiatric arena as well, critical discourse analysis of how adult power operates when children are understood as 'acting up' or 'acting out' and labeled 'unruly' and with 'disruptive behavior' may mirror ableist and childist prejudice and paternalistic behavior that children react against.

In problematizing socio-political approaches of classifying conditions in childhood, we may ask whether multiple normative assumptions overlap in how we understand mental disorders. These categorizations may be underpinned by adult biased ideas about children's development, heteronormativity, gender stereotyping, ableist normativity, and adult normativity. Ableist and adult normativity reflect dominant ideas about the ideal child, the ideal able-bodied individual who, for example, restrains from any impulses of energetic curiosity or frustration in situations where these are deemed 'inappropriate.'

The ideal individual in these respects may not actually exist, but the ideas associated with the ideal nevertheless hold individuals and especially children to a discriminatory standard. Anti-childist and anti-ableist lenses on classifications in childhood invite critical reflection on adult bias, a reflection that does not necessarily lead to interpreting such categorizations as discriminatory in themselves. Ableist and adult normativity nonetheless deprive society the aptitude to value heterogeneity. Behaviors, abilities, and characteristics that lie outside the norm drive innovation and development in society, but may also meet criteria in classifications of disorders in childhood.

Stigma can result from categorizations in our language use. If the term 'diverse abilities' were to be used instead of 'disabilities,' such a discursive shift could raise awareness that certain abilities are valued in society due to a perceived majority possessing them. On the other hand, the categorization of disability is connected to rights and thus a questioning altogether of such categorizations would derogate rights discourses around disability. Of interest here is how to strengthen the rights discourse related to disability while simultaneously countering ableist and adult normativity that lead to abilities possessed during childhood being devalued.

Oralism and 'language impairment'

From a medical and individual perspective on disability, the child with 'hearing disability' may be expected to get an implant to improve hearing. From a social perspective, the child has a right to pedagogical and communication support through the use of sign language in school. But, as long as the 'norm' is the hearing pupil, children with 'hearing disabilities' and children labeled as having 'language impairment' will be treated through a clinical gaze of how to assimilate a child into the norm and not through social models calling for a pedagogical gaze on how to offer new learning opportunities (Branson and Miller 2002, 205). What alternative forms of communication and instruction are needed in classrooms to accommodate diversity?

'Deafness as disability' serves as an example of how deviations from a perceived norm become socially constructed into a problem to be fixed on an individual level. The not-hearing child becomes the carrier of a socially constructed problem which would not exist if multilingual learning environments were encouraged instead of monolingual school environments (Adami and Adams Lyngbäck 2024). A person perceived as disabled is judged against perceived 'desirable abilities,' but hearing impairment, for example, requires the development of other abilities. The abilities to read lips and to use sign language are skills that individuals with 'normal' hearing ability generally lack and are thus not acquired by a majority. Communicating through sign language is an ability that would enable infants to communicate earlier and create more peaceful social environments—for example, in school—if individuals have the ability to switch between sign language and other ways of communicating than only through the dominant use of oralism.

When oralism is the dominant form of communication, this jeopardizes concentration by creating loud and noisy environments for large groups of children 'trapped' in classrooms throughout their school years. Conversely, if all adults and children mastered sign language, the additional effect apart from diminishing discriminatory practices would be that of children who could help each other more during lessons by communicating across the room without disturbing others. To use your body more in articulating difficulties and being able to receive help from peers without having to wait to be recognized by the one teacher would benefit those who today are not attended to properly due to lack of time available for adults in assisting each and every child.

Ableist attitudes that discriminate against people who do not master oralism will continue being felt by children who are labeled in school with 'language impairment' as long as these prejudiced attitudes based on ideas about 'normality' are not called out and contested (Hall, Hall, and Caselli 2019; Paul and Adams Lyngbäck 2022). In a signing community, on the contrary, a person who does not master oral communication is not disabled but the non-signing individual will be. Signing parents and educators have important insights to share with adults who master only oral communication skills on the improved relational possibilities gained through more diverse interactions with infants and children with perceived 'language impairment.'

What could be the additional social values of learning sign language from an early age? Parents who use sign language with their baby infants are able to communicate and receive responses earlier than through using oral language only, since babies can respond to gestures within their first months. It seems that communication between adults, babies, and infants improves radically and earlier on through sign language. This is partly because usage of the eight muscles of the tongue, crucial in oral language, is a very complicated set of coordinated muscles to master (Snyder Shall 2013).

Babies and infants are singled out in daily ableist-infused childist discourse for their 'lack of communication skills.' What has been recognized, however, is that newborns use different cries depending on their need, coupled with facial expressions (Sandru et al. 2015). Since they communicate with different sounds to make adults attentive early on to their need, it is possible to decipher what babies try to communicate.

Improved communication with newborns requires from adults to question dominant prejudice about babies: That they would lack intention and meaning behind early signs of discomfort. With the help of a mobile phone application, Sandru et al. (2015) have collected in hospitals databases seven times bigger than the initial classification of five signals by Priscilla Dunstan with baby cries that classify their signals in relation to basic needs. Parents' experiences of frustration in not being able to communicate with their babies are seldom problematized on the adults' part as poor understanding of babies' communication skills in deciphering different sounds. Do caregivers face infants in communication by giving proper attention to non-verbal interactions? There might be several adult biased reasons for adult negligence of research on this topic, as there might be several overlapping abled biased reasons for the general lack among adults who master oralism to also learn signing communication skills.

An adult negligence to master attentive listening is motivated by childist discourses about the natural inferiority and irrationality of children. A child is dependent on adult care during infant years for survival, and a lack of communication between adult and child will constitute primarily a suffering on the child's part in not having basic emotional and physical needs met.

5.3 Cultural, social, and political aspects of 'normativity'

If 'disability' and 'neurodevelopmental disorders' among children may be stained by adult biased descriptions of physical, cognitive, social, and behavioral deviations from the 'norm,' then what is perceived as a problem in children to be cured and assimilated risk being marked by ableism and childism. Through anti-childist and anti-ableist lenses, however, current definitions of 'disability' and classifications of 'neurodevelopmental disorders' among children would instead pose needed critical questions about 'ableness' and 'normativity.'

> Rather than viewing disability as an individual problem, disability studies focus attention on the social, cultural, economic and political aspects of disability, examines how environmental barriers, social attitudes and cultural images create and re-create disability.
>
> (Traustadóttir 2009, 5)

Behavior patterns deviating from the norm risk being classified as social problems in highly structural and formal environments. Adultism demands of children not to disturb the adult order, by, for example, sitting still, being quiet, and not to interrupt when an adult speaks in a traditional formal setting. 'Disruptive' or 'unruly' behavior in response to adultism can be labeled as 'defiant' characteristics, a key element listed in the so-called Oppositional defiant disorder (ODD) or Pathological/Extreme Demand Avoidance (PDA/EDA); this 'uncooperative' behavior can be in a manner of openly 'oppositional' or 'extreme shyness or passivity.'

How would psychiatric professionals judge children's cognitive, mental, and emotional development if research on internalized childist prejudice, on 'normal' reactions to adultism, and on emotional and cognitive reactions to age-related violence against children had a more central role in the knowledge acquired by adults working with children?

What are the ways in which perceived abilities and mental health are built on prejudicial beliefs about children and how does childism thus affect the life quality of children perceived as deviating from the norm? A change in attitudes when it comes to the stigma of mental healthcare is important, as is repositioning the problematizing focus from the characteristics of the individual child. Critical inquiry into children's rights through anti-childist lenses would shift the focus away from trying to cure the observable effects of childism and adultism toward the need to start describing the characteristics of prejudiced damaging environments that limit children's rights and freedoms that are in need of change.

Classifications and epistemic harm of children

> Hyperkinetic children are often reckless and impulsive, prone to accidents, and find themselves in disciplinary trouble because of unthinking breaches of rules rather than deliberate defiance. Their relationships with adults are often socially disinhibited, with a lack of normal caution and reserve.
>
> (World Health Organization 2016, F90)

Diagnosing adults with hyperkinetic behavior or pointing to their defiant behavior as a disorder is not the usual praxis among psychiatrics and the above criteria from the *International Classification of Disorders* (*ICD*)-*10* manual of the World Health Organization address this behavior solely in children. How do children feel about these descriptions? Nancy Vansielegheim conducted in 2012 'philosophical conversations with children diagnosed as children with behavioral disorders' (2014, 209). 'The ambition was to shed light on what a young person with a behavioral disorder says and how this relates to what is said *about* youngsters with behavioral disorders' (Vansieleghem 2014, 209). The study was carried out in light of a research project by the Flemish Children's Right Commission that had observed an increase in medicalization of 'disturbing behavior' of children. 'The Commission refers to the recent upward trend in the use of psychotropic drugs by children and young people. Between 2005 and 2008, the use of Ritalin has increased from 1.7 to 4.2 million [in Belgium]' (2014, 209). According to the Commission, this trend was not only observable in Belgium. Surrounding countries, too, displayed an increasing use of psychopharmacology (2014, 209). The children participating in the study spoke of how the diagnosis placed on them became a part of their identity, influencing how they viewed themselves, their perceived possibilities in life, and who they fundamentally were. The children mentioned the skepticism they felt toward the pills they were told to take; a boy said he felt like a half-zombie, although the pills helped his concentration (2014, 218). The conversations with the children seemed to exhibit a discouraging insight into how children with ADHD in the study thought adults perceived them: Ultimately as a problem to be cured, fixed, or removed. Their experiences of alternative school facilities for children with disabilities included a sense of having lower expectations, being less motivated, and feeling superfluous and excluded from the norm.

Being diagnosed with an identity disorder, a mental disorder, or a neuropsychiatric disorder labeled and regarded by many adults in her, his, or their environment as dysfunctional can cause the child epistemic harm.

> Epistemic injustice is a harm done to a person in her capacity as an epistemic subject (a knower, a reasoner, a questioner) by undermining her capacity to engage in epistemic practices such as giving knowledge to other (testify) or making sense of one's experiences (interpreting).
> (Crichton, Carel, and Kidd 2017)

Children who are diagnosed will suffer epistemic harm from the fact that they will be seen as less trustworthy by adults as long as ableist prejudice in society persists. This can lead to discrimination against children with perceived mental disabilities, compromising children's rights to be heard and in instances where the child has to testify in court. Being perceived as mentally disabled intensifies the already devaluing ableist and childist discourses about children's ability to give credible testimonies. The power relation between adult and child, by which adults are assigned the role of expert, will be further cemented for children who are diagnosed. Their knowledge and right to autonomy, and their perceived ability to make individual decisions, will be further diminished by discourses upholding childism and ableism.

Whether one perceives disability from purely medical or social perspectives, the crucial point from a rights-based outlook is whether the person—and not their environment—is primarily made into a problem to be cured, or hidden away.

Being the carrier of a perceived disability or disorder becomes for the individual child an epistemic injustice due in part to strange, hostile, degrading, and childist ways in which people who uphold the norm interact and relate to people viewed as deviating from it.

During a university course I taught on special needs education and children's social relations, several teacher students initially asserted that they could not teach children with special needs. The main reason given was that their role as teachers was not to make adjustments for children's needs in classrooms, but instead to focus on the knowledge content of the instructions. Can we approach the teaching profession in relation to a 'normal' classroom filled with 'normal' pupils, who will attentively follow the teacher's lesson regardless of the pedagogical premises given by the conditions of that environment, the quality of communication, or chosen method of instruction? There seemed, additionally, to be a conflation of ideas stained by prejudice among the teacher students on the relation between intelligence and mental 'disorders': That some children are unable to learn, or 'un-teachable.' Ableist prejudices against diagnosed children could lead to epistemic injustice whereby they are not seen as sources of knowledge, as believable speakers, or as true testifiers when situations escalate to conflicts in school. Ableist prejudice about intellectual capacity against children with special needs could rather easily be redeemed. A simple search for individual public figures with different diagnoses on the internet will indicate that some of the most genius leaders and innovators have in different ways deviated from a perceived norm. The necessity to place a diagnosis on children with seeming learning or concentration difficulties can as well be perceived as a default in society, in how schools are structured, and how diversity is not celebrated. Conflating ideas of intelligence with ideas of what a diagnosis refers to endangers marginalizing children with different 'disorders' as less intelligent. A child who is fidgeting during a lesson may be regarded as having difficulty concentrating, but the cause for this could be different things, ranging from tiredness, physical need to move, emotional and mental stress, or under-stimulation and boredom.

From an anti-childist lens that seeks to upset adultism, let us ask the following: Who are the children in one's close environment that could be medicated for reacting to and defying gendered and age-related roles assigned to them by adults? In a patriarchal system that often disregards children's rights in their striving toward autonomy, who are the children medicated for symptoms that can also be traced to causes of violence and abuse, especially if professionals lack training in how violence, abuse, and neglect affect the emotional, cognitive, and psychological development of children as well as their behavior and interactive social patterns? 'Acting out' can be a reaction.

The Committee on the Rights of the Child (UN CRC) in its general comment on the right of the child to freedom from all forms of violence stresses the need for children with aggressive behavior to receive adequate support.

> Children who are aggressive towards other children have often been deprived of a caring family and community environment. They must be regarded as victims of their child-rearing conditions, which imbue them with frustration, hatred and aggression. Educational measures must have priority and be directed to improve their pro-social attitude, competencies and behaviors. Simultaneously, the life conditions of these children must be examined in order to promote their care and support and that of other children in the family and neighborhood.[2]

5.4 Power and voice in classifications during childhood

Psychiatric classifications of mental disorders provide a medical language to the advancement of treatments. A person seeking a psychiatric description of a 'mental disorder' may do so for several reasons. A psychiatric description of a mental disorder helps to define and name the characteristics of particular challenges or behavior patterns connected to distress thus creating a conceptual scheme for understanding these challenges. A mental disorder additionally serves to illustrate that one is not alone in experiencing a certain type of distress related to cognitive, emotional, and behavioral patterns. As medical problems can be treated and sometimes even cured, being classified with a mental disorder may inspire hope for improvement, as well as opening up the possibility for individuals to seek adequate support, resources, and medication to relieve the current condition (Smith and Whooley 2015, 40).

Psychiatric classifications of mental disorders in childhood, however, beg questions of power: For example, who has the voice to determine the value of such classifications? Can we assume that it is the child who is suffering when adults are the ones seeking a psychiatric description for a child's 'behavioral challenges'? Are children informed of the social advantages and disadvantages of being diagnosed, are they included in formulating their needs in the current environment, and do they have a right to dissent to treatment and medication? Might there be discriminatory consequences for a child in being labeled with a mental disorder during early childhood, unforeseen by diagnosing-seeking adults?

Negative consequences for children being diagnosed with a mental disorder derive partly from prejudices that lead to discrimination in education and later in the workplace. The differences in meaning between mental disorders, mental disease, and mental illness have been largely debated since the 1990s in relation to whether these terms are 'scientific or biomedical terms, or whether they are socio-political terms that necessarily involve a value judgement' (Kendell 2002, 111). The common feature is that each of these terms refers to some kind of individual distress and to patterns of unwanted, undesirable social behavior, which are viewed as amenable to alteration through treatment (Kendell 2002). A critical child rights perspective on the classification, diagnosis, and medical treatment of perceived disabilities is not to argue for a specific attitude or manner toward mental disabilities but to invite reflection on those instances when the intersections of prejudice against certain children may lead to discrimination.

A neurodevelopmental disorder placed, for example, in early childhood can be re-evaluated later in teenage years. Mental classifications describe symptoms but, depending on its cause, do not need to be chronic. A descriptive explanation of a child's behavior depends also on the interpretive lens through which the person making the diagnostic judgment observes it. The formulation and updating of classification criteria in the fifth edition of the *DSM* involved hundreds of people working for a period of 12 years. The American Psychiatric Association states in the fifth edition that 'mental disorders are defined in relation to cultural, social and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs and behaviors that are criteria for diagnosis' (American Psychiatric Association 2013, 14). The word 'symptoms' may be misleading in these classifications, as in medicine, 'symptoms' are results of an underlying disease but in 'mental disorders,' these are descriptions to uncertain underlying causes that may be social, cultural, political, relational, emotional, and biological.

The *DSM* is structured according to 'developmental and lifespan consideration' (American Psychiatric Association 2013, 13). It begins with classifications thought to reflect developmental processes that manifest early in life (e.g., neurodevelopmental and schizophrenia spectrum and other psychotic disorders), followed by classifications of mental disorders that more commonly manifest in adolescence and young adulthood (e.g., bipolar, depressive, and anxiety disorders), and ends with classifications relevant to adulthood and old age (e.g., neurocognitive disorders) (American Psychiatric Association 2013, 13). Disorders relating to elderly people in the manual refer mainly to the loss of cognitive functions associated with ageing.

Each disorder in the *DSM* is described alongside the condition's typical symptoms and the age in which the disorder is generally noticed. For instance, schizophrenia is stated to be recognized in children, as well as in women over 40 or in married women. Another disorder deemed to only concern women is 'hair-pulling disorder,' which also 'may be seen in infants' (American Psychiatric Association 2013 DSM-5 312.39 (F63.2)). Some disorders are said to 'only be diagnosable in childhood' and beg the critical question of whether the behaviors listed as unwanted could be symptomatic of broader discriminatory or oppressive structures in childhood. 'Disruptive Mood Dysregulation Disorder' exemplifies such a case, listing 'temper outbursts' noticed in individuals aged 7–18 years (American Psychiatric Association 2013, 157). Selective mutism is another disorder that only mentions childhood behavior in its description: 'When encountering other individuals in social interactions, children with selective mutism do not initiate speech or reciprocally respond when spoken to by others. Lack of speech occurs in social interactions with children or adults' (American Psychiatric Association 2013, 195). Selective mutism can, for example, mean that the child speaks only with peers and not with adults, or only with selected trusted adults. Wetting the bed can be diagnosed in children as part of 'elimination disorders.' Such disorders refer to when children void bodily substances at 'inappropriate times' and in 'inappropriate places.' Might there be an adult bias in the listing of the unwanted behaviors associated with this label? Again, if we take into account the social, cultural, economic, and political aspects of childhood, then we might identify underlying environmental barriers, social attitudes, and cultural images of the ideal child that serve as norm to any deviation. Social anxiety, selective mutism, and 'dysregulation' of mood could also at times be symptomatic responses to childist attitudes and misopedic sentiments directed toward children and their emotional, physical, and psychological needs, whereas wetting the bed can in other instances be a normal reaction to stress caused by internalized childist and ableist prejudice or to pressure of living up to adultist norms related to school and other activities or, in worst cases, by fear of adult repression, humiliation, and violence. Again, this is not to say that one should reduce the range of explanations for behavior to symptoms resulting from childism and adultism; the questions rather beg reflection on whether there might be other causes for distress a child might feel that could be connected to prejudice, negative attitudes, adultist and ableist normativity, and expectations on children based on adult norms, behaviors that do not fit into explanations deriving such symptoms to individual development and biology.

Due to children's weak social position in society, it becomes even more urgent to ask questions of whether a child's distress stems from social and structural disadvantage rather than from biological deficiencies. It is rather convenient to place a problem connected to more complex questions of social injustice with individual children and their unwanted behavior. Without posing critical questions and only searching for answers through medical perspectives, the individual child risks becoming the carrier of political, economic, and social problems caused by systemic childism, systemic racism, ableism, and sexism. When mapping individual deficiencies to be treated, we focus on symptoms. A social relational perspective by contrast requires as well inquiries into adult–child relational power and oppression as children may suffer from unexamined subtler to explicit forms of epistemic violence and intersectional discrimination that seldom are taken into consideration when a child is the sole carrier of distress. The most extreme of such cases that also involve physical violence and oppression are to be found in Munchausen syndrome by proxy where a parent is abusing the child but claiming the child to be the carrier of sickness (Makar and Squier 1990).

Dealing with conflicting and incomplete data

When the World Health Organization worked together with the American Psychiatric Association to harmonize the *ICD* with the *DSM*, they faced the complexity of 'where to place a disorder in the face of incomplete—or, more often, conflicting—data' (American Psychiatric Association 2013, 11).

> Thus, for example, on the basis of patterns of symptoms, comorbidity and shared risk factors, attention-deficit/hyperactivity disorder (ADHD) was placed with neurodevelopmental disorders, but the same data also supported strong arguments to place ADHD within disruptive, impulse-control and conduct disorders.
>
> (American Psychiatric Association 2013, 11)

The UN CRC has noted with concern '[t]he significant increase in the number of children diagnosed with so-called learning or behavioral disorders, in particular Attention Deficit/Hyperactivity Disorder (ADHD)' in its fifth periodic report of Sweden.[3] Placing ADHD with neurodevelopmental disorders is from a medical perspective to classify it as neurological and as relating to developmental deviations. The work groups recognize that 'the simple and linear organization that best supports clinical practice may not fully capture the complexity and heterogeneity of mental disorders' (American Psychiatric Association 2013, 11–12). Diagnoses are narrow categorizations primarily of observable behavior, and it has been acknowledged that one diagnosis is not always enough to describe an individual's condition. Comorbidity is a term that psychiatrists use to describe how several diagnoses follow from one original one (there are additionally disorders that may follow from medicating an original one, called substance use disorders).

As mental disorders focus on the symptoms that an individual exhibits, and as the cause of such symptoms can be difficult to establish, what is at least known is that the symptoms exhibited impact brain function, emotion, and mood. The causes that have generated such symptoms, from a medical perspective, include injury, infections, medication side effects, genetics, and cerebral dysfunctions. On the other hand, the causes identified using a social and relational model include the social environment, relational interactions, and social events that lead to stress. A child's sense of loss of control would, from a focus on intersectional bias and discrimination against children, be connected to different forms of structural discrimination stemming from negative prejudice against specific groups of people, from unequal distribution of resources that negatively impacts individuals' life conditions, as well as from a lack of legislation and political will to end widespread human rights violations against children, especially against children with intersectional identities.

Whether the original cause of mental disorders lies in the social environment, in the societal structure, or in the cerebral functions, what is known is that behavioral and emotional patterns, in themselves, can impact the brain function. One mental disorder that includes a mentioning of an external cause for its symptoms is in the category of stress disorders. The term post-traumatic stress disorder (PTSD) first appeared in the 1980, in the third edition of the *DSM* (Crocq and Crocq 2000, 47). It was primarily associated with the horrors witnessed by veterans of the Vietnam War. Marc-Antoine Crocq and Louis Crocq discuss the history of psychotramautology stating that 'It is noteworthy that the symptoms [of PTSD] are not caused by a physical wound, but by fright and the vision of a killed comrade and that they persist over the years' (2000, 48). In the British military during the First World War, 'patients presenting with various mental disorders resulting from combat stress were originally diagnosed as cases of shell shock' (2000, 50). Soldiers who suffered symptoms of 'tremor, paralysis, contractions, limping, or fixed postures' (2000, 50) were treated with electric shock therapy at the front lines, which after the war was criticized as cruel. Soldiers who claimed to suffer from war-neurosis were accused of trying to escape service on the front line. Almost a quarter of the soldiers sent 'to Vietnam from 1964 to 1973—required some form of psychological help' (2000, 53). 'This post-Vietnam syndrome, increasingly diagnosed in veterans in the seventies, ultimately led to the adoption of PTSD as a diagnostic category in 1980 in DSM-III' (2000, 53). PTSD as used today does not only refer to trauma caused by war. Rather, in the fifth edition of the *DSM*, it is stated that a person suffering from PTSD should have 'experienced, witnessed, or been confronted with' trauma of any source (American Psychiatric Association 2013, 61).

The use of 'disorder' to name humans' mental and emotional reactions to traumatic experiences has been criticized by the US military, believing the word 'disorder' makes many soldiers experiencing PTSD symptoms reluctant to ask for help (Smith and Whooley 2015). The military urges the American Psychiatric Association to rename it to post-traumatic stress injury, argued to be more in line with the language of troops and to reduce stigma. Smith and Whooley argue that '[C]onceiving of war trauma as mental illness is wrong because the behaviors that manifest themselves as PTSD are actually normal reactions to abnormal circumstances' (2015, 42).

Likewise, one could argue that in children, perceiving of trauma from abuse and violence as a mental illness is wrong, because the behaviors that manifest themselves as PTSD are actually normal reactions to abnormal circumstances.

Is waking up every morning in a home where violence and abuse are dreaded realities supposed to be 'normal' for children, because physical punishment of children is not legislated against in most countries? As Smith and Whooley observe in their examination of soldiers' symptoms, 'PSTD pathologizes individuals instead of pathologizing the true toxin, war itself' (2015, 42).

Symptoms of a disorder say nothing about the cause—diagnosed children are symptom carriers—and unwanted behavior in children can at times be a normal human reaction to environments that are problematic. With PTSD, the cause that has led to the cognitive, mood, and behavioral symptoms—having experienced trauma—is part of the diagnosis. With other mental disorders, the list of symptoms (cognitive, mood, and behavioral) tells professionals about the mental health state of the child but nothing about what caused the child to feel, think, and behave in a manner that fits the description of symptoms according to the diagnosis criteria.

'Disorder' as a term suggests with PTSD that post-traumatic stress is chronic. The military instead suggested 'injury' as a term referring back to the damaging environment in which soldiers are injured, both physical and mentally, stating that new terms would alter perspectives. In order not to stigmatize soldiers for their reactions to the traumatic experiences of war, it was posited as important to view post-traumatic stress as something that people can actually heal from, not suffer from chronically (2015, 42).

This line of reasoning from the military is interesting, in several aspects, when addressing adult power and age-related violence against children. If we suppose that children react to external circumstances and environments in different ways—some of which are labeled as 'disorders'—social environments in themselves may be causing certain unwanted behavior. Hence, societal responsibility for widespread mental illness among children requires its causes to be addressed and altered (2015, 43).

Certain ways of responding to or dealing with individual pain, loss of control, and fear are deemed from a social viewpoint to be destructive and in need of labeling. These include anorexia, self-harm, pulling one's hair, wetting the bed, medicating oneself with drugs or alcohol, screaming, or being mute. They are nevertheless ways that may momentarily relieve pain, loss of control, or fear. Finding constructive ways of dealing with pain, loss of control, and fear may be difficult for adults and children alike, although adults have more options and access to constructive ways of grappling with mental and emotional pain. In comparison to children, adults may have greater economic means, the ability to independently contact therapists, a personal integrity and safe space which cannot be overstepped by guardians, and access to self-help literature and individual choices of alternative treatments and care at their disposal.

With PTSD, professionals identify people who cannot cope with trauma and try to help them. Can we discern here a limitation in that the term 'disorder' obscures a broader search for answers to what causes such mental illness in a world ridden by war, violence, and abuse and different forms of oppression that also psychologically harm children? The systemic issue that must be confronted here from a critical child rights perspective is the need for collective mobilization to avert trauma from happening in the first place.

PTSD was removed from the anxiety disorders category as considerable research has demonstrated that the 'disorder' entails multiple emotions (e.g., guilt, shame, and anger) outside of the fear/anxiety spectrum. Symptoms of PTSD include difficulty concentrating, irritability, increased temper or anger, tiredness or exhaustion, hypervigilance, and being easily startled.

If we look at the symptoms of ADHD along with those of post-traumatic stress syndrome and depression in children, we see how the list of criteria for these three diagnoses overlaps. Symptoms of depression in children are listed as irritability or anger, continuous feelings of sadness and hopelessness, social withdrawal, increased sensitivity to rejection, excessive eating or rejection of food, being very sleepy or unable to sleep, vocal outbursts or crying, difficulty concentrating, fatigue and low energy, physical complaints (stomach-aches, headaches) that don't respond to treatment, low ability to function during activities in school, feelings of worthlessness or guilt, impaired thinking or concentration, and thoughts of death or suicide. Next, the behavioral symptoms of ADHD consist of aggression, fidgeting, hyperactivity, impulsivity, irritability, and lack of restraint. Its cognitive symptoms include absent-mindedness, forgetfulness, and problems paying attention and to focus. As for mood-related symptoms, ADHD is typified by an increased incidence of anger, anxiety, boredom, and mood swings. Other common symptoms for ADHD are depression or learning disabilities. ADHD, as a result, was argued to fit in the developmental disorders category as well as the disruptive behavior disorder category. With overlapping list of symptoms for PTSD, ADHD, and depression among children, judgments of professionals bare a heavy ethical weight. Increased understanding among adults working with children of how they react to repressive environments can add additional layer to identifying the symptoms not only to provide treatment but for examining the social, economic, and relational aspects of causes for 'unwanted behavior' in childhood that could be altered as well.

Problems arising from discrimination?

From anti-childist and anti-ableist lenses, it would become important to critically study possible prejudices and political dimensions of certain labels and classifications instead of pathologizing a condition as abnormal and in need for treatment. One criterion in determining whether a psychological characteristic warrants diagnosing according to the American Psychiatric Association is the extent to which the characteristic poses a problem to the person with the disability. The social, cultural, or political reason to *why* a person may experience a condition as a problem is, however, not problematized from a purely medical model of 'disability.' 'Normalcy' is a political question of power.

By looking at the recent history of labeling 'mental disorders,' we can see how in certain instances the medical perspective helps discern broader patterns of social illness where prejudiced attitudes and discriminatory structures in society have been in need of adjustment toward more justice-oriented approaches to diversity. When such broader discriminatory practices and prejudice in society have been challenged politically and legislative measures changed, earlier medical labels have lost their validity (such as 'female hysteria'). An apparent example of this shift is when homosexuality was removed from the second edition of the *DSM* in 1973. The decision to delete homosexuality from the DSM was met with criticism by psychiatrists that used to pathologize homosexuality (Drescher 2015, 565). 'Homosexuality' as warranting treatment was replaced in the *DSM* by the new diagnosis of Sexual Orientation Disturbance, an 'illness if an individual with same-sex attractions found them distressing and wanted to change' (2015, 571). This was later replaced once again in *DSM-III* by the category Ego Dystonic Homosexuality. Neither of these diagnoses were long-lived, as different psychiatrists then asserted that identities deviating from heteronormativity cannot all be considered psychiatric disorders (2015, 571).

> [D]ebates about homosexuality gradually shifted away from medicine and psychiatry and into the moral and political realms as religious, governmental, military, media and educational institutions were deprived of medical or scientific rationalization for discrimination.
>
> (Drescher 2015, 571–72)

The socio-political aspects of these kinds of shifts reflect the ways in which societal prejudice and discrimination, when not faced on a more structural level, place on individuals the emotional and psychological burden of being treated unjust. In the fifth edition of *DSM*, Gender Dysphoria is regarded as a mental disorder characterized by 'a marked incongruence between one's experienced/expressed gender and assigned gender' (American Psychiatric Association 2013, 452). The criteria include a strong desire to be of the other gender and a strong preference for cross-dressing.

Sex and gender are assigned at birth or during pregnancy from the inspection of the genitalia of the baby generally without the expectation of ambiguity. This assigned gender may later be contested by a self-identified gender by the child. The criteria for Gender Dysphoria focus on characteristics noticeable in childhood, like the type of play engaged in by younger children. The discrepancy between the assigned and expressed gender is the 'core component of the diagnosis' (American Psychiatric Association 2013, 453). Gender Identity Disorder of Childhood is also listed by the World Health Organization in its latest manual *ICD-10* as 'a disorder, usually first manifest during early childhood (and always well before puberty), characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex' (World Health Organization 2016, F64.2).

The World Health Organization has an equivalent manual to the *DSM* that lists the criteria for both physical and mental disorders, the latest version being *ICD-10*. This is the manual most frequently used in Europe.

Evidently, from medical perspectives, the social, environment, and parental expectations and traditional values in society are not addressed as factors contributing to the generation of gender-related distress in childhood. Rather, the manuals point to mere identification with a gender other than the assigned one. *ICD-10* further strengthens the idea of a 'normal' gender identity by stating that 'the diagnosis requires a profound disturbance of the normal gender identity; mere tomboyishness in girls or girlish behavior in boys is not sufficient' (World Health Organization 2016, F64.2).

Individuals are assigned gender identities with reference to biological differences, which is a social custom, and not 'naturally' given. The description today of Gender Dysphoria in the *DSM-VI* and of Gender Identity Disorder of Childhood in *ICD-10* as mental disorders in need of treatment illustrates the narrowness of the heteronormative and binary gendered categories into which children are assigned. The freedom to choose one's preferred gendered or sexual identity is a human right. When labeling individuals who deviate from a social norm as suffering from mental disorders, do we—as in the mentioned instances—risk placing the discriminatory political, legal, and social frameworks that cause distress in the background while foregrounding the problem as an individual one?

Summary: Childism and ableism intersecting

By exploring interlocking systems of oppression, as ableism and childism, we can gain increased understanding of the prejudiced ideas held about children and their capability, for example, important insights needed into how children suffer from being continuously compared to a perceived 'ideal child' and 'normal' developmental stages, to an adult and abled-standard of perceived 'normality' and how children's rights may not be met in school, at social services, or at hospitals. Critical disability studies concerning children's rights provide a rich source for further entanglements to be studied between childism, ableism, and the rights of the child (see further Ashley Stein 2016; Degener 2016; Mackelprang and Salsgiver 2016; Rieser 2000a, 2000b; Cole 2006).

Ableism and childism are sustained due to ableist normativity and adult normativity by which dominant norms are connected to perceived abled-bodied individuals and adults from which 'disabled' and 'children' deviate. Adult ignorance, however, blinds adults and professionals to the destructive and oppressive ways that keep children, and especially children with disabilities, in subordination and there is a risk that real efforts to address discriminatory structures of ableism and childism are lacking.

Through intersectional lenses on sexism and childism when exploring mental health issues among children, what could be the causes for the high prevalence of 'hair-pulling disorder' in childhood as observed in the *DSM* along gendered lines? 'Female hysteria' was once a mental diagnosis in western Europe, considered to be both common and chronic among women. Nowadays, we might instead problematize the limiting gender roles that were assigned to women in the 1800s and find it understandable that women would repeatedly suffer from mental breakdowns when historically lacking legal protection against abuse, assault, discrimination, harassment, and other physical, emotional, and psychological violations. By exploring such connections to outdated diagnoses for which suffering has now become explained in more political terms, we may discern how the effects of racism, sexism, ableism, and childism cause epistemic injustice that could be addressed in other ways than only labeled as individual problems. The arguments in this chapter aim to invite critical reflection over ableist and childist prejudiced practice, not to provide simplified answers or solutions.

Given the amount of space taken up in the *DSM-V* by the list of mental disorders in childhood, can this be partly traced to ableism and childism and related to heteronormativity and the negative, degrading, and discriminatory effects that the intersections of these discriminatory systems have on children with intersectional identities? If subjective and normative elements that define disorders are scrutinized through norm-critical anti-ableist and anti-childist perspectives, political and legal dimensions of discrimination may counter prejudicated beliefs of 'normalcy.'

Notes

1 *Disableism* is the more common term in the United Kingdom.

2 UN CRC, *General comment No.13 (2011): The right of the child to freedom from all forms of violence*, 18 April 2011, CRC/C/GC/13, p.20.

3 UN CRC, "Concluding observations on the fifth periodic report of Sweden," CRC/C/SWE/CO/5, p.10.

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