

Ableism, Disability, and Systemic Injustice in the Lives of Runaway Youth and Youth
Considering Running Away

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ABSTRACT:

It is well documented that marginalized youth, including Black and Brown youth and LGBTQ+ youth, experience much higher incidence of homelessness and running away. National studies frequently discuss the roles of systemic racism and heterosexism in influencing family resources and dynamics. However, in these discussions about systems of oppression and their relationship to runaway incidence and youth homelessness, there is rarely, if ever, mention of the words “disability” and “ableism.” This research, then, seeks to address that gap. Using 150 posts from the National Runaway Safeline’s public crisis forums, I analyze young people’s experiences with disability and ableism as they consider running away or do run away from home. My findings indicate the pervasive nature of ableism and disability in the lives of runaway youth and youth considering running away from home despite the lack of attention to ableism and disability in national data.

Keywords: disability, youth homelessness, ableism, abuse, runaway youth

INTRODUCTION

When I was eighteen years old, I ran away from home and subsequently became homeless. Disability, undiagnosed physical illness, mental health struggles, forced treatment, and repeated encounters with sexual abuse in numerous settings played roles in my eventual decision to flee from home. As an older teenager, I had brief interactions with the criminal justice and child welfare systems. None of these systems helped me, all of them created harm, and the stigmatized nature of the disability diagnoses given to me by the mental health system had lasting effects on how other systems responded to my disclosures of surviving violence. In the midst of these experiences, the National Runaway Safeline, a crisis line for youth experiencing homelessness or at risk of homelessness, helped me navigate to temporary shelter while system failures left me otherwise on my own.

Four years after my homelessness experience, I now work in the youth services sector as a consultant for several organizations working to prevent and end youth homelessness. Despite the knowledge that disability and ableism played key roles in the abuse I experienced within various systems and at home, I observed a lack of engagement with ableism in spaces surrounding youth housing justice. Simultaneously, as I joined youth advisory boards and Facebook groups made up of youth like myself with lived experience of homelessness, I realized many of my peers also struggled with mental and physical health challenges or disabilities. My peers talked about being abandoned at hospitals, denied medical care, and forced into abusive residential or psychiatric treatment. As a result, I learned through lived experience and personal connections that disability and ableism have significant impacts on the lives of runaway and homeless youth.

This research, then, builds upon this personal and anecdotal knowledge. In what follows, I engage in a sociological analysis of how ableism and disability impact youth who have made anonymous posts on the National Runaway Safeline’s public crisis forums. I first give an overview of the lack of engagement with disability and ableism in research surrounding youth homelessness. I then define ableism and disability and discuss critical disability studies as a theoretical framework to aid my analysis. Finally, I engage in a content analysis of 150 posts on the National Runaway Safeline forums. I pay close attention to how ableism impacts runaway youth, identifying three key themes that emerge in the lives of runaway youth and youth considering running away¹ from home. These themes are forced treatment and the threat of forced treatment, how disabled identity is targeted, and how disabled identity is neglected, ignored or minimized. My analysis is informed by my own lived experience as a person with a disability who ran away from home and became homeless as a teenager. Contrary to the belief that research that is personal is invalid because it cannot be “objective,” I draw on feminist methodologies that emphasize the importance of naming both the value and inherent biases in any personal standpoint. As a result, while I apply sociological methods to my analysis, my personal experiences also provide me key insight into my understanding of the stories on these forums.

YOUTH HOMELESSNESS AND DISABILITY

In the United States, 1 in 10 young people between the ages of 18-25 and 1 in 30 young people between the ages of 13-17 experience homelessness throughout the year (Morton et al., 2017). These youth and young adults are without parents or guardians, stable access to shelter,

¹ “At risk youth” is generally the term used to describe youth considering running away. I make a deliberate effort to step away from this terminology as it further pathologizes youth in unsafe situations by making the “risk” seem inherent to the youth, not their situation.

food, transportation, and healthcare. They are often without critical documents such as social security cards, insurance information, birth certificates, or state IDs. Many young people experience homelessness because they are fleeing family conflict, are rejected by their family because of their gender or sexual identity, are struggling with poverty and financial precarity, or are entangled in systems that disrupt a young person's access to safe and stable connections such as the criminal justice system, the child welfare system, or residential care (National Network for Youth, 2022; Choi, et al., 2015; National Conference of State Legislatures, 2020). The National Runaway Safeline is a national hotline for runaway and homeless youth and youth considering running away or otherwise at risk of homelessness. 2021 data from their annual crisis contacts report indicates that the number one reason youth contacted the safeline was because of "family dynamics," a reason cited by 85% of callers. The second most common reason youth contacted the safeline was because of emotional abuse, a reason cited by 32% of callers, and the third most common reason youth contacted the safeline was because of mental health, a reason cited by 28% of callers (National Runaway Safeline, 2021).

These data indicate that abuse and harm within the family system, as well as the ongoing toll this takes on a young person's mental health, are central contributing factors to youth running away from home. The harm created within family systems, however, is not separate from harm created by external systems of oppression such as racism, homophobia, heterosexism, and ableism. These larger systems of oppression influence family belief systems and interpersonal conflict. For example, LGBTQ+ youth are 120% more likely to experience homelessness than non-LGBTQ+ youth, and 40% of youth experiencing homelessness are LGBTQ+ despite being about only 7% of the population (Morton et al., 2017; NRS, 2022). The reason for such a vast overrepresentation of LGBTQ+ youth in the youth homelessness

population is often because of family rejection (Choi et al, 2015). Young people who identify as LGBTQ+ often are often forced out of their homes or run away once parents discover their sexual identity or gender expression, which may lead to harassment, bullying, physical, emotional, and sexual abuse and other forms of violence (Choi et al., 2015). While family rejection because of queer expressions of sexual or gender identity might be interpreted as a mere “family issue,” it is also a product of larger social structures which enforce compulsive heterosexuality and binary ideas of gender.

Similarly, Black and Brown youth face youth homelessness at much higher rates than white youth. Black or African American youth have an 83% higher risk of experiencing homelessness, and Hispanic, non-white youth have a 33% higher risk of experiencing homelessness than white youth (Morton et al., 2017). These disparities that Black and Brown youth face are deeply entangled with existing racial disparities related to systemic anti-blackness and white supremacy. Organizations such as A Way Home America identify how systems such as criminal-legal systems, immigration systems, and family policing² systems have deep roots in structural racism (A Way Home America, n.d.). These systems further the overrepresentation of Black and Brown youth in the homelessness population by fragmenting families and severing young people’s access to natural community supports (A Way Home America New Deal, n.d.).

To tackle these disparities, several organizations such as True Colors United, A Way Home America, and Point Source Youth, have created federal policy agendas, specific trainings, and QTBIPOC youth action boards composed of youth with lived experience of homelessness in an effort to correct centuries of systemic injustice leading to homelessness among LGBTQ+ youth and youth of color (True Colors United, 2022; A Way Home America, n.d.; Point Source

² “Family Policing system” is a term used by Dorothy Roberts to uncover the true functions of the child welfare system and other social services systems that masquerade as benevolent and caring (Roberts & Evans, 2022).

Youth, 2022). Federal standards have evolved over time to mandate training for youth services providers on these overrepresented populations. The Family and Youth Services Bureau, for example, organizes a series of annual national trainings for organizations serving runaway and homeless youth (Runaway and Homeless Youth Training and Technical Assistance Center, 2022). These organizations require trainings that address core areas, including “LGBTQ Youth” and “Youth of Color” among other areas such as “permanent connections” and “social and emotional wellbeing” (RHYTTAC, 2022).

However, despite the much-needed focus on Black, Brown, and LGBTQ+ youth experiencing homelessness, there is no comprehensive national study that documents runaway and homeless youth’s experience with disability and ableism. Studies that do exist are few, they often do not take place in the United States, or they only analyze one category of disability such as intellectual disability or mental illness (Baker Collins et al., 2018, Russell et al., 2021). For example, in one of the most comprehensive national studies done on youth homelessness to date, the University of Chicago at Chapin Hall identifies that 69% of homeless youth indicate struggling with mental health and 29% indicate having issues with substance use (Morton et al., 2017). However, the study itself makes no mention of the word disability (Morton et al., 2017). Other data is not national but local. For example, one study on youth homelessness in Massachusetts public schools indicates that students enrolled in these schools had a 3.5% rate of experiencing homelessness if they had a disability compared to only 2.4% of students without disabilities (Rubenstein et al., 2022). In Dane County, Wisconsin, youth with disabilities spend on average 144 days homeless compared to 129 days homeless for youth without disabilities (U.S. Department of Housing and Urban Development, 2021a).

Additionally, Federal data standards mandated by the department of Housing and Urban Development (HUD) and the family and youth services bureau (FYSB), which require runaway and homeless youth programs to document certain data about the youth they serve, often separate disability from other categories of identity in data reports (Morton et al., 2018). Disability is typically not included in general identity-based demographic overviews but instead separated into different sections of reports or broken down by type of “disabling condition” including “mental health disorder,” “physical disability,” “chronic health condition,” “alcohol use disorder,” “drug use disorder,” or “developmental disability.” (U.S. Department of Housing and Urban Development, 2021b). Collection of disability demographic information is further challenged by young people’s inaccess to healthcare, lack of insurance information, and fear of disability disclosure. Many young people simply do not have the resources to receive a medical diagnosis and may therefore not see their condition reflected in intake surveys. Further, when this data is reported or summarized, reports typically do not explicitly name youth as disabled, but instead often indicate physical or mental health challenges as conditions that youth struggle “with,” rather than being part of who they “are.”

Collectively, these methods of data collection undermine the idea that disability can be a category of identity, just like gender, sexuality, race, and ethnicity, and in doing so, undermine the role that systems of oppression such as ableism play in contributing to youth running away or experiencing homelessness. Unsurprisingly, then, research on runaway youth has historically operated from ableist frameworks primarily grounded in fields such as psychology or social work. These fields tend to identify running away as a “problematic behavior” rather than focusing on external factors and structural inequity or injustice (Holliday, et al., 2017). Several psychologically rooted studies associate homelessness and running away with other behaviors

such as “delinquency,” substance use, dealing drugs, depression, and disengagement from school or “conduct disorders” (Tucker et al., 2011; Holliday, et al., 2017; Embry, 2000). Even studies that do identify running away as intricately related to family systems tend to pathologize young people’s views of family dysfunction, suggesting that their views of having an unsafe and harmful home environment are a matter of distorted perception (Holliday, et al., 2017).

Collectively, this tendency to pathologize youth who run away in psychological research and the limited national data, training, and focus on disabled youth calls for an urgent and critical analysis of the role that ableism plays in the lives of runaway and homeless youth and youth considering running away. As a result, it is imperative to begin to untangle the ways in which ableism influences the lives of youth who consider or do run away, the ways it impacts their family systems, and the ways it impacts the larger social institutions that runaway and homeless youth must pass through in their search for safety and care. In the next sections, I define ableism and discuss the role of critical disability studies in creating an expansive definition of disability. Then I turn my analysis to a collection of anonymous forum posts on the National Runaway Safeline to discuss how these posts illuminate key features young people’s experiences with ableism and disability.

UNDERSTANDING AND DEFINING ABLEISM

Ableism is the system of power that constructs disability as a stigmatized and devalued social category. Ableism associates humanity, worth, deservingness, and other positive qualities with a particular kind of body/mind, one that is viewed as fully “capable,” “healthy,” “unmarked,” “human,” and most often one that is white, heterosexual, cisgender and associated with other dominant social identities. According to Fiona Kumari Campbell, “Ableism denotes the ideology of a healthy body, a normal mind, appropriate speed of thought, and acceptable

expressions of emotion. Key to a system of ableism are two elements: the concept of the normative (and the normal individual); and the enforcement of a divided between a “perfected” or developed humanity and the aberrant, unthinkable, underdeveloped, and therefore not really human.” (Campbell, 2015; 13-14). In other words, ableism dehumanizes the non-able, the disabled, by constructing ideas of normalcy and defining everything that falls outside of the norm as sub-human and non-human. Historically and presently, this kind of thinking has been enacted through eugenics, a mode of thought that applies statistics to the human population and defines the “average” or “normal” human as the “ideal” (Davis, 2017). People with characteristics that fall outside of the average, particularly disabled people, poor people, and people of color are defined as deviant and criminal. These people are then systematically targeted for elimination, institutionalization and sterilization and denied full integration into society (Davis, 2017; Chapman et al., 2014).

As a result, ableism is not detached from other systems of oppression such as racism. For example, ableism is apparent in ideologies that define social deviance as inherent to racialized biology and Black people as inherent “dangers” (Erevelles, 2015). The idea that certain traits or characteristics are a matter of “biology,” rather than constructed by social systems, is a core function of ableism. Ableism individualizes social problems and diverts attention away from structural inequity. It also upholds existing systems of power by refusing to identify how those systems of power benefit from constructing hierarchies of human worth. Typically, the idea that disability is understood as an exclusively “biological” phenomenon is referred to as the medical model of disability (Kafer, 2013; Siebers, 2001). This model defines disability as an individual and internal pathology that limits a person’s capacities in some way (Adams et al., 2015). The medical model has upheld ideas that disabled people are inherent problems who should not be

allowed integration into society unless they assimilate through subjecting themselves to treatment or using individual willpower to “overcome” their differences, impairments, and limitations (Chapman et al., 2014; Menash, 2020; Clare, 2017).

Currently, the idea that disabled people are inherent problems in need of cure is not dead, especially when it relates to constructions of disabled people experiencing homelessness. For example, in New York City, the Mayor recently announced that police officers and outreach workers should do sweeps of the city to round up homeless individuals perceived to be psychiatrically disabled or otherwise “unable to meet their fundamental needs” with the purpose of involuntarily committing them to psychiatric institutions (Card, 2022). This call to involuntarily commit homeless individuals to psychiatric institutions because they cannot meet their basic needs diverts attention away from the fact that people experiencing homelessness are unable to meet basic needs because of the very systems of incarceration, institutionalization, systemic racism and ableism that have denied them access to community, connection, and safe and stable housing. This call to commit people experiencing homelessness to institutions is even more violent given the fact that federal definitions of homelessness define being in an institution for over 90 days, regardless of the location the individual resided prior to institutionalization, as automatically canceling out an individual’s homeless status, thereby denying that person access to housing by bumping them off of coordinated entry³ waiting lists (National Alliance to End Homelessness, 2012). This example illustrates how ableism is often shrouded in the language of “care,” “help,” “treatment,” and “cure.” These terms propose themselves to be benevolent forces when in reality they are often euphemisms for violence (Clare, 2017). Institutionalization and involuntary commitment are examples of this; confinement is referred to as treatment even

³ Coordinated entry is a tool used to assess, refer, and prioritize people for housing services and related assistance (Homeless Services Consortium of Dane County, 2022).

though historically it has always been a mode of segregation and containment (Chapman et al., 2014; Clare, 2017) and a majority of survivors of institutionalization tell stories of severe trauma, physical, emotional, and sexual violence, restraint, seclusion and other forms of degradation and dehumanization while receiving so-called “care” (Menash, 2020; Simonson, 2018; National Disability Rights Network, 2021).

While I have focused mainly on psychiatric institutionalization and involuntary commitment because of their heightened relevance to individuals experiencing homelessness, they are just one of the many ways that ableism appears on a structural level. Ableism is also embedded in the structure of all social institutions that systematically deny disabled people the right to autonomy, safety, care, and freedom to live integrated into their communities. It is fundamental to state benefit structures that limit funding for home and community-based services and instead only make institutions such as nursing homes Medicaid entitlements (Shapiro, 2022). Ableism is also embedded in the structure of the economy and labor market, with insurance coverage being tied to work and limited insurance options for people who are only able to work part-time jobs or unable to work at all. Ableism is disabled people’s mandated poverty, the requirement that people who rely on supplemental security income (SSI) not be allowed to own more than \$2000 in assets at any point in time. Ableism is the lack of accessible housing options, the lack of accessible transit, the lack of accessible work policies, and the refusal of student financial aid to those who are unable to enroll full-time in higher education. Finally, ableism is embedded into the cultural fabric of dominant America society which has always defined hard work, individualism, productively, and self-sufficiency as ideals while defining dependency, need, and inability to work or be productive as repulsive or undesirable (Nario-Redmond, 2019; Clare, 2017).

These cultural ideologies about who and what is valued trickle down into interpersonal relationships and internal self-thought. Family systems are not immune to beliefs conveyed by systemic ableism, and individuals, disabled or not, often internalize these beliefs. When considering runaway and homeless youth, it's especially important to understand how these larger social systems shape beliefs about ability, disability, normality, and deviance, ultimately shaping how young people are perceived regardless of whether or not they may call themselves "disabled."

CRITICAL DISABILITY STUDIES AND DEFINING DISABILITY

When considering the role that ableism plays in shaping the lives of runaway youth and youth considering running away, it's important to not only define ableism, but to also define disability. As previously discussed, medical models of disability have defined disability as an individual pathology. However, disabled activists have recognized that such a model reinforces oppression and limits disabled people's ability to organize for systemic change (Wendell, 2001; Kafer, 2013). As a result, the social model of disability emerged alongside the disability rights movement as a method of claiming collective identity. Opposed to the medical model's focus on disability as individual pathology, this model defines the "problem" of disability as one created by the social world (Hall, 2015; Kafer, 2013). The social model creates a distinction between disability and impairment. Under this model, impairments are physical limitations or differences whereas disability is the category constructed by the inaccessible environment (Hall, 2015). For example, the social model would identify someone as disabled not because they have paralyzed legs (an impairment) and therefore use a wheelchair, but because the social world is not set up for wheelchair users, with transportation, housing, and other public spaces frequently being wheelchair inaccessible. In other words, it's society "doing" the disabling, rather than disability

being intrinsic to the individual. By identifying social inequity, the social model allows for disabled people to organize collectively for rights such as wheelchair-accessible spaces, equal access to public housing and transportation, and anti-discrimination legislation. However, because the social model tends to reject the idea of disabled people being in need of “cure,” it often leaves out individuals who have chronic illnesses who *are* in fact disabled by pain, fatigue, and the frequently uncomfortable material realities of their bodies (Wendell, 2001; Kafer, 2013). The social model may also overlook individuals who may not identify with the disability community for one reason or another. For example, Black individuals may be less likely to identify as disabled because of disability’s entanglement with racist oppression and myths about biological racial inferiority (Miles, 2020).

As a result, the social model, while useful, does not comprehensively document the disability experience. Critical Disability Studies is a mode of analysis, then, that helps critique the role that varied systems of power, including ableism, racism, sexism, and heterosexism, have in defining and constructing certain bodies as deviant, abnormal, or otherwise disabled (Minich, 2016; Schalk, 2017). Critical disability studies also critiques the binary approach between impairment and disability, emphasizing that these categories are fluid and that both impairment and disability are constructed and influenced by social forces (Meekosha & Shuttleworth, 2009). As a result, critical disability studies moves away from the strict divide between the medical and social models of disability by rejecting the idea that these models are in opposition to each other (Meekosha & Shuttleworth, 2009).

More in line with a critical disability studies approach is an expansive definition of disability that identifies how disability is constructed in relationship to other people, the environment, and political and social realities rather than constructed by biology or society

alone. In contrast to the more limiting social and medical models of disability, the political/relational model of disability emphasizes that disability is *political* because dominant medical models of disability have attempted to depoliticize the realities of disabled people's lives through defining disability as a pathological or individual "problem" (Kafer, 2013).

Depoliticization of disability undermines the idea that disability is even a category of identity or analysis. Therefore it is especially important to identify disability as political, especially given current data collection methods about runaway and homeless youth that continue to address disability as something young people struggle "with" rather than as central to their identity and therefore central to and their experiences of discrimination and oppression.

Disability is also relational in that its meaning arises in context. Disability is constructed in relationship to ideas about ablebodiedness/abledmindedness, in relationship to access to material resources and cultural signifiers like diagnosis, and in the relationships we have with our own bodies. As a result, the political/relational model of disability considers a more nuanced definition of disability that includes individuals without "proper" medical diagnoses and even those who may not identify as disabled themselves but experience ableism nonetheless (Kafer, 2013). Together, critical disability studies and the political/relational model make it easier to discuss how inaccess to care, recognition, and cure can, indeed, be key features of ableism just like the tendency to pathologize and individualize are key features of ableism as well. I use these models and theories to frame my analysis because many youth and young adults do not have access to medical diagnosis or they face overdiagnosis of their behaviors, both of which serve as mechanisms of power and control. Finally, as a disabled individual and former runaway youth myself, I am aware of my own refusal to identify as disabled at the time of and proceeding my homelessness experience because doing so would have allowed systems and individuals to enact

more violence against me. As a result, a critical disability studies approach is essential to allowing for an expansive analysis of ableism and disability in the lives of runaway and homeless youth despite the dangers of claiming disabled self-identity.

METHODS

I conducted this research using 150 posts from the National Runaway Safeline online forums. The National Runaway Safeline is crisis response service and national communication system located in Chicago, Illinois for runaway youth and youth at risk of homelessness or running away. The safeline provides several ways that youth can get in touch with crisis responders, including by phone, email, online chat, and anonymous forum posts, the latter of which are open to the public for view. Users of the National Runaway Safeline are predominantly teenagers. Nearly half of the youth who contact the safeline are between the ages of 15 and 17, with 20% being between the ages 12-14 and 17% being between the ages of 18-21 (NRS, 2021). 66% of contacts identified as female, 23% as male, and 10% as nonbinary or transgender (NRS, 2021). 45% of youth contacting the safeline are white, 25% are Black or African American, and 16% are Hispanic/Latinx.

I proceeded to analyze the forum posts for content related to ableism and disability. To do so, I first conducted a keyword search using 30 terms⁴ that were most reflective of a broad range of disability experiences, including chronic physical illness, mental illness, autism, and disability in general. I also searched keywords related to systems that disabled youth must navigate including hospitals, doctor's offices, psychiatric institutions, and residential care. I downloaded

⁴ Key Terms included the following: ADHD, anxiety, autism, autistic, chronically ill, chronic illness (migraine, diabetes, epilepsy, arthritis, asthma), conservatorship, crazy, depression, diagnosed, disability, disabled, disorder, doctor, hospital, institution, medical, mental hospital, mental illness, panic attacks, psychiatric hospital, PTSD, rehab, residential, sick. For chronic illness, I searched five common chronic illnesses because of low yield for the term "chronic illness."

450 unique posts from the forums using these search terms, downloading more posts from search terms that had more results. Overwhelmingly, those search terms with the most results tended to be posts related to mental health and youth receiving or being forced into mental health “care.”

After downloading these posts, I then uploaded them to NVivo for qualitative coding. I used a keyword search and code feature, which allowed NVivo to automatically code posts that had any of my 30 keywords in them. As a result, the posts with the most keywords rose to the top of my queue in NVivo. I then coded those top 150 posts with the most keywords to use for my analysis. As I coded, I used a grounded theory approach (Charmaz, 2006). This approach allowed themes to emerge naturally as I read, rather than me coming in with pre-imposed categories. Several themes emerged as I coded, with the most frequently coded themes being “ableist abuse,” “trapped because of disability,” “disablement as a product of abuse,” and “survival strategies.” Because “ableist abuse” had the most codes and was most relevant to the role of ableism in the lives of runaway and homeless youth, I chose to focus on this code in a second round of coding, breaking it down into many subcodes. These subcodes detailed the many ways that ableist abuse functioned, including “ignoring disability,” “denied medical care,” “forced treatment and the threat of forced treatment,” “contesting reality,” “triggering disability,” “blaming for disability,” “undermining intelligence,” “constructing disability,” “infantilization,” “medical care interference,” “violence and exploitation,” “invading privacy,” “isolation,” and “benefits abuse.”

In this paper, I will focus on the subcodes related to ableist abuse that were the most common. These subcodes include the roles of forced treatment and the threat of forced treatment, how disability is explicitly targeted (triggered, blamed, direct violence), and how disability identity is ignored or neglected (denied medical care, contesting disability reality). While these

categories aren't mutually exclusive, I found it useful to break them down in this way for purposes of analysis.

In the next sections, I give an overview of my findings related to each of these categories, paying special attention to how disability is constructed in relation to family dynamics, social and cultural institutions, and ideologies that shape the meaning of disability. Paying attention to *how* and *why* disability is constructed in the lives of runaway youth and youth at risk of running away is central to understanding how ableism operates, whether or not a youth asserts their disability does/does not exist.

FORCED TREATMENT AND THE THREAT OF FORCED TREATMENT

Youth and young adults frequently discuss the role that forced treatment or the threat of forced treatment has in their lives, their social-emotional and physical wellbeing, and in creating conflict in their homes. Out of 150 unique posts, 64 discussed the role of forced treatment or the threat of forced treatment. Frequently, youth identify how forced treatment is weaponized as a mechanism of power and control to get youth to comply to dominant social norms, keep quiet about abuse and violence, or behave in ways that don't draw negative attention to an unhealthy or harmful family system.

Forced treatment refers to any kind of "treatment" given without explicit, enthusiastic, non-coerced consent. This includes practices such as involuntary commitment, forced medication, forced medical or mental health treatment (including individual or family therapy mandated by child protective services or other state agencies), conversion therapy, residential treatment, rehabilitation programs, hospitalization, applied behavioral analysis, drug testing, conducting bodily exams or other forms of body surveillance, and calling emergency services or crisis responders (usually police). Threat of forced treatment refers to threatening to do any of

the above, often in a deliberate effort to get a young person to modify or abandon certain behaviors labeled as undesirable, deviant, dangerous, self-destructive, or transgressive of social or family norms. Again, while “treatment” typically has positive cultural connotations, youth and young adults consistently attest to the violence of treatment, especially as it relates to forced treatment surrounding mental health.

For example, one youth talks about the violence of forced medication. Living in their grandmother’s house, they discuss how they are frequently verbally abused. Afraid of intervention from child protective services, the grandmother does not let the child out of the house. In a forum thread titled “I don’t feel safe or loved at home anymore,” the young person states,

she always blames me saying I’m depressed that I want to kill myself and she’s been making me take medicine for years because I have adhd and that I “need” them but it makes me lose my appetite and quiet but when I don’t take it I’m fine.

Here, the young person addresses how their grandmother forcibly medicates them because it makes them easier to control. The medications make the young person “quiet.” They subdue not only their appetite but their emotions. This docility is ideal in the setting of a family home where disclosure of abuse and violence could lead to unwanted attention by the state. As a result, disability is constructed to divert attention away from a harmful external environment and suggest behaviors that may be a product of trauma are merely an individual problem. Even though the young person knows they have been diagnosed with a mental disability, that disability doesn’t pose a problem to the youth themselves but only to their grandmother. As a result, the young person feels rejected because their identities are being labeled the source of the problem, and as a result they are forced to take medications that physically and emotionally harm their wellbeing. This leads them to consider running away.

While forced medication is one of the many ways that young people speak about having their bodies harmed because of perceived or constructed differences from an ableist norm, youth more frequently talk about the harms of forced treatment in relation to institutionalization. Institutionalization refers to placement in any kind of restrictive permanent or temporary setting that denies autonomy, agency, freedom of movement or choice. Most frequently, young people discuss being placed in a mental hospital or the threat of being placed into one. Mental health institutions are often sites of violence, with sexual violence being embedded in the fabric of these institutions in routine procedures like strip and cavity searches, disguised as a form of medical care, or perpetrated with the knowledge that institutionalized individuals are uniquely unable to safely disclose abuse due to institutional power dynamics (Zavirsek, 2002; Crossmaker, 1991; McMurphy, 2018). Death due to neglect or physical abuse by staff members is also not uncommon (NDRN, 2021). This violence is well-known and, as a result, the threat of institutionalization serves as a means of control. For example, one young person states,

My mom mentally abuses me and I've told her about my mental state and she saw my cuts on my arms and threaten to throw me in a mental hospital where she said I'd be raped and murder.

Here, the knowledge that mental institutions are sites of violence serves the purpose of enforcing normative behavior. The young person engages in self-harm as a coping mechanism to deal with mental distress as a product of abuse. The scars are physical indicators of mental distress that could potentially alert authorities to abuse or dysfunction in the family home. As a result, the threat of institutionalization, leveraged because of its potential to perpetrate violence as severe as “rape and murder,” serves as a firm warning to keep such behaviors hidden and silent.

In another particularly illustrative example of how mental hospitals are used to enforce compliance and silence, an 18-year-old girl writes a post about a 15-year-old girl whom she met while hospitalized together on an adolescent psych unit. Referring to the 15-year-old girl under the pseudonym “Samantha,” the author of the post discusses how Samantha was being severely physically abused at home and had experienced rape in an implied family circle. As a result, Samantha grew depressed, and her parents sent her to a mental institution. The treatment was ineffective because it did nothing to remedy the abuse she faced at home. As a result, her parents began to repeatedly institutionalize her because of her continued depression. The treatments became more and more aggressive, with doctors injecting her with so many sedatives that she had a seizure and ended up in the ICU with heart failure. However, even after this violent, near-death event, Samantha’s parents continued to send her back to the mental hospital. Speaking to how Samantha ended up in the author’s house, the author of the post states,

Samantha’s last discharge was March 22nd, and she ran away the next day because her parents said that they were going to send her back to the hospital because they said she was still depressed and that they weren’t going to tolerate it. She bounced from house to house, and now she’s here.

Further, when discussing why state authorities had not intervened despite Samantha disclosing abuse, the author of the post states,

CPS has been involved before, but did not take action because she is a diagnosed schizophrenic, and she says they wrote it off as her making it up because of her illness.

This particular example illustrates several key features of ableism. First, it illuminates how forced treatment and the threat of forced treatment work together to keep young people effectively trapped in cycles of violence. Samantha’s parents are well aware of the trauma caused by institutionalization, and so too is Samantha, having nearly died as a result of “treatment.” As a result, the threat of forced treatment isn’t just something to be feared through imagination: it is

known and real. Second, this post illustrates how neurodivergence is a key feature of Samantha's identity that family members reject. Samantha's depression is likely a product of trauma, but it is also real and disabling and not something that Samantha can just "get rid of." However, her parents lack of tolerance for this aspect of her identity is what causes them to repeatedly institutionalize her in an effort for her to change. This causes Samantha even more distress as this is not an aspect of her identity that she wants or has capacity to change in an unsafe environment. Finally, this post illustrates how ableist cultural narratives surrounding mental disability are leveraged to cast young disabled people as unreliable narrators, therefore maintaining violence. In Samantha's instance, her diagnosis of schizophrenia is leveraged by her parents and state systems to discredit the abuse Samantha faces at home. Ableist cultural narratives consistently cast mentally disabled people as delusional and unable to speak the truth (Bonomi et al., 2018). As a result, forced treatment, which allows for the diagnosis of a stigmatizing mental illness, serves to justify the lack of intervention on the part of the state, leaving Samantha with no other option but to run away.

To summarize, then, youth and young adults overwhelmingly discuss how forced treatment and the threat of forced treatment are sources of trauma. Forced treatment and the threat of forced treatment are frequently leveraged to enforce normality, silence, and erase or construct aspects of a young person's disabled identity. Doing so often causes the young person severe distress, as their bodyminds are medicalized, identities are rejected, and medical/mental health institutions merely externalize and reproduce, often to a heightened degree, the abuse youth already face at home. As a result, to avoid that harm, youth see running away as the only viable alternative even as they express fear that doing so may heighten their risk of forced treatment if they are found.

TARGETING DISABILITY

Youth and young adults also discuss the ways that their disabled identities are explicitly targeted. Targeting disability involves older adults identifying disability as a critical aspect of a young person's identity and leveraging negative cultural and social constructions of disability as well as the unique material realities of a disabled person's body to perpetrate harm. This harm can look like explicit violence and exploitation, verbal abuse, including blaming a young person for their disabilities, or triggering a young person's disabling condition for the purposes of causing physical and emotional distress. 17 out of 150 unique posts discussed violence and exploitation directly targeted at disabled identity. 42 discussed youth being blamed for disability, and 34 discussed how adults deliberately triggered disabling symptoms.

Violence and Exploitation

Violence and exploitation can include physical abuse, sexual abuse, verbal abuse, harassment, intimidation, and denial of care necessary to survival. Young people speak about a variety of different forms of violence including a father bashing their autistic child's head through a door, hitting a young person for "being depressed," screaming at an autistic sibling because they are crying, grounding a child for being diagnosed with depression, using ableist slurs like "retard" and "psycho mental patient," and piercing a young person's skin with a razor because they were self-harming. Often, violence and exploitation against a person with disabilities might look different than dominant narratives surrounding violence and exploitation because of ableist norms that define violence against people with disabilities as permissible, justified, or necessary. For example, ableist cultural narratives often define unwanted physical contact received by a disabled person as acceptable because of the ableist norm of forced

intimacy, which defines touching disabled people without their consent as “necessary” for their survival and therefore absolved from being labeled as violence (Mingus, 2017).

In the forum posts, youth speak about many forms violence that directly target or exploit disabled identity. For example, in one post, a young person with ADHD discusses how parents leveraged this young person’s diagnosis to define social media use as pathological behavior. While calling this young person a “social deviant” for violating a household no social media policy, parents then drove the young person to an (implied psychiatric) hospital in a performative and threatening attempt to get the young person to adhere to household rules. While the young person was not admitted to the hospital, when they returned home,

my mom was ready with a drug test, which was a urine sample, and my dad stood in bathroom while i did it, which was humiliating. throughout all this ive been dissociating and trying to remove myself from the situation. my mom called me a “social deviant” and a bunch of other names.

To be clear, watching a young person take a urine sample is sexual abuse, but ableist narratives cast this father’s behavior as “care” because of the presumption that violating social or family norms mandates “corrective” action. For example, strip and cavity searches are routinely justified in psych wards based on false perceptions that mentally disabled people are “dangerous” and that doing so is not truly violation but rather “for their protection” (McMurphy, 2018). As a result, even crisis responders in the forums failed to recognize this drug testing as sexual violence despite the young person stating they were humiliated, terrified, and dissociated. Additionally, calling this young person a “social deviant” calls upon historical terminology used to associate criminality with disability (Chapman et al., 2014).

While some of the violence perpetrated against disabled individuals is more covert like sexual violence disguised as a drug test, other violence targeted against disabled young people is

more explicit. For example, one diabetic young person discusses the punishment they received when they didn't keep their blood sugar in check:

I'm 16 in a few months, and diabetic. My mom gets extremely upset if my blood sugar is out of range. We used to get into very violent fights, ending in bruises and scars and screaming. I told the cop here at my school often, and CPS got involved but no one believed me... My dad has been emotionally abusive a lot of my life... accusing me of lying about my diabetes.

As the young person states, both of his parents target this young person's diabetes as a means of control. By definition of this young person's diabetes diagnosis, their blood sugar is naturally out of normal range. However, in the context of these family dynamics, out of range blood sugar becomes a means of reifying existing social hierarchies of power that place children under adults. Unfortunately, ableist narratives might define this mother's anger and physical abuse as a form of "concern" for her child since uncontrolled blood sugar often has grave health consequences. As a result, authorities, as indicated here by the young person, are less likely to see violence against a disabled individual as violence even if it would be easily identified as violence in another context.

Blaming for Disability

Overt physical violence and sexual violence are commonly discussed by youth considering running away from home, but young people also speak about how adults in their life target their disabilities by blaming them for symptoms they cannot control. Young people speak about being blamed for their disability by parents and family members who state that suffering as a result of a disabling condition is "their fault." They also speak about family members who blame them for not being able to "control" their disability or hide it so that it is non-apparent. Young people are also blamed when medications don't work or treatment is costly or ineffective. They are called slurs such as "weak," "selfish," or "lazy" and are often accused of not trying

“hard enough” to “get better” or “get over it.” For example, one young person discusses how their mom blames them for “not trying” to hide their symptom of ADHD:

I have symptoms of adhd (badly) and I get yelled at when I show them. She says I learned them from stupid people and to stop, when I can't. This causes her to [yell] at me and say I'm not trying, or I can do it I'm just not doing it, or that I need to stop 'acting like the dumbasses'

As this young person indicates, their mother assumes ADHD symptoms are voluntary and therefore capable of being stopped. The mother sees these ADHD symptoms as undesirable and indicative of perceived negative social qualities such as “stupidity.” The belief that this young person can merely “overcome” their disabling condition is grounded in ableist narratives that idealize hard work, individualism, and individual willpower and strength. The belief that neurodivergence indicates stupidity is also grounded in ableist beliefs that differences in thinking, behaving, and communicating that depart from the norm are indicative of lack of intelligence. Enforcing these narratives benefits those in power in the family system by not drawing perceived negative attention. Such narratives are also grounded in disability hatred, and as a result, the young people being blamed for their disabilities feel ashamed for core aspects of their identity. This has devastating consequences for young people’s wellbeing.

Triggering Disability

Finally, when young people speak about how they are directly targeted and exploited because of their disabled identities, they also talk about how parents and family members will deliberately trigger uncomfortable, distressing, or painful symptoms in order to reinforce power and control. Young people speak about the many different ways that their disabilities are deliberately triggered in order to reproduce harm. For example, one young person discusses how their parent tells them to “slit their wrists” when they are suicidal or “just do it” in reference to killing themselves. Another young person discusses how their mom will deliberately smoke in

the house despite being told it triggers the young person's asthma. Parents will take away coping mechanisms such as phones, pets, music, and stuffed animals in order to trigger panic attacks or emotional distress. Many adults will trigger eating disorders by making comments about weight, food, and sexual appearance. One young person in the custody of a state group home is denied a way to contact their mother, despite DSS workers knowing well this triggers their anxiety.

Young people will be placed on meds that adults know make the young person's symptoms worse. They are told that triggering their disability "builds up resilience." Additionally young people discuss how parents trigger disabilities in order to leverage other forms of control like forced treatment. One young person states about his mother,

She also will put me down to the point of me self harming and/or making a suicide threat. Once I do, the police are always immediately called on me and I get put in a hospital for being to mentally unstable... My mum knows what she's doing, ive straight up told her before about what she's doing and how it effects me. She told me to get a sense of humor and lighten up.

Finally, young people will discuss how parents will trigger disability by triggering gender dysphoria and rejecting transgender identity. While transgender people do not generally consider transness as a disability, scholars have discussed the intersections between transness, disability, and systems of oppression such as ableism and cisgenderism, as well as the disabling effects of gender dysphoria that could lead some aspects of transgender identity to be considered disabilities (Baril, 2015). For example, one young person states they desperately feel like they need to leave home because of the psychological toll of gender-based rejection:

Im scared, if I stay any longer with her I'm going to kill myself, my body dysphoria is horrible and she doesn't care, she doesn't think that being trans affects me at all, she thinks I just go by male pronouns and a name, I know she sees me as a girl, and no matter what I do she won't try and make me comfortable, I feel so emotionally tortured.

Here, the young person indicates that it's not just feeling rejected because of being trans that causes distress, it's the triggering of disabling symptoms of dysphoria through deliberate

misgendering that causes the young person to feel unable to tolerate rejection any longer. This is why it's important to consider expansive definitions of disability that consider how bodily differences are identified and exploited regardless of whether or not a young person identifies as disabled. As a result, ableism impacts this young person and all young people mentioned here because their bodyminds are identified as abnormal or pathological in one way or another. Those perceived differences are exploited and targeted, resulting in young people feeling helpless, harmed, rejected, terrified and confused. Ultimately, this profound distress causes these young people to consider running away. Not able to merely "overcome" their disabilities because they are core parts of their identities, young people reach out to the safeline desperate for guidance on what to do next.

NEGLECTING, IGNORING, AND MINIMIZING DISABILITY

Finally, youth and young adults discuss the ways that their disabilities are ignored, minimized, and neglected. 68 unique posts out of 150 discuss the ways disability is ignored, minimized, and neglected, including through denied medical care. Just like ableist logic can construct disabled individuals as abnormal and deviant, identifying their bodies as the source of the "problem," ableist logic also constructs disabled individuals as "fakers," overreacting to their bodily symptoms and environment, and disabilities as not really "real." For example, a common ableist trope is "the disability con," the belief that disabled people aren't really disabled, they are just faking to gain perceived "special rights" like access to disability benefits, dismissal from work, disabled parking spaces, and academic accommodations (Dorfman, 2018). It's important to note, however, that disabled people's perceived "special rights" are non-existent: disabled people wouldn't need access to perceived "special rights" if the environment was constructed already with disabled people in mind, and many of these perceived special rights, such as

reliance on state benefit structures that trap disabled people in poverty, are in fact, emblematic of disabled people's oppression.

Likewise, many youth and young adults speak to how older adults and other family members ignore their disabilities through this perception that youth are “faking.” Youth speak to how parents consistently minimize the reality of mental illness, claiming mental health isn't “real” and therefore youth are not “entitled” to interventions like counseling or psychiatric medication. In relation to mental health, youth speak about parents who tell them to “suck it up,” “get over it,” “stop being dramatic,” “just control your feelings,” or being told suicide attempts are just “for attention.” Others speak to how ableism merges with other forms of oppression such as adultism. For example, one youth discusses how parents minimize mental illness by claiming it is merely a “teenage thing.” Another young person speaks to how sizeism merged with ableism when they tried talking to their parents about having an eating disorder but weren't believed because they were not skinny or underweight. As a result, ignoring disability because it is perceived as fake has real world consequences. Symptoms go untreated and they can cause profound suffering in a young person's life. One young person speaks to the consequences of their mom ignoring their paranoia and sleep paralysis:

my mom knows I'm diagnosed ... she's always forcing me to do something and whenever we come back home it's like I never exist... The reason why I want to run away is [she] refuses to help me with my paranoia and sleep paralysis I'm paranoid of many things at night it's like I see shadows but my mom says I'm just delusional and she blocks me out so I barely get enough sleep and I'm always tired at school.

For this young person, the effect of ignoring paranoia and sleep paralysis is extreme exhaustion that interferes with school. Not only that, but the young person is also forced to do things at home despite the extreme fatigue and lack of sleep, leading the young person to feel as if they don't exist. This feeling unseen is distressing to the young person, just as much as the

symptoms themselves. Additionally, as this young person indicates, even medically sanctioned “official” diagnoses hold little weight. The knowledge that this young person is diagnosed does nothing to make their mom pay attention, despite certification from medical authority. However, other youth and young adults speak to how parents will try to prevent young people from getting a diagnosis in the first place, likely out of fear that it could make a disability “valid.” One young girl states about their mom,

*She refuses to take me to a doctor even for yearly checkups claiming that it's too expensive even though I very clearly have areas of concern. She believes mental health is a giant performance to get the attention of others. She makes fun of my anxiety attacks and yells at me for saying I'm depressed. I even came to her saying I have considered suicide but she simply told me I was an attention w*ore.*

This mom’s belief that disability is a “performance” likely influences her refusal to take her daughter to the doctor. This is because medical authorities might counter her ableist constructions of her daughter’s disabilities not being “real” by defining mental illness and other health concerns as diagnosable medical conditions. As a result, the mom avoids taking her daughter to the doctor out of potential fear that diagnosis could counter her constructions of her daughter as “faking.” Additionally, this mom leverages both ableist and sexist tropes to write off her daughter as an “attention whore.” Not only do ableist tropes define many disabled people, especially those with invisible disabilities as lying about their symptoms, sexist tropes define young women in distress as “hysterical” and “attention seeking” as well (Dusenbery, 2018).

Combined, ableism, sexism, sizeism, adultism, and other forms of oppression merge to cause young people to have their reality questioned and health needs go unmet. The consequences of denied medical care, in particular, put young people in considerable danger. One young adult speaks to how their parent’s refusal to believe their severe pain from a burst appendix led to delayed treatment and almost dying. Several young adults speak to how the

perception that depression, self-harm, and other mental illnesses are not real or are just for attention lead them to attempt suicide and wish they were not alive. Young people internalize these messages about “just faking” and see themselves as burdens, worthless, selfish, overreacting, and undeserving of love and care. They come to the safeline asking if their concerns are “justified” or “valid” and if they are entitled at all to feel the pain that they do. As an alternative to killing themselves or dying as a result of lack of care, as a means of survival, young people see leaving home as the only path toward safety. Speaking to the necessity of leaving home as a result of neglected health concerns, one young person states,

... I had an asthma attac for two days straight and just couldn't breathe anymore. My mom always tells me to walk it off and waits until i'm In danger to take me to a doctor. They always say [that] I'm making everything up. My mom tells me that i am victimizing myself and that my "perception of reality is twisted" i want to leave I hate staying here.

Clearly, the consequences of neglecting a severe asthma attack are dire. Despite the idea that abuse is direct and active, refusing to provide care is also abuse. However, ignoring disability, by telling the young person their “perception of reality is twisted” minimizes the reality of abuse by defining the health problem as non-existent and therefore neglect as non-existent. Medical care and medicalization, then, even though they are sometimes understood as unneeded, over-reaching, and harmful to disabled people because of their ability to identify disabled people as “problems,” are also clearly needed when disabilities and chronic health conditions pose a threat to a young person’s life or create suffering. As a result, a critical disability studies approach is important here because it can help identify how the refusal of treatment, cure, and diagnosis is grounded in ableism just like the tendency to pathologize. Both the refusal to acknowledge disability *and* the overpathologization and direct targeting of disability reinforce existing hierarchies of power that place adults over children and serve to minimize the impacts of abuse.

CONCLUSION AND WAYS FORWARD

I have discussed how disability and ableism impact runaway youth and youth considering running away. Even when youth and young adults do not specifically identify as disabled, disability is often constructed in the lives of these youth because it justifies ableist means of power and control. Youth and young adults speak about disability being constructed in their lives through forced treatment and the threat of forced treatment. Practices such as institutionalization and forced medication pathologize core aspects of young people's identities, such as neurodivergence, that are perceived as undesirable and abnormal. Parents' eagerness to "get rid" of the disabled aspect of young people's identity through practices such as forced treatment has damaging impacts on young people's mental and physical health, much like the impacts of family rejection of sexual/gender identity. Ultimately, like youth and young adults who are rejected due to their sexual/gender identity, disabled young people whose identities are rejected consider running away.

Additionally, disabled youth consider running away when their disabilities are explicitly targeted or exploited. Direct violence perpetrated against disabled youth and young adults out of hatred for disability, blaming young people for their disabilities, and triggering young people's painful or distressing symptoms are other reasons that youth speak about wanting to run away or leave home. Runaway youth and youth considering running away also speak about the impacts of their disability being ignored. The perception that disabled young people are merely "faking" their symptoms or "doing it for attention" causes young people to feel unseen and unheard, and often puts them in grave danger when their symptoms pose a threat to life.

While the ways young people are treated are often within family systems, family dynamics are always influenced by larger cultural narratives. These larger cultural narratives

around disability, in particular, justify containment of people perceived as socially “deviant,” beliefs that disabled people are frauds faking their symptoms for “special treatment,” and beliefs that disabled people should be “grateful” for any kind of “care” they receive because it is necessary for survival, even if it is violent or abusive.

This is why it is critical to identify ableism and disability in social justice spaces that discuss runaway and youth homelessness prevention. As it stands, ableism and disability are still rarely discussed in national and federal initiatives that provide training and technical assistance to runaway and homeless youth serving agencies. Discussions surrounding cultural competency and social identities often leave disability out. This is in part because of continued ableist constructions of disability as a non-essential or undesirable aspect of identity and therefore something that young people struggle “with,” the end-goal being to eliminate it. Moving forward, it’s essential that federal, state, and local agencies begin to address disability as a core aspect of identity, include disability in trainings and educational material around intersectional identities, and center disabled individuals and anti-ableist frameworks in agency structures and policies.

Additionally, it’s important to name ableism so that youth serving agencies do not merely reproduce the very same cycles of harm that youth seek to escape in their home environments. For example, many runaway and homeless youth services will funnel youth and young adults into restrictive institutional settings when these youth experience mental health crises, rather than resorting to community-based alternatives or questioning the true need of this kind of “care.” Shelter environments can also mirror institutional settings, with rigid rules and regulations that often deter young people with lived experience of institutionalization or incarceration from accessing services because the shelter is retraumatizing (Davis, 2021). Considering the role that

these institutions play in keeping disabled and other marginalized people oppressed is critical to ensuring that youth serving agencies are providing safe, equitable, and affirming care. Instead of punishing young people for engaging in perceived “negative” coping mechanisms, agencies can take a survivor-centered harm reduction approach that does not condemn young people experiencing mental health crises, but instead works to minimize the impacts of self-harm (Hassen, 2022).

Finally, it’s critical to identify disability and ableism in the lives of runaway and homeless youth because the abuse that causes many youth to flee their homes and the resultant instability that youth face couch surfing, on the streets, or otherwise homeless is incredibly traumatic. While I did not discuss it in this paper, a frequent theme that emerged in my coding was how abuse and violence created disablement through trauma. Many young people discussed their wish to run away because abuse and violence within the home created disabling mental health struggles and suicidal ideation.

As a result, identifying ableism can help shift the focus away from defining youth and their mental health struggles as inherent “problems” but rather toward their disabling, traumatic environments. Doing so, however, does not reject the idea that young people deserve access to affirming treatment or mental healthcare. Rather, identifying ableism can help highlight failures of the current mental health and crisis responses systems, with their current function being to individualize and pathologize, so that these systems can be transformed to truly provide the kind of safety, care, and freedom from harm that youth wish for and deserve.

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