Against the Medicalization of Humanity:
A Critical Ethnography of a Community Trying to Build a World Free
of Sanism and Psychiatric Oppression

by

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Graduate Department of Adult Education and Counselling Psychology
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Abstract

We have to stop inventing disorders for every human experience that challenges the status quo... I dream of a world where people can peacefully co-exist... [where] differences are accepted... [and where] I, and everybody else, has a place (Jackie, psychiatric survivor and mad person).

The thesis is a critical ethnography of a political community in Toronto, Canada whose members are challenging the theories and interventions of biological psychiatry and developing approaches to understanding and responding to human experience in alternative ways that empower people who are conceived of as “mad”. Based on the emerging ideological and practical differences among participants, a model of the community was developed that includes three main constituencies: the psychiatric survivor constituency, the mad constituency, and the antipsychiatry constituency. This thesis includes descriptive accounts of the philosophical understandings, priorities, goals, actions, and strategies emerging from each of these constituencies; some tensions and conflicts that arise in the community around working across difference; the genuine attempts made by community members to build alliances, the challenges they face, and the notable progress they have made. The thesis grapples with how
community members might work towards building a paradigm for solidarity work with others who share a stake in building communities that are free of sanism and psychiatric oppression. The dissertation ends with an exploration of how clinical and counselling psychologists might proceed in their work taking into consideration the experiences and perspectives shared by participants.
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Chapter 1: Introduction

Over the last century, biological psychiatry has gained acceptance in the medical world, and its proponents have used its status as a scientific discipline to naturalize and propagate the medical model as an essential way of organizing and managing human experience. With the support of governments and mental health industries, the theories and physical interventions of biological psychiatry have had a significant influence in key institutions, including media, education, medicine, law, and the social services, and are now accepted as necessary in the public consciousness. Assumptions about people and the organization of society stemming from psychiatry now go unnoticed, because of their prevalence, such as that “madness” constitutes illness; that distressing experiences are located within the individual person rather than in oppressive contexts to which people cannot adapt; that the problem is “madness” itself, rather than the lack of support available to people who cannot function well in the current organization of society; that madness is dangerous and needs to be controlled; and that “madness” is what drains people, rather than systems that hurt them. These widespread beliefs allow professionals to continue using traditional psychiatric interventions, such as diagnosis, drugging, electroshock, and institutionalization, and to spread psychiatric practices into the community through the development of community treatment sanctions, mass screenings for “mental illness,” and mandatory reporting laws in the helping professions.

While psychiatry continues to gain social and economic power at a rapid rate, there is a worldwide movement that is questioning its theories and interventions, turning them around, and examining approaches to understanding and responding to
human experience in alternative ways that empower people who are conceived of as mad, rather than treating them as problematic individuals who are inherently flawed (Mind Freedom Ghana, 2005; MindFreedom International Global Campaign Committee, 2011; Salie, 2010; Tanasan, 2011). This movement is made of up smaller political communities in different locations around the globe that come together on the basis of political orientation, priorities, experiences, identity, culture, and history, each one made up of people coming from different backgrounds and experiences, but who share a common concern about how people who are defined as mad within dominant culture are being treated, particularly under the current psy-regime\(^1\) known as the mental health system. This worldwide movement has many different goals emerging from particular communities based on specific local contexts, but each recognizes itself as part of a larger global community of people committed to questioning how human experience is understood and treated under the surveillance of the psy-disciplines.

This dissertation focuses on one such community located in Toronto, Canada. It is a critical ethnography that begins with the study of the ideological underpinnings, empowerment, and social change goals in the community, as well as the actions and strategies used by community members to meet these goals. From the outset, I was interested in developing an in-depth understanding of some of the barriers blocking community members from meeting shared empowerment and social change goals. During the data collection process, I learned that one aspiration that most community

\(^1\) Throughout this dissertation, I use terms such as *psy-disciplines*, *psy-professionals*, and *psy-regime* in reference to the various disciplines and professionals that accept and implement the theories and practices of biological psychiatry. It is not sufficient to simply refer to psychiatry, given that in contemporary times, many related professions including psychology, social work, and nursing are greatly influenced by the psychiatric paradigm and are in many ways complicit in maintaining psychiatric hegemony. Nikolas Rose was the first to use this term (Rose, 1999).
members share is to build stronger alliances with others in local and global contexts and to develop more effective strategies for solidarity work. In order to achieve this hope, I realized that it is important to understand the differences in how community members theorize problems stemming from psychiatry and other sanist institutions, how they go about creating change in the world, and how they respond to these ideological and strategic differences. With this realization, the purpose of this dissertation became to offer an analysis, grounded in specific events and experiences in the community, of patterns of tension and conflict that continue to arise among differently situated people, and to consider ideas and strategies for how they might approach these problems in productive ways.

**What Is Community?**

Community is a highly idealized construct. It typically brings to mind notions of home, coziness, safety, comfort, comradeship, and a place of protection against an outside world, which is often perceived as dangerous and hostile (Phelan, 1994; Mohanty, 2003). Its membership is frequently understood to be based on commonality or shared characteristics, whether that be shared identity, experience, culture, history, beliefs, desires, commitments, understandings, or values (Phelan, 1994). Such notions are widespread within the community at the centre of this dissertation and serve an important role, particularly for those many who have been ostracized from other

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*Sanism* is a term widely used within the community that refers to the inequality, prejudice, and discrimination faced by people who are constructed as “crazy” within dominant culture. Perlin (2003, p. 683) defines sanism as “an irrational prejudice of the same quality and character as other irrational prejudices that cause and are reflected in prevailing social attitudes or racism, sexism, homophobia and ethnic bigotry.”
social domains because of their locations as mad or psychiatrized. The community\textsuperscript{3} offers many people, who otherwise lack a sense of home, a network of social relations that can represent a place of belonging and shared purpose.

The emphasis on commonality is useful in that it fosters this sense of belonging for some, clarifies what types of characteristics make up community, and offers an optimistic bent towards unity and solidarity (Phelan, 1994). Yet, in its common usage, the notion of community often focuses on sameness to the point of ignoring the differences that exist within (Mohanty, 2003). When particular points of similarity are valorized as the most important characteristics or experiences, and an ideal citizen is constructed based on these characteristics, those who do not fit this archetype are further marginalized, and the community as a whole closes itself off to possibilities of change that might emerge from recognizing both commonalities and differences (Phelan, 1994). This is how notions of community can become oppressive to people and even create blocks towards change, despite being liberationist in intent.

This dissertation strives to look critically at community, moving beyond discourses that emphasize sameness to an examination of difference. This approach requires readers to leave idyllic fantasies of community behind, to face the nuances and complexities among us, and to seriously contemplate how to work across difference in ways that the community has not yet been able to achieve. As we challenge our thinking in this way, our current understandings of community will necessarily come under scrutiny and transform. This is not meant to be an easy or comfortable endeavour, but will hopefully move us in the direction of fostering solidarity work and broader alliances that make sense. It is a process that requires

\textsuperscript{3} See pages 11 to 13 for a detailed explanation of the community I am referring to here.
intense self-reflection, recognition of contention within the community, and openness to change.

For the purposes of this dissertation, I am conceptualizing the community itself as a perpetually transformative process that shifts and changes as people join and bring in different perspectives and understandings about people and society, and as people shift and change when they come into community with others who share particular visions of change (Phelan, 1994). This focus on process allows us to envision how community, individuals, and their possibilities are constantly emerging (Phelan, 1994). The challenge in this, as Mohanty states (2003, p. 226), “is to see how differences allow us to explain the connections...better and more accurately [and] how specifying difference allows us to theorize universal concerns more fully.”

Throughout the research, I struggled with many different approaches to defining community, most of which were a poor fit, as they did not capture the perpetually changing boundaries and complexities that define what I was studying. My understanding of community most closely approximates what Anderson (1983) and Mohanty (2003) have referred to as an imagined community. It is imagined, not because it is not real, but because it is defined by “potential alliances” and “collaboration across divisive boundaries” based on shared political interests, rather than on necessary face-to-face contact, or natural characteristics; and it is community, because regardless of internal hierarchies, a “horizontal comradeship” connects people across a variety of social locations and ideological differences (Mohanty, 2003; Anderson, 1983). This understanding of community is useful, because it leads us away from essentialist notions of mad people’s struggles, signifying political rather than biological or cultural bases for solidarity, and allows us agency for defining priorities.
and choices in forging links among and between struggles (Mohanty, 2003). It also opens up discussion about how the various ideological approaches emerging from the community relate to people who are most vulnerable to sanism and psychiatric oppression. The community I imagine is one of people invested in challenging the oppression of mad and psychiatricized people, coming from different histories and social locations, “woven together by the political threads of opposition to forms of domination that are not only pervasive, but also systemic” (Mohanty, 2003, p. 46).

My working understanding of the community is embedded in the politics of my own location, as an activist, helping professional, and researcher, and my commitment to “a politics engaged with constructing solidarities across social... positions of difference” that are transformative and mutual (Traub-Werner, 2010, p. 4). It is a political understanding of community and includes people from a diversity of social locations-people who identify as psychiatric survivor or mad and those who do not, all of whom share an interest in challenging sanist and psychiatric oppression. I believe that it is important to consider as community all people who understand sanism and psychiatric oppression as a threat to humankind, as history shows that various groups are constructed as “mad” and targeted by institutions of social control in different ways at different times; pathologizing categories are not defined on the basis of inherent or natural characteristics; and there is no “eternal mad subject”. As Prilleltensky and Prilleltensky (2006, p. 265) point out, communities that define themselves “in inclusive terms reminiscent of solidarity” are more likely to promote wellness at individual and collective levels.

At the same time, I am aware that some others engaged in community work delineate the lines of membership differently, prioritizing identity and experience with
the psychiatric system, and might include only those who have direct firsthand experience with the psychiatric system or only those who identify as psychiatric survivors. While I include and explore such understandings throughout this dissertation, I do not adopt an identity politics framework in this project, even though I maintain that community work should always be founded on a historical and material analysis of the concrete disenfranchising effects of systems that construct people as deviant and in need of intrusive interventions, taking into account the everyday lived experiences of those who are currently theorized and persecuted as mad.

**A Community Model**

The above section addresses the philosophical understanding of the community I bring to the project; I have also developed a concrete model of the community to set workable parameters for the research. The defining features of the community are a shared commitment to curtailing sanism and psychiatric oppression, connection to actions and projects working towards these goals, a sense of comradeship with others involved in related struggles, and the geographic location of Toronto, Canada. Within these boundaries exists a vast array of ideological approaches, priorities, and goals, as well as particular experiences that are viewed as essential by some community members. These various ideological and strategic trends led me to create sub-categories to describe various factions and patterns in the community.

I have identified three main constituencies in the community: 1) the psychiatric survivor constituency; 2) the mad constituency; and 3) the antipsychiatry constituency. Each includes particular understandings of madness, sanism, and the
psy-complex; sub-goals aimed at transforming sanist and otherwise oppressive conditions in people’s lives; and strategies for meeting these goals. I named these constituencies according to the terms used most commonly by community members to describe their respective ideological or strategic approaches.

![Venn Diagram]

**Figure 1.1 Community Model**

As is seen in Figure 1.1, these three constituencies are not mutually exclusive. While each emphasizes different priorities, they overlap a great deal, and many community members identify with two or even all three constituencies. The psychiatric survivor constituency is at the heart of the community and overlaps significantly with both the mad and antipsychiatry constituencies. While the antipsychiatry and mad constituencies also overlap, they do so to a lesser extent, and are both largely defined within the community by their association and history with the psychiatric survivor constituency.

This model was derived from my observations of the community prior to beginning the formal period of data collection for the dissertation, and while its
organization makes sense from my vantage point as a community member and researcher, I would like to acknowledge that it does not represent the only way this community can be conceptualized. While it serves as a useful organizing tool in this dissertation, I am aware that differently situated community members with other priorities and understandings might see the community very differently. Most notably perhaps is the absence of consumer as a main constituency—a constituency that indeed has a deep connection to this community. However, given that the consumer constituency grew out of the psy-professions and government initiatives rather than the community itself, and that the consumer designation does not necessarily indicate attachment to the political community under study nor a commitment to challenging sanist and psychiatric oppression, I decided to treat it as peripheral for the purposes of this project. This is not to say that people who identify as consumers are not a central part of this community, for they certainly are present in large numbers, but their participation can unequivocally and consistently be traced to events and actions emerging from one of the three constituencies included in this community model. Indeed, due to the immense influence of the consumer constituency, it will be discussed at length at points in this dissertation, particularly in chapters 2 and 4, which focus on the community’s historical context and the contemporary psychiatric survivor constituency respectively.

My Social Location, My Values, My Career in Psychology, and My Stake in the Community

In this section, I provide some background information about who I am as a researcher, what my relationship is to the community, and what my professional, political, and personal interests are in relation to the subject matter of this
dissertation. This information helps shed light on my social location and contextualizes some of the assumptions, values, and perspectives that inform the framework of the current study.

My disillusionment with psychiatry began at a young age, as I learnt about family members who had sought “help” from psychiatry and who were subsequently given decontextualized diagnoses and were prescribed pills ranging from antidepressants to antipsychotics. I am a grandchild of holocaust survivors, and it upset me that my family members were being labeled as mentally ill for their foreseeable and understandable reactions to war and anti-Semitism. It was clear to me that the psychiatric framework did not do justice to the experiences of trauma survivors or their children, and the concept of drugs as a solution to their experiences seemed naïve and generally unhelpful. Throughout my teen years, a number of my friends ended up in the psychiatric system, and their experiences corroborated much of what I already knew. Their psychiatrists often did not focus on what was actually happening in their lives, but rather on the symptoms and behaviours that needed to be changed, whether that was starvation, cutting, or drug use. Again, the psychiatric response was to prescribe psychiatric drugs and to take away basic freedoms if they did not comply with their treatment protocols, such as the right to be in contact with friends and family, to wear clothes, or even to leave their hospital beds. At various points in my development, I really hoped that there were seeds of help in a system that seemed to be deeply flawed, but I could see little benefit derived in the lives of those I loved.

Witnessing the experiences of family and friends was in part what led me to pursue an undergraduate degree in psychology. I was interested in becoming a
psychologist who would help to transform the system into an establishment that would be more helpful and less oppressive to people. I was disappointed with my psychology education, which turned out to be rather inflexible, with only dominant perspectives taught, and very little room to develop critiques in the context of the courses. I decided to add women studies as a double major in order to learn in a space that was more politically in line with my worldview and used the women studies part of my degree to develop my critical thinking so that I could develop skills to critique oppressive theory and practice within the psy- complex. In the last year of my undergraduate degree, I came across writings from antipsychiatry and psychiatric survivor movements, quickly delved into reading about this political community, and made contact with a local consumer/survivor group to learn more. By the end of my undergraduate degree, I was convinced that I would not continue in a psychology graduate program. I had already decided that psychology as a discipline was too enmeshed with dominant perspectives that further oppressed those already marginalized.

When I found a graduate program in counselling psychology with many faculty members who identified as feminists and one faculty member who was an antipsychiatry academic and activist, I decided to apply. I was excited at the prospect of pursuing my childhood dream of becoming a psychologist without having to continue in an education system that contradicted so many of my values. I was ecstatic the day I received my acceptance letter. Some of my professors at graduate school were more open to critical thinking, but the curriculum was still shaped in many ways by dominant perspectives. I began to see how professional
psychological organizations had a lot of power in determining program curriculums. Although there were interesting feminist and anti-oppressive courses in the department, there were so many mandatory courses in diagnosis, assessment, and research methods that it was difficult to find time to take many of the courses that would help me develop into the kind of psychologist I was striving to become. I also witnessed students around me come to accept diagnosis and psychiatric assessment as helpful to clients. I developed research interests in the homophobic, sexist, and racist history of the psy-complex, and the critiques that I developed were generally accepted in my academic and activist settings, where people were to some degree committed to queer-positive, anti-racist, and feminist politics. Yet, even with this historical knowledge of psychiatric oppression, my colleagues would often fail to question psychiatry’s current approaches to understanding and treating people who struggle to survive in contexts that reject their means of processing, interpreting, and coping with the world. I found this to be particularly true in courses about diagnosis and assessment, as well as practicum courses where some students were in placements where they put into practice what we had learnt in the diagnosis and assessment courses. The psychotic disorders seemed to provide the ultimate truth for many students that mental illness is a real biological fact. I learnt that it would be a struggle to get the education and experience I wanted without compromising my values, even in what was considered to be one of the most progressive psychology programs, yet I was determined to continue and develop as a psychologist without contradicting my personal and political commitments.
I needed to counterbalance my academic life in psychology with an outside resistance to the aspects of my profession that contradict my political commitments. I joined the Coalition Against Psychiatric Assault (CAPA), a local antipsychiatry group that welcomed any person who rejects the theories and practices of biological psychiatry. This group consisted of psychiatric survivors, mad people, artists, actors, academics, and radical professionals. I found a home for myself in the antipsychiatry constituency, where I had not in the survivor movement in earlier explorations of resistance against psychiatric oppression. The focus on eradicating oppressive structures, rather than on connecting through identity and experience, created a dynamic where I could be centrally involved in community struggles. Some key antipsychiatry initiatives I have been involved with over the years include campaigns against ECT, public hearings about the effects of ECT and psychiatric drugs, and a conference called PsychOUT. I have also participated in organizing efforts that are associated primarily with the other two constituencies. For example, I was a key organizer of Psychiatric Survivor Pride one year and volunteered at Mad Pride for two years. At this point, I feel strong connections to various ideological perspectives and strategic actions emerging from different parts of the community, although I still believe that I fit most easily within the antipsychiatry constituency, because of my social location as a person deeply invested in community struggles who is not a survivor.

As I became more involved in the community, I met psychiatric survivors and mad people who had understandings about human experiences that were new to me and influenced my thinking and worldview. I met many people who had ended up in the psychiatric system because of how they reacted or coped with
oppressive conditions and traumatic events, and I met others who ended up in the system because they processed events in the world differently from what is considered to be normal, not necessarily due to experiences of trauma. Meeting the latter group of people challenged my previous conceptualization of what was considered to be “crazy” based on my experiences with family members and friends and led me to view some of my own emotional and perceptual experiences in a different light. I came to accept that there is a vast diversity in human cycles and processing of events in the world, and that sometimes, the only traumatic aspect to these human differences is the oppression of being seen and treated as “crazy,” and thus excluded from many aspects of society. I have met some people who have worked through and integrated their life experiences in ways that work with their current situation. I have seen others who have experienced trauma and have not gotten to this point, and those who process emotions and experiences in ways that deviate from what is deemed as acceptable that get them into trouble. Since dominant culture is not designed to prioritize community support and care, people suffer and are disabled by their environments that are not equipped with necessary support.

Today, my commitment in the community is to participate in transformative projects that work towards eradicating systems, which further marginalize many people, and building communities and contexts that are founded on values of equality, nurturing, mutual responsibility, collaboration,
support, and distributive justice. I see the work of building a more just world as a complex, perpetual, and transformative process that involves ongoing dialogue among diverse political communities addressing key ethical and strategic questions about how people can work together to uphold the common good. I believe that the needs of the most disempowered need to be at the centre of this dialogue, along with the understanding that each and every individual is affected by systems of power and oppression in different ways. I am in part driven by the belief that all people benefit from lifting oppression at the margins in the long-term, even if this means that some individuals must give up some power and privilege to help equalize current imbalances. This process entails an ongoing interrogation of the disempowering discourses that are propagated as static truths to open up space for the development of alternative understandings and potentialities. I believe that the knowledge required to (re)build systems must be grounded in diverse local communities. I do not expect that there will ever be complete agreement among all people, but by coming together around the vision of (re)making systems founded on principles of justice, diversity, collaboration, caring, and mutuality, we will be moving in a direction that better serves human needs.

I intend to continue engaging in the process of social transformation by

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4 Critical psychologist Prilleltensky (1997, p. 518) emphasizes the importance of professionals articulating their “personal and collective vision of the good life and good society” to generate dialogue about how psychological practices work towards particular moral visions. I agree that it is important to be transparent about the values and assumptions underlying our work as psychologists in order to avoid the common problem in our profession of “moral inertia,” which leaves the dominant social order in tact (Prilleltensky, 1997, p. 517).
working side-by-side with psychiatric survivors, mad people, and other marginalized people, while continuing to challenge regressive trends in the field of psychology in my role as an academic and professional. In my professional life, I will continue to work with other practitioners who share similar visions of transformative change; hold myself accountable to the above listed values and priorities; learn from local understandings emerging from various political communities; and in my work with individuals, do my best to help people stay away from, or navigate more safely, dehumanizing services, while they pursue their own transformative visions of a better life.

**Who Is This Research For?**

In my various roles as a community member, helping professional, and academic, I am living in drastically different social spheres, each with its own lens and entry point into the issues that I am addressing throughout this dissertation. Yet, I believe that the understandings presented in the research are relevant to all three of these different areas.

The sphere I kept at the forefront of concern throughout the entire research process is the community at the centre of this dissertation. My intent is to help open doors to new understandings and strategies that take into account the complexity of needs and desires of community members that might help foster building stronger alliances and solidarity networks. I was inspired to pursue this research because of concerns that grew out of the community, and my hope is that the findings and analysis will be useful to people engaged in community work.
This research is equally a contribution to social movement and feminist scholarship on working across difference and building solidarity. I draw on the wisdom of Black feminists, Womanists, lesbian, queer, disabled, working-class, and transnational feminists in the analysis of challenges and problems in the community, as well as in my interpretations of the problems faced by community members in building alliances with other political communities. Furthermore, the research brings concerns of psychiatric survivors, mad people, and antipsychiatry activists into feminist discourse about inter-community and inter-movement solidarity, while addressing compound oppressions, at a time when these concerns are addressed too infrequently, superficially, or not at all.

Finally, the information provided about the ideological, philosophical beliefs, and priorities emerging from the community, comprised primarily of psychiatrized people, can also prove useful to clinical and counselling psychologists. It is not often that the perspectives of psychiatric survivors, mad people, and antipsychiatry activists are presented in the psychological world in complex and nuanced ways, and I view this research project as an opportunity to bring this knowledge into the psy-realms in my role as a psychologist. I have included a chapter at the end of this dissertation written specifically for psychologists to highlight the insights gleaned from the research that I consider to be particularly relevant to their work, and I have plans to bring the research into various psy-venues as part of future consciousness-raising efforts aimed at individual and systemic change.
Outline of Dissertation

In the chapters that follow, I examine the philosophical and ideological understandings, priorities, goals, actions, and strategies emerging from the community; some tensions and conflicts that arise in the community around working across difference; the genuine attempts made by community members to build alliances, the challenges they face, and the notable progress they have made; as well as ideas for how community members and psychologists might proceed in light of the findings presented in the dissertation.

Chapter two provides information about the evolution of the Toronto community and a literature review of major works emerging from both the community itself and from professional and academic realms that have contributed significantly to the ideological, political, and philosophical development of the community.

Chapter 3 describes the methodology, design, and process of the research. It includes a description of participant demographics; the overarching methodological framework; data collection and recruitment procedures; and approaches to data management and analysis. It also introduces two levels of analysis that represent the main research findings and discusses various issues related to quality and limitations of the present study.

Chapters 4, 5, and 6 describe the unique ideologies, goals, aspirations, tensions, and struggles within each constituency, as well as the various ways in which community members have responded to questions of difference. The analysis of findings begins with the psychiatric survivor constituency, examining the historical tensions between survivors and consumers as well as other divisions that exist within
the constituency. It then goes on to explore how members of the mad constituency have tried to address these historical divisions, while creating new dynamics that affect solidarity work. It ends with the antipsychiatry constituency and describes the unique challenges that come with organizing around political ideology rather than identity, including both those who have been psychiatrized and those who have not in community organizing.

Chapter 7 turns toward an examination of inter-constituency and inter-community relations looking at specific examples of tensions between and among constituencies and communities that share transformative visions. I analyze problems blocking community members from building stronger solidarity networks and consider strategies for overcoming some of these blocks, drawing on analyses developed by feminist theorists who have grappled extensively with questions about building alliances and solidarity networks.

Chapter 8 concludes the dissertation with a section written for clinical and counselling psychologists, highlighting insights gleaned from the research that are critical of different aspects of professional practice.

Having introduced the relevant background and mapped the journey through the following chapters, we now move on to chapter 2, which puts into context the community under study and presents a literature review that includes literature from the community itself and from academic and other theoretical sources.
Chapter 2: Historical Context and Literature Review

The community made up of psychiatric survivors, mad people, antipsychiatry activists, and others involved in resistance against sanism and psychiatric oppression in Toronto is not without strong foundation. It grew out of a rich history of multiple efforts spearheaded by ex-patients, ex-inmates, self-proclaimed lunatics and crazy people, radical professionals, academics, feminists, and leftist activists. At many points in its history, the community looked different than it does today; its current form is the result of various events that took place at different points over time. Likewise, the way I conceptualize the community and the distinctions I make among the psychiatric survivor, mad, and antipsychiatry constituencies did not always ring true. In fact, many early initiatives, led primarily by ex-patients and ex-inmates, made little or no distinction among terms such as antipsychiatry, ex-inmate, or psychiatric survivor.

This chapter will provide information about the evolution of the Toronto community, shedding some light on how it has evolved to its current state, putting into context how it emerged, the key priorities which have defined it from the very beginning, and the differences that have led to divisions. The chapter will conclude with a brief review of literature emerging from both the community itself and from professional and academic realms that has contributed significantly to the ideological, political, and philosophical development of the community.

Early Resistance Efforts

To help situate the emergence of the Toronto community, it is helpful to briefly look at some key pieces of history. The beginnings of the contemporary global
community are not easy to trace, as there are many instances of people throughout the ages resisting the oppression of people deemed as mad. Common dates used to mark its beginnings range from as early as the mid-19\textsuperscript{th} century, when Elizabeth Packard of Illinois founded the Anti-Insane Asylum Society after being committed involuntarily to Jacksonville Asylum by her husband (Burstow, 2005; Chamberlin, 1990; Reaume, 2002), to as late as the 1970s, when ex-patients and ex-inmates\textsuperscript{5} joined forces with radical professionals, feminists, and gay liberation activists who were also challenging the psychiatric system (Starkman, 1981). There are also historical periods when other groups of people instigated resistance to get rid of inhumane interventions, albeit their efforts did not always take into consideration the perspectives of those deemed as “mad” and usually advocated for different kinds of intervention that would also pose problems (Gollaher, 1996). Whatever date is used to mark the community’s emergence, it is clear that there is a long history of resistance, and that while some of this history may not have direct connections to the contemporary community as we know it today, the resistance efforts primarily led by psychiatrized and mad people themselves have influenced the community’s self-understandings and have inspired several generations of activists.

\textbf{Ex-Patients and Ex-Inmates Joining Together in Struggle}

One of the first groups organized by psychiatrized people in North America was called We Are Not Alone (WANA), initiated by a group of people incarcerated in the

\textsuperscript{5} Throughout this dissertation, I use a variety of terms that refer to how people identify themselves in the community, including psychiatric survivor, mad, consumer, ex-patient, ex-inmate, among others. What terms I have chosen to use in any given context depends on the historical period and how the individuals to which I am referring identified themselves.
Rockland State Hospital in New York in the mid to late 1940s (Reaume, 2002). This was a self-help group run exclusively by psychiatrized people that offered a place where people could provide support and advice to each other (Reaume, 2002). By the early 1950s, WANA was taken over by psy-professionals who transformed it into a social service agency and clubhouse for people coming out of hospital, causing a political dispute that led to the dissolution of WANA as a self-help group (Reaume, 2002). The founders were pushed aside by professionals, who felt entitled to reconstitute the organization, and found themselves back under the control of those from whom they were seeking independence (Reaume, 2002). They resented the patronizing attitudes of professionals who believed that they could not function without psychiatric intervention, the same resentment that in the 1970s led psychiatrized people to revolt against this type of professionalized dynamic (Reaume, 2002).

There were a number of developments that created a situation ripe for an eventual widespread revolt against psychiatry. In the 1960s, a number of radical professionals and academics issued critiques of psychiatric theory and practice, describing psychiatry as a pseudo-science that runs prison-type facilities to keep those who have problems in living or who disrupt the hegemonic order out of the way (Szasz, 1960; Goffman, 1961; Laing, 1960; Foucault, 1961; Scheff, 1966). These attacks on psychiatry, alongside the rise of many social justice movements advocating for the civil rights of various marginalized groups, the prevalent use of neuroleptic drugs, and changes in fiscal policy, all led to large-scale deinstitutionalization in the 1960s in Canada and the United States, resulting in greater numbers of psychiatrized people being released into the community than ever before (Reaume, 2002).
Shortly after mass deinstitutionalization, in the spring of 1970, the Insane Liberation Front was founded in Portland, Oregon by a group of ex-patients (Reaume, 2002; Chamberlin, 1978). Though this group survived for only six months, news travelled throughout the continent that ex-patients were organizing, and this inspired others to organize similar groups in California, New York, and Boston (Reaume, 2002). These groups were drawing on the works of radical professionals and were primarily antipsychiatry in their vision, actively opposing forced treatment, drugging, ECT, and involuntary commitment (Starkman, 1981; Reaume, 2002). There was a militant energy to these groups, as people publically spoke out about their horrifying experiences with the psychiatric system, demonstrated in front of hospitals to confront their abusers, and made it clear they were fighting back against their oppression (Starkman, 1981; Reaume, 2002).

Around this same time, in 1971, a group of ex-patients in Vancouver, BC called a public meeting to discuss their experiences with the psychiatric system (Chamberlin, 1978). This meeting led to the founding of the Mental Patients’ Association (MPA), the first ex-patient group in Canada, made up of psychiatristized people who were determined to provide much needed services they were unable to find within the existing system (Chamberlin, 1978). MPA went on to do groundbreaking work in peer support and housing controlled by psychiatristized people and publicized their efforts via a newsletter called In a Nutshell first published in 1972 (Chamberlin, 1978; Reaume, 2002).
The Toronto Community Taking Root

Movement initiatives took hold in Toronto by the mid-1970s, when a small number of psychiatrized people in Toronto began corresponding with ex-patients in various US cities and in Vancouver, BC, keeping up with what was happening in the ex-patient/ex-inmate movement across North America mainly through grassroots publications and conferences (Weitz, 1988). Before long, they were inspired to begin organizing around issues pertinent to psychiatrized people in Toronto, and in 1977, they called a historic meeting in Cabbagetown for people with psychiatric histories to come together and share their stories (Weitz, 1988). This meeting spawned the very first community group in Toronto, originally named the Ontario Mental Patients’ Association, and later renamed On Our Own (1977-1996) in 1980 (Weitz, 1988; Shimrat, 1997).

The first pressing issue identified by the group was the dire need for a safe place where psychiatrized people could gather to support one another and to organize away from the psychiatric system (On Our Own, 1980). Congruent with this need, they first established a drop-in space where psychiatrized people were welcome to spend time, drink coffee, find people to help with self-advocacy, and talk to others about what was going on in their lives (Weitz, 1988). Out of this initiative grew others. For example, before long, it became clear that the group needed money to fund its projects, and group members needed to learn skills that would help them regain confidence, restore belief in themselves, and provide work. With this realization, On Our Own established the first survivor-run business in Ontario called the Mad Market, initially a booth at a flea market that raised money for the organization, which evolved into a
store (Weitz, 1988). Consciousness-raising and outreach were other critical priorities at this time, and so group members founded a publishing collective that started a magazine called *Phoenix Rising* (1980-1990). This publication discussed problems faced by psychiatrized people from a critical perspective and broadened the scope of the community by increasing communication with those who were not already involved (Weitz, 1988). Building a sense of community was a very high priority for psychiatrized people involved with On Our Own, given the sense of abandonment and isolation many people felt in familial and other social contexts during and after being treated as mentally ill. They tried to organize venues where people who had been through similar experiences could connect with each other, “find power,” share information, develop alternatives, and strategize about how to change “unjust mental health laws” (On Our Own, 1982, p. 2).

**The Defining Issues**

Building community, questioning imposed psychiatric identities, developing empowering identities, and helping psychiatrized people to believe in themselves have always been defining priorities in the community. At the same time, there are other key priorities that have defined what this community is all about: exposing and ending psychiatric violence, coercion, and involuntary intervention; developing affordable and sustainable housing options for psychiatrized people; creating employment opportunities and non-medical alternatives so that people who need support do not have to turn back to the psychiatric system. This is not an exhaustive or detailed list, but provides a sense of the major issues that have been central to the community from its inception to the present.
Challenging Psychiatric Violence, Coercion, and Involuntary Intervention

From the outset, community organizers identified psychiatric violence, labeling, incarceration, and forced psychiatric interventions as major problems. While positions on psychiatry have always been diverse among community members, there has also been a consistent and strong radical contingent centrally involved in organizing actions and demonstrations protesting these manifestations of psychiatric violence and coercion, educating psychiatrized people and the public about the dangers posed by psychiatry, challenging laws that allow doctors to declare people as incompetent and force treatment on them, organizing public hearings where psychiatrized people can speak out about the harmful effects of psychiatric interventions, and publicizing the deaths of those who were killed within psychiatric institutions. Although there is much left to be done, these efforts have been rewarded. Movements that oppose psychiatric violence are growing and resistance has resulted in achieving some policy changes and establishment of government-funded bodies designed to ensure some degree of accountability within the system.

Many of those who have organized around these issues have been psychiatrized themselves, although some groups and initiatives have always remained open to working with radical professionals and non-survivors who share the same social change goals. Nevertheless, even within mixed coalitions of survivors and non-survivors, a strong value is often placed on the need for initiatives and actions to emerge out of the political agendas of psychiatrized people themselves.

In the early days of community organizing, many psychiatrized people were becoming more radical in their visions as they connected to community, as evidenced by a shift in terminology in the early 1980s. For example, in 1980, in the first issue of
Phoenix Rising, many writers were no longer using terms such as patient or ex-patient but rather were employing the more radical terms psychiatric prisoner, psychiatric inmate, and ex-inmate. This was language, first introduced by labeling theorist Goffman (1961), which emphasized the parallels between being locked up in a psychiatric hospital and being locked up in a prison (Phoenix Rising Collective, 1980). By 1985, the term psychiatric survivor began to appear in the literature of radical magazines (Phoenix Rising; Madness Network News), implying that one’s experience with psychiatry was a harmful ordeal to survive.

In 1982, in Toronto, On Our Own hosted the tenth Annual International Conference on Human Rights and Psychiatric Oppression, an important event in the community’s history, which attracted over 130 ex-inmates and ex-patients from across Canada and the United States (Weitz, 1988). Attendees drafted and adopted the Declaration of Principles, a document very radical in its vision, stating that “the psychiatric system cannot be reformed and must be abolished” (Burstow & Weitz, 1988).

The following year, in 1983, the anti-electroshock movement in Toronto really took off, when a group of ECT survivors and allies held a public forum at Toronto City Hall to share their experiences with ECT. This event inspired about 30 activists to demonstrate against ECT on the following day in front of what was then known as the Clarke Institute of Psychiatry (now renamed the Centre for Addiction and Mental Health) (Burstow, 1988; Weitz, 1988). The momentum from these events culminated in a small group of people founding the Ontario Coalition to Stop Electroshock, an organization whose mandate was to advocate for a ban on ECT in Ontario. This group used a variety of tactics to lobby government and to raise awareness about ECT.
including: interacting with media, mobilizing demonstrations and sit-ins when
government officials would not cooperate with their demands, and organizing a set of
public hearings where ECT survivors testified about their experiences with the
procedure (Burstow, 1988; Weitz, 1988). This group succeeded in getting the
government to form an ECT review committee to investigate the risks and efficacy of
the procedure, but ultimately, the committee’s report came out in support of ECT
(Weitz, 1988). Nevertheless, a small but persistent group of activists, made-up of both
psychiatric survivors and non-survivors, some of whom experienced ECT and some
whom had not, continued to organize around this issue in a variety of groups that were
founded throughout the years, such as Resistance Against Psychiatry (1989-present)
and the Coalition Against Psychiatric Assault (CAPA) (2003 – present). In 2007, CAPA
reignited the flame of anti-ECT activism in Toronto by organizing a feminist anti-
electroshock campaign, Stop Shocking Our Mothers and Grandmothers!, which
highlighted that particular groups are more frequently subjected to ECT, in particular
elderly women and new mothers (Diamond & Weitz, 2008). This campaign caught on
in other locations in Canada and around the world, including Montreal, QC, Cork,
Ireland, and Ottawa, Ontario, and continues to thrive on a global scale, despite no
government having yet given into the demands of anti-ECT activists (Weitz, 2010).

The community is also motivated to organize and mobilize around the deaths of
people incarcerated in psychiatric institutions. Community magazines such as *Phoenix
Rising* (1980, 1982) have publicized the deaths of psychiatristized people, publically
exposing the dangers of psychiatric drugging and the abuse and neglect that takes
place routinely behind institutional walls that lead to such tragedies. A series of
publicized deaths in 1980 and 1981 and mounting pressures from the community
resulted in the establishment of the Psychiatric Patient Advocate Office (PPAO) (1982-present), funded by the provincial government, to address the poor treatment of incarcerated individuals and advance the “legal and civil rights of psychiatric patients in the province’s psychiatric hospitals” (PPAO, 2011). The PPAO has since proved to be a useful information resource for community members to keep track of the deaths of incarcerated people, to publicize the conditions surrounding the deaths, to pressure government for policy changes, to prevent future deaths, and to honour those who have died by commemorating their deaths at community vigils (PPAO, 2011; Martinuk, 2009). Community members have also tried to create change and seek justice through the pursuit of legal action against institutions where people have been harmed or killed due to abuse or neglect (Fabris, 2006). A number of individual survivors have tried to sue psychiatrists and psychiatric institutions for harm done through various forms of abuse within the system, and some survivors have worked together to file class action suits against psychiatric institutions or pharmaceutical companies (Fabris, 2006). While there have been many legal defeats, there have also been some remarkable victories in Canada and elsewhere that have inspired survivor resistance in Toronto. For example, in August 2005, Mullins won a legal suit against the Vancouver General Hospital for being wrongfully held in isolation and being forcibly injected with haloperidol by attendants (Mullins v. Levy, 2005 BCSC 1217). Taking legal action can be intimidating, lengthy, exhausting, and costly. Yet, survivors have witnessed people compensated for damages, public recognition of psychiatric assault and misconduct, some changes enshrined in law, and these markers of progress, however isolated, have had a tremendous impact on the sense of empowerment and collective spirit of community members in Toronto.
Over the last decade, the spread of psychiatric monitoring and control into community settings, in the form of Community Treatment Orders (CTO)⁶, has forced members of the community to enact a resistance response. As Toronto scholar and mad activist Fabris (2006, p. 2) points out in his M.A. thesis, people under CTOs share many of the same rights as ‘voluntary patients’ and ‘outpatients’ who cannot be physically restrained, forcibly drugged, or confined in a small room. Nevertheless, unlike ‘outpatients,’ people under a CTO are formally monitored and legally forced (not physically forced) to comply with appointments, treatments and other requirements as per the CTO ‘treatment plan’. Should they refuse, their legal status can easily be changed so that physical force can be delivered. When the possibility of CTOs was first introduced, there was resistance from psychiatric survivors, other community members, and vocal helping professionals who viewed these legal sanctions as a violation of human rights (Canadian Mental Health Association cited in Fabris, 2006). Groups like the No Force Coalition have been vocal in their opposition to CTOs and have used institutional procedures such as government hearings and independent education events to denounce their use. These actions have not succeeded in preventing the implementation of CTOs, and as such, psychiatric monitoring in the community still remains a major concern (Fabris, 2006).

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⁶ Community treatment orders are legal sanctions in Ontario used to monitor psychiatrized people in the community to make sure they are adhering to their “treatment” regimens.
Developing Affordable Housing Options and Eradicating Homelessness

While psychiatric violence was the primary focus of organizing in Toronto in the early days, other developments at the time also had a major impact on the direction of community activism. Most notably perhaps, in the late 1970s and early 1980s, a housing crisis erupted in Ontario during a period of deinstitutionalization, when large numbers of people incarcerated in psychiatric facilities were released into the community without adequate supports (Slater, 2005). In the mid-1970s, the Ontario provincial government began the process of deinstitutionalization as a cost-cutting measure, and in Toronto alone, thousands of psychiatrized people were released from the Lakeshore Psychiatric Hospital and the Queen Street Psychiatric Hospital (Slater, 2005). A minority of people who were discharged from hospitals moved into group homes, which were supervised by mental health professionals and shared many similarities with psychiatric institutions, such as mandatory psychiatric diagnoses and drugs, fixed bedtimes, mandatory reporting of daily activities and whereabouts, and forced activities during the day. Many others in the discharged population ended up homeless on the street or in unofficial boarding homes with extremely poor living conditions (Zinman, 1982; Capponi, 1982).

The housing crisis sparked action within the growing community of activists who were committed to challenging psychiatric violence and the oppressive conditions in the lives of those who were labeled as mentally ill. They recognized that adequate housing was absolutely critical in the lives of many psychiatrized people and an important starting point in helping people stay out of the psychiatric system (Capponi, 1992). Activists lobbied the provincial government and managed to get
them to react by closing down substandard boarding houses and by funding housing initiatives, such as HouseLink, a non-profit organization founded in 1977, established with the mandate to provide permanent, affordable, and supportive housing to people leaving psychiatric institutions (HouseLink, 2010).

Over the years, community members have continued to work to establish better housing options and to address poverty on a broader scale. They have often developed initiatives in coalition with organizations such as the Ontario Coalition Against Poverty or the Disabled Action Movement Now, or with agencies and organizations that have money to fund housing initiatives, such as the Parkdale Activity and Recreation Centre, which recently opened Edmund Yu Place, an apartment complex for psychiatrized people in Toronto (Balkissoon, 2010), and the Mental Health Commission of Canada, which is currently running the At Home/Chez Soi Project housing 770 psychiatrized people across Canada (Mental Health Commission of Canada, 2011). While some major gains towards adequate housing have been made at various points in the past 30 years, poverty and homelessness have not yet been dealt with in a systemic way and thus remain key concerns within the community.

**Creating Workable Employment Options**

In the early days of organizing, activists were also addressing other poverty-related issues affecting large numbers of psychiatrized people, such as unemployment, underemployment, and exploitative labour practices (On Our Own, 1980). In the 1970s, the government was pushing sheltered workshop programs, otherwise known as vocational rehabilitation programs, which segregated psychiatrized people and
disabled people within the workforce. These programs were established to provide disabled people with work, as a transitional step towards entering the competitive workforce, but generally consisted of doing menial jobs for extremely low pay, well below the minimum wage, and did not typically lead to market wage employment (Taylor, 2002; Wilkinson, 2009). This meant that psychiatrized people were not earning a living wage and did not have real opportunity to establish themselves in the outside world, thus remaining poor and vulnerable to further psychiatrization (Taylor, 2002). Psychiatric survivor activists in Toronto knew from firsthand experience the dismal working conditions in sheltered workshops and wanted to establish better work opportunities for psychiatrized people that would protect their dignity and give them a chance (On Our Own, 1980). Many had already witnessed the personal benefits of working in more empowering environments, for example, with On Our Own’s Mad Market. While this initiative did not provide survivors with income, in the words of Weitz, “it proved to ourselves and to the public that we weren’t a bunch of mental incompetents” (Weitz, 1988, p. 292).

This community-based knowledge led activists to lobby government to set up survivor-run businesses that would create employment opportunities with market salaries and the kind of flexibility that many psychiatrized people need (Caledon Institute of Social Policy, 1997). Their lobbying efforts were successful, and a number of businesses were started. The first survivor-controlled business supported by the government in Ontario was ABEL Enterprises, a woodworking business that started out as a work cooperative in 1981 (Caledon Institute of Social Policy, 1997). Other early prominent examples of survivor-controlled businesses in Toronto include A-Way Express Courier Services started in 1985 and Fresh Start Cleaning and Maintenance
Company started in 1990 (Caledon Institute of Social Policy, 1997). Since the 1990s, with the help of government funding and organizations such as the Ontario Council for Alternative Business, many more enterprises have been set up and are still in operation today, including the Raging Spoon Catering Company and Out of this World Café. In addition, there are various programs within psychiatric institutions, as well as within community agencies, that work at arms-length from the psychiatric system, that employ psychiatrized people as peer support workers, so that they can help support others who share similar experiences within the psy-complex. However, the number of employment opportunities for psychiatrized people are limited in number, often work environments do not provide adequate accommodations for the workers’ needs, and even when psychiatrized applicants are able to meet the requirements of a given work environment, discrimination against people labeled as mentally ill remains a barrier to getting the job.

Alternatives

Developing non-medical support options for psychiatrized people has always been a defining goal within the community. Even as community activists dedicate their resources to contesting psychiatric practices, there is always the looming question, if not psychiatry, then what? Community organizers are well aware that ending psychiatric violence is only one part of the equation and that sustainable alternatives need to be in place for people who are suffering, have problems in living, and have no place to turn. The earliest groups, such as On Our Own, strove to provide supportive alternatives by offering people peer support, a place to spend time, work and responsibilities, and mutually respectful social networks. Of course, the unmet needs
of many psychiatricized people are far greater than what grassroots volunteer organizations can offer, which has led many community organizers to seek out funding sources that allow them to set up other types of supports on an ongoing basis. Housing and employment programs are seen as the most important alternatives, given that, if these basic needs are met, the problems and stressors faced by the predominantly poor population of psychiatricized people will decrease significantly. Other important alternatives that community members have taken part in organizing or have consulted on include, non-medical crisis centres (i.e. Gerstein Centre), community drop-in spaces (i.e. Sound Times), feminist counselling and therapy services (i.e. Women’s Counselling, Referral and Education Centre), leadership and empowerment programs (i.e. Voices from the Street), structured peer support groups (i.e. Call Us Crazy), and community activism.

**Marked Divisions: Consumers, Psychiatric Survivors, Antipsychiatry Activists, and Mad People**

The rise of the consumer movement had an enormous impact on community organizing, particularly in the 1990s and onwards. This movement began in the late 1970s with a group of professionals trying to connect ex-patient advocacy with the notion of consumer rights (Reaume, 2002). At this time, professionals, such as Louis Kopelow and Robert Sadoff (1977), were urging other professionals to listen to the demands of consumers in order to create a more responsive mental health system that would be sensitive to the needs of patients (Reaume, 2002). This was a reformist movement that emerged within mainstream psychiatry and used the term *consumer* to advocate that patient perspectives be considered in planning their own psychiatric treatment (Reaume, 2002). However, the concept of *consumer* was eventually picked
up by governments across North America and people within grassroots communities to establish programs fully or partially run by people with firsthand experience of the psychiatric system (Reaume, 2002).

Some psychiatric survivors looked to the consumer movement with optimism, believing that cooperation with government could lead to funded programs that would alleviate problems of poverty, homelessness, unemployment, and might lead to the establishment of state-funded non-psychiatric alternatives (Church, 1997). Indeed, activists did find ways to use the notion of consumer to communicate with government officials in order to secure funding for work that would help improve the situations of many psychotraumatized people. For example, in 1991, the Ontario Ministry of Health committed almost 3.5 million dollars from the Anti-Recession Program budget for the Consumer/Survivor Development Initiative (CDSI) (in 2001, renamed the Ontario Peer Development Initiative), which funded a large number of survivor-run organizations and businesses. By 1992, 81 full-time equivalent positions had been created by CDSI projects with a total of 307 people employed (OPDI, 2010). Additionally, in 1992, CDSI convened a conference of economic development projects, which resulted, one year later, in the establishment of the Consumer/Survivor Business Council (now renamed the Ontario Council for Business Alternatives), which over the years has worked at sustaining consumer/survivor-run businesses and providing support to new ones (Church, 1997). Other types of support services were also set up in response to the needs identified by the ex-patient/inmate/psychiatric survivor community using government funding. For example, some key organizations that were set up during this period included the Gerstein Crisis Centre (1990 – present), a non-medical service established to provide a place for people in crisis to spend time and to sleep instead of
going to hospital; the Queen Street Patients Council (1992-2001), an organization whose mandate was to act as a survivor/consumer voice regarding hospital services provided at the then named Clarke Institute of Psychiatry; and Sound Times, an already existing drop-in centre that became survivor-run at this time (1992 – present)\(^7\).

While there were many apparent gains being made during the rise of consumerism, not all psychiatric survivors were comfortable with the consumer designation. Many felt that the term *consumer* undermined their political position, as it clashed with their analysis of psychiatry as a coercive institution, while promoting the capitalist myth that people can choose services and purchase them, when in reality, this is a luxury that most psychiatricized people cannot afford, given that the majority live in poverty (giannakali, 2007; Weitz, 2002; Shimrat, 1997). Skeptics of consumerism also feared from the outset that the consumer movement would lead to co-optation and worried that consumer initiatives would further divide psychiatric survivors, thus weakening grassroots initiatives (Shimrat, 1997). This led psychiatric survivor activists in different directions. For example, some community activists, such as the core group organizing the Ontario Psychiatric Survivor Alliance (1990-1993), a provincial wide organization supporting and connecting psychiatric survivor organizations across Ontario, had a strong distaste for consumer initiatives, but to some degree, decided to use consumer ideology in order to secure government funding by representing the organization as “comfy for consumers as well as...

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\(^7\) While the agency was in existence prior to this, Sound Times Support Services of Metropolitan Toronto was incorporated in August 1992 with the vision of the founding board to have Sound Times be staffed and governed by consumers of mental health services and psychiatric survivors (Sound Times, 2011).
survivors” with a mandate “to empower survivors to participate in making decisions about mental health policy... in the planning, implementation, delivery and evaluation of mental health services” (Shimrat, 1997, p. 97). They succeeded in their efforts when they received funding for half a million dollars from the Ministry of Health, but then were also forced to shift their founding mandate as a result (Shimrat, 1997). Other survivors felt that moving in this direction was a mistake and refused to use consumer language or ideology at all. For example, the West End Psychiatric Survivors (n.d. – 1995), a grassroots organization, never applied for government funding for fear of endangering the transformative vision of their group (Shimrat, 1997).

**Different Responses to Community Divisions: Formulating the Psychiatric Survivor, Antipsychiatry, and Mad Constituencies**

The rise of the consumer movement helped to clarify many of the ideological and philosophical differences within the community. It became evident that for some people, it is most important to maintain an uncompromising position against psychiatric violence and coercion; for others, it is more critical to do whatever it takes to meet the basic needs of the psychiatrized people in Toronto by addressing issues such as housing and employment, even if this means compromising with funding bodies that do not comprehend what activists want; and for others still, it is top priority to connect psychiatrized people with each other and provide community empowerment initiatives, without regard to analysis of psychiatry or approach to working towards social change. Groups of diverse ideological foundations have blossomed in the community, representing different priorities of the various constituencies. There has always been a great deal of overlap in terms of who actually
belongs to these various groups, while the groups themselves remain distinct from one another in terms of their stated goals and visions.

One major division within the community is between survivors and non-survivors. While at most times there have been at least a small number of non-survivors involved in community organizing, the first established groups, such as On Our Own, were only open to people who had experienced the psychiatric system firsthand (Weitz, personal communication, April 18, 2010). Some other initiatives that started out as being open to radical professionals and other people who did not have psychiatric histories became stricter with their boundaries of membership, as they felt that the presence of professionals compromised the ability of psychiatrized people to organize on their own terms\(^8\). In the contemporary community, these tensions persist. Some community groups and organizations have continued to organize along identity-based lines, working only at arms-length with people who have not been psychiatrized, either by only allowing members who have firsthand experience of psychiatry to join, or in some cases, by only granting voting privileges to people who have this experience (Shimrat, 1997). The philosophy of these groups emphasizes the importance of maintaining independence from psy-professionals, protecting the priorities that emerge organically from people who have been psychiatrized, and developing initiatives aimed at empowering psychiatrized people. I conceptualize such groups as belonging to the psychiatric survivor constituency.

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\(^8\) For example, there was much debate at the third Annual International Conference on Human Rights and Psychiatric Oppression, held in 1975, about how psychiatric survivors should respond to professionals who were dominating sessions (Burstow, 2005). They ended up boycotting the professionals’ sessions and declared their independence. At conferences in upcoming years, the organizers decided that professionals could only attend if they presented a letter of support from an ex-patient or ex-inmate organization (Weitz, personal communication, April 18, 2010).
Some psychiatric survivors and ex-inmates have grown frustrated with the limitations that come with trying to organize in groups with other psychiatricized people who do not share their political analysis and goals (Shimrat, 1997). This has led to the development of groups that are organized along different lines, defined by political ideology and political stance on psychiatry, and which often include both survivors and non-survivors. They are particularly focused on challenging various theories and practices that define biological psychiatry, often with a specific emphasis on psychiatric drugging, ECT, incarceration, or other types of forced intervention, and are known to organize direct actions, such as protests and demonstrations in front of psychiatric institutions, lobby government, and rarely (if ever) accept funding from government bodies. Examples of such groups include the Ontario Coalition Against Electroshock (1982-1987), Resistance Against Psychiatry (1989-present), and the Coalition Against Psychiatric Assault (2003 – present). I am conceptualizing these types of groups as belonging to the antipsychiatry constituency.

I would like to reiterate here that although I am naming divisions within the community, I am not suggesting that the psychiatric survivor and antipsychiatry constituencies are mutually exclusive. There is and always has been a great deal of overlap between the two, and indeed, it is quite possible for a psychiatric survivor group to also espouse an antipsychiatry philosophy (Burstow, 2005). However, the diversity of views among psychiatricized people dictates that identity-based organizing necessitates compromise that will always leave some people feeling uneasy. Those who prioritize identity politics view this as a productive endeavour nonetheless and struggle to find ways of accommodating different perspectives. For example, some community members and agencies have moved towards using the hybrid term
consumer/survivor since the early 1990s, viewing this as a compromise that acknowledges both survivor and consumer camps (Reaume, 2002). Many psychiatric survivors remain dissatisfied with this term, however, as they feel it renders both identity terms meaningless, erasing the critique of psychiatry from “survivor” and the element of choice from “consumer” (Reaume, 2002).

The emergence of the mad constituency represents yet another response to the lack of unity and an attempt to bridge some of the political differences among members of the community, particularly among those who have been oppressed as crazy. The term mad has been around for a long time in the community, used since at least the 1970s in reference to psychiatric survivor activism (Madness Network News; Phoenix Rising, 1990), but the mad movement really took off as something on its own in the early 2000s, after the book Mad Pride was published in the UK (Curtis, Dellar, Leslie & Watson, 2000). The main focus of the mad constituency is challenging the various forms of oppression faced by people who have been labeled and treated as mad within the psychiatric realm and other institutions, as well as asserting the subjective experience of mad people and mad pride – that is being proud of who one is regardless of how one is constructed by dominant cultural discourses.

Responding to Compound Oppressions and Power Dynamics

Historically, the most widely recognized issues of difference in the community have been based on ideological and social differences defined by one’s experience with psychiatry. Community members have debated time and time again how organizations and initiatives should locate themselves in relation to psychiatry and psy-

professionals, from whom they should accept funding, whether or not to admit as
members people without firsthand experience of psychiatrization, and which non-survivors should be embraced as allies. While not as yet a primary focus of community organizing, there have also been efforts throughout the years to address the specificities of differently situated people’s experiences, as shaped by various other factors, including sexism, racism, ageism, homophobia, classism, ableism, and many other forms of oppression.

There have been four key community responses to addressing difference in the community: 1) by addressing specific oppressions and how they are infused with experiences of psychiatrization; 2) by reaching out to other marginalized communities that are vulnerable to psychiatrization; 3) by creating separate identity-based organizations within the community addressing the specificities of particular experiences of marginalization and psychiatrization; 4) by creating venues where people can critically examine their coalition building efforts and re-evaluate what needs to be done.

The first response was perhaps the earliest in the community dating back at least to the early 1980s. While organizers were not considering compound oppression in all of their work, certainly there was a genuine attempt to include feminist, queer, and poor people’s voices in community organizing. Throughout the history of Phoenix Rising (1981a; 1982a; 1985; 1990), for example, there were complete issues devoted to addressing women’s experiences of psychiatrization, violence, and incest; the intersections of poverty and psychiatrization; and homophobic psychiatric theories and practices. Historically, community initiatives have also sometimes addressed other dimensions of oppression such as ageism (faced by both youth and the elderly),
racism, colonization, transphobia, and ableism, albeit far less often (Phoenix Rising, 1981b; 1981c; 1982b; Burstow & Weitz, 1988; Shimrat, 1977).

This leads us to the second approach addressing difference: outreach to other communities. Organizers have sometimes made efforts to link up with organizations in other marginalized communities with the hope of building diverse coalitions against psychiatric oppression (Burstow, 2005). This approach has met with varying degrees of success, and indeed, at times, has provided a much stronger foundation for community initiatives to move forward (Burstow, 2005). However, at other times, psychiatric survivors have found such connections to be damaging when potential allies have engaged with problematic discourses about psychiatrized people, such as, for example, the acceptability of involuntary incarceration or the inability of psychiatrized people to make decisions for themselves (Burstow, 2005). At other times, community organizations have not succeeded in attracting diverse groups of marginalized people, despite outreach efforts, an issue that will be explored further throughout this dissertation.

While not particularly common, community organizers have at times mobilized groups to address the specificities of particular experiences of psychiatric oppression, as well as the power dynamics within community groups. For example, the Psycho Femmes, an all-women arts-based performance group of psychiatric survivors that came together in the mid-1990s, was initiated by women psychiatric survivors who felt they needed a place where they could speak more freely about their experiences (Goodwin, 1997; Burstow, 2005). Another example that emerged in the 1990s was a survivor group that formed within and eventually separated from the Hong Fook Mental Health Services, which served Asian (primarily Vietnamese, Cambodian, and
Chinese) communities in Toronto (Capponi, 1997). There were benefits to groups like the Psycho Femmes and Hong Fook, as they provided safer spaces for some marginalized people to explore the specificities of their experiences and what to do in response to the oppressive conditions in their lives, away from other survivors who may not understand or acknowledge such differences among psychiatrized people (Burstow, 2005). Yet, despite these potential benefits, identity-based organizing emphasizing dimensions of identity and experience that expand beyond and shape psychiatric intervention was never long-lived nor common, with the few organizations taking these approaches lasting no more than a few years (Burstow, 2005).

Finally, the most recent strategy aimed at addressing difference in the community has involved first acknowledging that differences and tensions exist and then providing forums that promote dialogue about working in solidarity with differently situated others and building effective and diverse coalitions. For example, the organizing committee of the 2010 conference, PsychOUT: A Conference for Organizing Resistance Against Psychiatry, tried to engage people from different constituencies, communities, and movements that have a stake in challenging psychiatric oppression, included presentations that directly addressed coalition building and various issues faced by differently situated psychiatrized people, and made all these issues central conference themes (Burstow, 2010; DAMN, 2010; Diamond, 2010; Withers, 2010). The outcome of this strategy will be examined later in chapter 6.
Literature Review

Now that this chapter has described the evolution of the community in Toronto and contextualized its emergence, including differences and divisions that have emerged, it is useful to examine the literature that has influenced the ideological, political, and philosophical foundations of the community. The works within this body of literature stand in opposition to dominant discourses that portray madness as wrong, immoral, sick, or deficient. More specifically, these works focus overwhelmingly on critiques of biological psychiatry, which in contemporary times has been the dominant force in defining professional and lay understandings of mad people as chemically imbalanced, mentally ill, and often violent. I will only be addressing literature that has had a significant impact on community organizing to date. This means that some of the professional and academic literature that critiques psychiatry from an anti-racist, anti-imperialist, or anti-capitalist perspective will not be included in this literature review, despite my seeing potential for how these works might impact community work, as they have not yet had much influence on the ideological or strategic approaches that define the community (Fanon, 1952, 1963; Littlewood & Lipsedge, 1982; Mama, 1995; Metzl, 2010).

The literature review is separated into two sections. The first includes works coming primarily from the professional and/or academic realms, written by those who are critical of psychiatry or are antipsychiatry; and the second includes works developed by those who are directly involved with psychiatric survivor, mad, and antipsychiatry community organizing.
Professional and Academic Literature Critical of Psychiatry

In the 1960s, when biological psychiatry was first becoming a major force in theorizing and treating madness, dissenting psychiatrists began to speak out against the medicalization of human emotion and perceptual experience, bringing forth important questions about how historical and social context shape the psyche and about the social control function psychiatry plays in the organization of society. In many cases, these theorists opposed physical interventions used in biological psychiatry and instead advocated for talk therapies or other types of alternatives. Many of these theorists were labeled as antipsychiatry and are recorded in the history books as antipsychiatry professionals, despite the fact that many did not meet the criteria of today’s antipsychiatry activists to merit this label (that is holding a political position for the total abolition of psychiatry), and despite the fact that many outright rejected the antipsychiatry labeling of themselves. Nevertheless, they developed theories that have had a major impact on what is known today as the antipsychiatry constituency, as well as particular strains of thought popular within both the psychiatric survivor and mad constituencies.

Two psychiatrists who had a major impact on the early foundations of the community were Thomas Szasz and R.D. Laing. Both were deeply critical of biological psychiatry, its reductionist theories, and physical interventions, but what they chose to emphasize in their work was quite different. Szasz first popularized the notion of mental illness as a “myth,” arguing that there are no “neurological defects” at the basis of thinking and behaviours that cause “problems in living.” His work picked up by ex-patients and ex-inmates emphasized that what is labeled as “mental illness” in
actuality represents “differences in personal needs, opinions, social aspirations, values” that cause “human disharmony” (Szasz, 1960) and that institutional psychiatry represents an infringement on individual civil rights that equips psychiatrists with legal powers in the “hunt for the happiness of the Other” (Szasz, 1974; 1989, xv). He problematized the fact that people are imprisoned, under the name of “help,” without any evidence that they have broken the law and opposed ties between the state and psychiatry. Laing, on the other hand, was much more focused on experiences of madness, what they entailed, and how they were caused, as well as the development of non-medical alternatives. His basic premise was that delusions labeled as schizophrenic could be understood by examining abusive dynamics experienced in her/his family (Laing, 1964). He believed that people who had such experiences needed to be treated with respect in a nurturing environment until their “psychospiritual” crises had passed (Kotowicz, 1997). In line with this perspective, Laing and his colleagues established Kingsley Hall located in east London, a facility that was meant to provide a non-institutional environment where people could pass through their psychological and spiritual journeys (Kotowicz, 1997).

At the same time as Szasz and Laing were introducing such ideas and initiatives, Foucault’s (1961) book *Madness and Civilization* was published in French. This classic did not have a strong influence in the English-speaking antipsychiatry movement in its early days, but with the rise of poststructuralist thought, became an extremely important text among many contemporary mad and antipsychiatry academics. In his book, Foucault (1961) examines from a historical perspective ideas, practices, institutions, art, and literature relating to madness, demonstrating how etiologies and treatments of madness throughout history were designed to mask the
limits of social order and keep those deemed as mentally ill in their place, and by
extension, psy-professionals in theirs. He refutes histories of psychiatry that present
the institution as a more humane and benevolent one than those which predate it,
arguing that the contemporary physical interventions of biological psychiatry are
equally controlling as, for example, the earlier confinement houses (Foucault, 1961).

Labeling theory was another approach that had a significant impact on the
early foundations of the community, emphasizing that behaviours associated with
“mental illness” are contextual, rather than manifestations of disease. One of the most
influential contributions from this body of literature was Goffman’s (1961) book
Asylums, which offered the first sociological examination of what he referred to as
“total institutions” and provided one of the earliest detailed accounts of life inside a
psychiatric institution. In the latter half of the 1960s, Scheff (1966) conducted
research that sought to support labeling theory. He argued that psychiatric
professionals developed diagnostic language to identify, label, and suppress
inconvenient behaviours under the guise of “treatment”. Like Goffman (1961), Scheff
(1966) and other labeling theorists viewed psychiatricization and criminalization as two
similar processes in place to manage and control deviant individuals, by labeling and
treating them as either “mad” or “bad”, both of which created behaviours in
individuals that would either appear or disappear according to the individual’s social
context.

In 1970, Radical Therapist, a journal in the United States aimed at psy-
professionals who were critical of psychiatry, appeared on the scene. The journal's
collective introduced their motto on its cover: “Therapy means change, not
adjustment,” and included articles that looked at how to work as a radical therapist,
promoting feminist and gay liberation, as well as anti-capitalist and anti-colonial struggles, and critically examined how traditional therapeutic approaches work to oppress women, queer people, colonized people, poor people, children, and other marginalized groups (Chesler, 1971; Brown, 1971; Shelley, 1971; A Redstockings Sister, 1971; San Francisco Bay Area US-China Friendship Association, 1973; Landerson, 1973; Bickley, 1973). In 1972, the collective changed the journal's name to Rough Times, reflecting a different philosophical direction of many of its members who had grown disillusioned with all forms of therapy, and included contributions by ex-patients (Rough Times Collective, 1973).

In the early 1970s, feminists started to issue strong critiques of psychiatry and various forms of therapy, exposing their role in enforcing patriarchal gender roles by punishing women who did not conform. In 1972, Chesler published a groundbreaking book called Women and Madness in which she analyzed how psychiatry has been used to punish and control rebellious women and described intrusive psychiatric interventions as a mere extension of patriarchal violence. A few years later, in 1975, Smith and David edited a book compilation entitled Women Look at Psychiatry, which included some pieces by psychiatric survivors and presented a diverse range of materials examining psychiatrists’ interactions with women, about the gendered character assessments they make, and about the construction of statistics in the psy-disciplines. These two books became classics that inspired many more feminists to tackle various topics relating to gender, institutional psychiatry, and therapy, such as Penfold and Walker's (1983) Women and the Psychiatric Paradox, which examines both the psychiatric oppression of women and possibilities for the development of feminist alternatives; Ussher's (1991) Women’s Madness: Misogyny or Mental Illness,
which contextualizes the reasons many women experience emotional distress in society and examines how psychiatry pathologizes women’s responses; Caplan’s (1995) *They Say You’re Crazy*, which demonstrates the social constructedness of DSM diagnoses and how these diagnoses medicalize women’s experience; and Burstow’s (1992) *Radical Feminist Therapy*, which takes a feminist antipsychiatry approach to examine women’s problems in living in a violent patriarchal society and critiques traditional therapies while advancing radical feminist techniques to help support women in surviving violence.

During this same period, in the 1970s, a critical body of scientific research literature was born with the work of psychiatrist Peter Breggin (1975; 1979; 1980; 1981; 1983; 1990; 2008) who began to compile results in the medical literature that would unearth the damaging effects of psychosurgery, ECT, and psychiatric drugs. His work demonstrates that even research that purports to support psychiatric interventions can likewise demonstrate the damaging, often irreversible, life-altering effects of many of these “treatments,” when results are re-examined with a critical eye, a realization that has been very useful to activists within the community. Breggin continues to produce work today that critically examines empirical research about ECT and psychiatric drugs, and his findings are used frequently by community members, particularly antipsychiatry activists, who believe that hard scientific facts are needed in order to convince the masses that these interventions are detrimental to many people.

Professionals and academics have created a prolific body of literature critiquing the theoretical foundations of biological psychiatry and its treatments. While most were not actively engaged in ex-patient, ex-inmate, psychiatric survivor, mad,
grassroots antipsychiatry struggles, they have provided fertile ideas ready to take root in the context of community activism. The contemporary work of professionals continues to inform the direction of community activism, with the research and initiatives of psychiatrists like the late Mosher (1999), who was a pioneer in setting up community programs of psychosocial care, such as Soteria Houses; Breggin (2008), who continues to produce scientific literature critiquing popular psychiatric interventions including psychiatric drugs and ECT; Burstow (2008, 2009), who continues to produce feminist analyses of the detrimental effects of psychiatric interventions and is an outspoken antipsychiatry activist; and Knight (2009), who writes about non-medical ways of working with people who have “delusions, obsessions, and unusual experiences” without psychiatric drugs. This is not to say that the theories of these dissenters have not posed problems for activists who had been psychiatristized themselves, as many radical professionals and academics continue to espouse various forms of professional intervention, albeit usually not medical in nature, and some even make exceptions for those individuals who they believe are truly “mentally ill” and in need of drugs, ECT, and other physical treatments.

**Community Literature**

The literature emerging from the community of ex-patients, ex-inmates, psychiatric survivors, mad people, and antipsychiatry activists offers some unique contributions from those who are actively involved in the community, who have lived experience of being psychiatristized, or who are close to people who have this lived experience. What is unique about these contributions is that, for the most part, they privilege the standpoint of people who have been labeled and treated as mentally ill,
bringing to light a particular kind of knowledge about madness and psychiatry that most professionals and others cannot access.

Many of the first major community-based works emerging in North America represented a collaborative process between radical professionals and psychiatrized people. For example, *Madness Network News*, a newsletter that was launched in 1972 with an editorial board made up of both radical professionals and psychiatrized people, showcased narratives of people who had firsthand experience of psychiatrization, research about the detrimental effects of psychiatric interventions, and stories about community resistance efforts. The last issue of *Madness Network News* was published in 1986, but this did not mark the end of magazines that played a key role in community organizing. In fact, this was only one of many publications developed to help people and groups in the movement keep in touch regarding developments in similar political communities around the world. Other significant community magazines and newsletters which played a similar role included *In a Nutshell, Off the Shelf, On the Edge, ACT/ACTION*, and in the Toronto context, *Phoenix Rising*, which was published from 1980 to 1990 and developed an impressive readership in Canada, the US, and Europe.

*On Our Own* was among the first groundbreaking books published within the community, written by American ex-patient activist, Judi Chamberlin (1978). To put it in its historical context, this book was published shortly after the third Annual International Conference on Human Rights and Psychiatric Oppression in 1975, where psychiatrized people boycotted professionals’ sessions and declared their independence from them after professionals dominated and ignored the needs and issues of psychiatrized people (Burstow, 2005). This was a time when many
psychiatrized people involved in the global community were growing weary of their alliances with radical professionals, and Chamberlin’s book title reflects this type of separatist sentiment, implying that psychiatrized people must organize on their own, away from professionals (Chamberlin, 1978). She emphasizes throughout her book the capabilities and strengths of ex-patients by providing descriptive accounts of the successful alternatives they have developed, such as the Mental Patients’ Liberation Project in New York, NY and the Mental Patients’ Association (MPA) in Vancouver, BC.

One decade after Chamberlin’s book was published, another influential book called Shrink Resistant, edited by Bonnie Burstow and Don Weitz, came out as an anthology of community perspectives in a Canadian context. The vast majority of the book was written by ex-patients, ex-inmates, and psychiatric survivors and included stories, poems, journals, and graphics that explored what it meant to be “branded as ‘crazy’ and imprisoned in Canadian psychiatric institutions,” as well as giving accounts of some community resistance efforts (Burstow & Weitz, 1988, p. 19). One important dimension of this book, particularly in relation to the topic of this dissertation, was its attempt to examine psychiatric racism, classism, sexism, and heterosexism, by including contributions by Aboriginal people (Harper, 1988; Vermett, 1988), women (Frank, 1988; Harries, 1988), queer people (Blackbridge & Gilhooly, 1988), and other marginalized people. While it was not the first publication to address the oppression of differently situated people, as the Phoenix Rising collective had certainly demonstrated a degree of commitment to examining psychiatric oppression through various different lenses, the extent to which the editors of Shrink Resistant attempted to do so is an important marker of the commitment of some community members to include diverse populations of psychiatrized people who are targeted by psychiatry, but are
not well-represented in psychiatric survivor or antipsychiatry initiatives across Canada.

Another type of literature issuing from the community is that which attempts to critically analyze the challenges and successes of the movement in order to help organizers develop more effective approaches. Almost one decade after Shrink Resistant was published, another book entitled Call Me Crazy, edited by Irit Shimrat (1997), was published that attempted to provide a critical analysis of the Canadian movement. This book, mostly narratives written by people who have firsthand experience of psychiatrization, goes into much more detail about community strategies that have worked and those that have not. Like Burstow and Weitz (1988), Shimrat (1997) also made an attempt to include a diversity of psychiatrized voices in her work by including Aboriginal, disabled, queer, and women’s perspectives in the compilation, offering a glimpse into some of the reasons it has been hard to mobilize differently situated psychiatrized people who face racism, ableism, and sexism within psychiatric survivor and consumer groups.

Likewise, at the recent 2010 PsychOUT Conference, there were a number of presentations that critically analysed strategic approaches used in community organizing and the power dynamics among differently situated community members (DAMN, 2010; Withers, 2010; Diamond, 2010). Although many of these perspectives are not found in the literature, some articles grappling with these issues were published in the conference proceedings, including Burstow’s (2010) keynote speech, which introduced an antipsychiatry abolitionist approach; Diamond, Burstow, Reaume, and Menzies’ (2010) panel contributions, which considered the role of
academia in mobilizing resistance; and Withers’ (2010) presentation, which addressed the problem of ableism within psychiatric survivor and antipsychiatry organizing.

Other literature emerging from the community has focused on developing history and a type of cultural etiology for mad people and psychiatric survivors. Some early works already mentioned included comments, articles, and editorial pieces devoted to examining the historical treatment and resistance of mad and psychiatristized people, going back in history to when “witches, midwives and wise women” were persecuted by the Church (Chamberlin, 1988; Burstow, 1992); the rise of the asylum in the late 17th century; and the rise of psychiatry in the 19th and early 20th centuries (Burstow, 1992). However, it was not until the mid- to late- 1990s that community members began to focus a great deal more energy on developing a strong community history and culture. One critical book in this regard is Reaume’s (2000) Remembrance of Patients Past, which provides a detailed history of the lives of people who were incarcerated in the Toronto Hospital for the Insane from 1870 to 1940, examining and describing their daily lives, their relationships, their work, their interests, and their resistance. The rise of the mad movement has also led to a much greater emphasis on mad history and culture. For example, the book Mad Pride, published in the UK in 2000, offers a compilation of stories, poems, pictures, and photographs by those who identify as part of “mad culture,” including some pieces focused specifically on the history of mad people dating back to the middle ages when, in the words of UK mad activist Leslie (2000, p. 67), “madness was an experience capable of expressing essential truths about the world.” This book uses the history of mad people and psychiatric survivors to demonstrate a trans-historical cultural connection among people oppressed as crazy, in an attempt to provide mad people with deeper
connection to one another and to the community at large (Curtis, Dellar, Leslie & Watson, 2000).

Finally, there is an important body of literature emerging from the community that focuses specifically on the dangers of psychiatric interventions, such as psychiatric drugs, electroshock, and other “treatments,” some of which are no longer in use today. These works tend to rely much more heavily on research coming from the professional realm, whether or not these works are ideologically aligned with the positions of professionals, in order to argue in scientific language that various psychiatric “treatments” are harmful to people’s well-being, often causing life-altering, permanent, and devastating effects. Some of this work appears in early issues of community publications such as *Madness Network News* and *Phoenix Rising*. Other influential publications in this stream of literature include Frank’s (1978) *The History of Shock Treatment*, which provides a comprehensive review of ECT, including historical precursors to the intervention, as well as a wide range of information drawing on scientific research, art, advertisements, articles, and many other primary sources; *Dr. Caligari’s Psychiatric Drugs* by Richman, Frank and Mandler (1987), a book designed to disseminate information about the effects of psychiatric drugs to psychotized people so that they are equipped to make informed decisions; Whitaker’s (2002) *Mad in America*, which provides a historical and scientific review of medical interventions used on mad people from 1750 to the early 2000s; and Andre’s (2009) *Doctors of Deception*, a book which draws on historical and scientific research about ECT, as well as her own experience, to demonstrate its dangers. Other works are focused specifically on how to apply this information to help individuals withdraw from addictive psychiatric drugs or to cope with difficult experiences without relying
on medical interventions, such as *Coming Off Psychiatric Drugs*, edited by Lehmann
(2004).

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The initiatives and literature emerging from the community represent a rich
tapestry of perspectives, weaving personal stories of madness and psychiatric trauma
with science, politics, and various approaches to healing, empowerment, and
resistance. What I have described here can only offer up a glimpse at the community's
vibrant history and but a peek at the expansive body of literature that is out there.
Nonetheless, it provides a focused picture of many of the key foundations that define
what this community is all about. The details that are included provide necessary
context to understanding the present study. I invite readers to let this context be their
guide as they work through the remainder of the dissertation looking next at the
methodology before meeting up with many of the cited activists and authors who have contributed to this research.
Chapter 3: Methodology

This chapter provides a description of the research methodology, design, and process used to conduct the present study, which looks at the heterogeneity of Toronto’s political community engaged in resisting psychiatric oppression and sanism and identifies blocks that prevent its members from working together more effectively. I begin with a summary of participant demographics to provide the reader with an understanding of who participated in the study, followed by a description of ethnography and critical ethnography, which make up the overarching methodological framework. I then go on to describe the particular research activities I used to collect data, the methods used to recruit participants, and the means by which I managed various data records. I provide a detailed account of how I approached data analysis, and I introduce two levels of analysis that emerged, the first examining the goals emerging from various constituencies within the community, and the second examining what blocks community members from building solidarity across difference and strengthening networks resisting psychiatric oppression and sanism. The chapter ends with a discussion centered on issues pertaining to the trustworthiness and credibility of research findings, as well as limitations of the present study.

Participant Demographics

A total of 40 people participated in this research through taking part in one or a combination of the following research activities: a Freirian codification group with psychiatric survivors and mad people (n=9), a focus group with community activists (n=14), a focus group with members of my research support team (n=3), semi-
structured one-on-one interviews (n=17), and unstructured interviews or conversations in person, over the phone, or via email (n=7). All participants in this study identified as part of this Toronto-based political community and had varying degrees of experience organizing and/or participating as community members, ranging from three months to 35 years. Most were actively engaged in the community at the time, with the exception of three people who were taking time off from active involvement due to either personal struggles or events in the community that led to their departure. The extent to which participants took part in the present study varied a great deal, with some people only participating in one group discussion, one interview, or one short conversation, and others taking part in both groups in addition to some of the various other research activities.

Participants had a wide range of identities in relation to the community, including psychiatric survivor, consumer/survivor, antipsychiatry activist, mad, crazy, lunatic, progressive or radical professional, and ally. The vast majority of participants (89%) had firsthand experience with the psychiatric system, while a few came to the community because of experiences they had with friends, family members, or clients in the psy-complex and/or because the political goals emerging from the community resonated with their broader political understandings and aspirations.

Participants represented a diverse cross-section of the community in terms of age, gender, sexual, racial/ethnic, disability, and class identities. Participants were fairly diverse in terms of gender identity and sexuality, with 22 women, 13 men, 5 people who identified as trans, genderqueer, or questioning/undecided, and with 55% of participants identifying with non-heterosexual or otherwise non-normative sexual identities, such as queer, gay, lesbian, bisexual, BDSM femme, butch, asexual, and
questioning. There was less diversity in terms of race, with only 25% of participants identifying as racialized (including Chinese-descent, Asian, Arab, Black, Mediterranean, and mixed race), 23% identifying as Jewish, 8% identifying as Italian, and the remaining 44% identifying as white or choosing not to disclose their racial/ethnic identity. This racial and ethnic representation is fairly representative of the cross-section of people who are actively involved in this political community, although not representative of the psychiatristized or general population of Toronto. Participants from many different age groups took part in this research, ranging from 20 to 88 years, with an average age of 44 years. Thirty-seven percent of participants identified as disabled, excluding experiences of madness⁹, and one participant identified as Deaf. Most participants identified as either working-class or poor (n=20), with a sizeable number identifying as middle or upper class (n=16), and a small number deciding not to disclose their class identity (n=4).

A combination of pseudonyms and real names are used throughout the dissertation. I gave participants a choice of how they would like to be represented in the write-up of this project, and while some wanted to remain anonymous, many wanted their real names to be included. In some cases, people who used their real names wanted certain ideas or experiences they shared to remain anonymous, in which case I did not use their real names in those specific instances. The write-up therefore contains a combination of real names, pseudonyms, and anonymous sources and reflects how participants wished to be represented in the research.

⁹ Some community members conceptualize madness as disability, while others do not. For the purposes of demographics in the present study, I excluded madness from the category of disability.
Methodological Framework: Ethnography and Critical Ethnography

The present study is of a critical and ethnographic nature. From the beginning, I set out to study and describe a particular community organizing against sanism and psychiatric oppression in Toronto, Canada (Spradley, 1979). In the world of ethnography, what is understood to constitute a particular community or cultural group is quite broad and can include any group that “shares and engages within a common psychosocial experience, in a given space” (LeFrancois, 2008, p. 45). For example, ethnographers have equally studied the “culture” of Hindu people from a South Delhi Punjabi community (Chawla, 2006), the “culture” of psychiatric inmates who are children living in an inpatient psychiatric facility in the UK (LeFrancois, 2008), or the “culture” of activists in the liberationist Catholic movement in Brazil (Burdick, 1995). In this dissertation, I am conceptualizing a political community consisting of psychiatric survivors, mad people, and antipsychiatry activists in Toronto as a distinctive community that is brought together based on their sense of comradeship with each other, their collective aspirations to challenge sanism and psychiatric hegemony, and their shared geographic location.

Ethnographic methods of data collection typically involve being physically present in the geographical location where the research is being conducted over an extended period of time, while participating in community events, engaging in participant observation, taking field notes, and/or conducting interviews (Malinowski, 2007; Gubrium & Holdstein, 1997; LeFrancois, 2008). My involvement in this community has spanned nine years at the time of penning this thesis, during which time I was extensively involved with the Coalition Against Psychiatric Assault,
participated in and organized various community events, developed social relationships with other community members, and came to understand many ideological and practical concerns emerging from various parts of the community. The actual period of my data collection lasted a total of three years, during which time I continued my regular involvement in the community while keeping observational records of events in my research journal and collecting information through formal interviews, two focus groups, a Freirian codification group, unplanned conversations, conferences, and public presentations. I attempted to make sense of community events and understand the ideas, beliefs, and knowledge characteristic of differently situated community members by drawing on their insights, as well as on my own observations and interpretations (Fielding, 1993; LeFrancois, 2008; Sorell & Redmn, 1995). I developed a complex and detailed understanding of the community through my participation as a community member and researcher, but at the end of the data collection process, realized that I had to take a step back from the community in order to make sense of the data I collected. This is in line with other ethnographic studies, which typically involve living closely among community members to develop an understanding of their culture and perspectives, and then leaving the community to make sense of the experience (LeFrancois, 2008).

Ethnography has been the subject of intense critique, particularly among postcolonial, feminist, and deconstructionist scholars. It originated as a colonial method of knowledge production that has been used as a tool to produce “the colonized Other as a knowable, bounded, and governable object” (Traub-Werner, 2010, p. 38). Postcolonial and feminist texts offer numerous in depth critiques of ethnography, which I do not intend to explore here (Visweswaran, 1994; Chatterjee, 1989).
2002; Spivak, 1988; Ismail, 2005; Gidwani, 2008). Rather, I am interested in examining what I have borrowed from other researchers who have used these critiques to develop ethnographic methods that problematize categories and positivist divisions in the social sciences (Traub-Warner, 2010). This emerging methodology is called critical ethnography, and it complicates the dualisms underlying traditional ethnographic research, such as the separations made between theory and method or subject and object (Traub-Warner, 2010). The present study draws on the insights of other activist researchers who are attempting to transform the epistemological foundations of ethnography and refuse traditional methods of colonial knowledge production, while acknowledging that this ethical and political commitment is a perpetually evolving project rather than something that can be easily accomplished (Traub-Warner, 2010).

One of the defining features of critical ethnography is that it explicitly addresses issues of power and domination (Koro-Ljunberg & Greackhamer, 2005; Thomas, 1993). This dissertation, then, has emerged from my ethnographic encounters with differently situated community members, a process of interrogating categories emerging from the psy-disciplines and analyzing the ways psychiatric survivors, mad people, and antipsychiatry activists communicate their experiences in relation to these categories. From the outset, this research de-centred hegemonic assumptions about psychiatry and other psy-disciplines, madness and mad people, while privileging the perspectives of psychiatric survivors, mad people, and other community members who are vested in challenging sanism and psychiatric oppression. I was committed to conducting research that did not reify dominant portrayals of psychiatrized and mad people—as defective, “emotionally traumatized”
and injured or as “frail revolutionaries”—as is typical in academic and psychological research (Fabris, 2006; Everett, 2000). I was determined to resist what has been termed as psychological hegemony (Fabris, 2005; Myers, 2002)—meaning the power relations that construct human difference as illness or weakness and psychiatry as a necessary service—and to bring forth the complex and sophisticated understandings, goals, and priorities emerging from the community.

In line with this commitment, the present study begins its inquiry from the perspectives of community members, all of whom maintain, to varying degrees, that psychiatric constructions of people and the world around them are flawed. Through ethnographic encounters, I seek to understand what community members are thinking about the problems posed by the psychiatric system and sanist attitudes defined by dominant culture and what they hope to do to alter the current organization of society. Drawing on feminist standpoint theory, I attempted to achieve this understanding by placing myself on the “same critical plane” as the subjects of inquiry, using my own personal experiences as a community member and by empathizing with the experiences of differently situated others (Harding, 1999). This methodology required study of community members’ ideological and practical concerns, their goals, hopes, and aspirations, which ultimately led me to focus the central question on the collective desire to build stronger networks with others interested in resisting psychiatric and sanist oppression, on the barriers preventing the creation of such networks or contributing to destroying existing networks, and on strategies for helping community members meet their shared goals. This focus is political in nature, privileges knowledge that critically examines power structures from below, rather than from the
top where oppressive conditions stem, and aims at developing knowledge that will help community members work towards their transformative visions of change.

I also attempted to take measures throughout the data collection process to ensure that those within the community who are not often heard would have a presence in the dissertation. The silenced voice of women was the first issue that became obvious early on in the research that I needed to address. When I was recruiting community members to take part in the focus group and Freirian codification group at Psychiatric Survivor Pride, two women told me that they would prefer to do one-on-one interviews, because they did not wish to take part in discussion groups where they expected sexist group dynamics. This fear was confirmed in the focus group at Psychiatric Survivor Pride, where one woman, Rachel, who had taken part in the morning codification group, noted that she found it difficult to speak about her experiences in the mixed-gender groups due to the differences in experiences between the men and women, as well as the tendency of the men to monopolize discussion. These dynamics were in part what inspired me to conduct one-on-one interviews, for which I specifically sought out encounters with people who might not otherwise be represented. While I made these efforts to create space for marginalized voices in the dissertation, in some ways, I did not address this issue to the extent I would have liked. In some areas, my data are dominated by the voices of well-known community leaders, rather than those at the margins. In part, the prominence of these participants came from my desire to capture their influential perspectives in my description of community ideologies and approaches, and in part, because I was not fully aware of the relative dominance of these perspectives until later in the data collection process, a period when I had little time left to gather
information. If I were to continue collecting data for this project, my focus would be on the marginalized voices within the community that are less prominent in the research findings and what ideological and strategic insights they have to offer.

Related to this issue, another dimension of power that is explicitly addressed in critical ethnography is my own subjectivity and positionality as a researcher and how this affects the research itself. This includes consideration of my social location in relation to others in the ethnographic context; my underlying interests, assumptions, and values that shape my interpretations; and the impact my actions have in the community (Madison, 2005; Ma, 2009). This means that while I attempt to place myself on the “same critical plane” as other community members, I also recognize that I do not share the same social location as all community members in terms of my experiences with psychiatry and sanism, sexism, racism, homophobia, transphobia, classism, ableism, and other forms of systemic oppression, nor do I share identical goals and priorities with all other community members. My personal, professional, and political interests all affect my understandings, approaches, and interpretations of the phenomena under study. I try to account for this by being self-reflective and transparent about my own social location, my political and theoretical orientations, assumptions, values, and struggles, and in how I account for all of these different factors at various points in the research process. For example, I acknowledge that my position in the community has affected to some degree who is represented in the research and to what extent.

Burdick (1995) argues that ethnographic research is particularly useful for developing knowledge helpful to activists in political communities by focusing attention on the “social and ideological heterogeneity of their mobilized and
unmobilized constituencies” often glossed over in literature on social movements (Burdick, 1995, p. 362). He states that the exploration of heterogeneity in the social composition, cultural practices, and political positions of various constituencies can potentially reveal processes of “growth, shrinkage, rupture, and disintegration” – all key factors in illuminating a community’s potential for mobilization and transformative change. In the hands of sympathetic and committed critics, Burdick (1995) contends that an analysis exploring heterogeneity and contestation can be extremely useful by helping community organizers develop a stronger understanding of the tensions and conflicts between constituencies and how these are linked to the particular ideas, beliefs, and experiences. I share Burdick’s (1995) hope that producing knowledge about the differences among constituencies in this political community can be used constructively to better understand patterns of tension and conflict that arise, address these patterns, and work towards building community defined by central values, such as mutual support, human caring, and equality.

Research Process and Design

**Research Activities**

My research journal, informal discussions, and participant observation. During the three years of data collection, I kept a research journal where I wrote notes about my various ethnographic encounters, including my observations at community events, informal conversations and online discussions with community members, and my thoughts and reflections about what I was learning. My research journal was an extremely rich source of data throughout all stages of my research that offered a way of recording impromptu interactions between myself and other community members.
that emerged organically at events and in social situations. Allowing myself to include these unplanned encounters resulted in people’s interests and concerns emerging in a more natural way than in the more structured research activities. While I had many impromptu conversations with many community members, some had more impact on the direction of my research and on my thinking than others. For this reason, I have included seven of these conversations in the write-up of the dissertation, because they generated novel insights on working across difference and building solidarity networks across constituencies and communities.

Without question, being immersed in the community and participating in community activities over a period of nine years, during three of which I spent observing and recording notes in my research journal in addition to my usual engagements, led to a much richer understanding of various community ideologies, priorities, and internal conflicts than what I could have grasped from the other research activities alone. Yet, the process of participant observation in the present study differed somewhat from what might be expected in traditional ethnographic research, because of my prior involvement in the community and the nature of my engagement as a community member. Typically, researchers enter into a community that they are not already part of and attempt to assume the role of community members to understand their thoughts, feelings, and actions (Wiersman, 1995; Bonner & Tolhurst, 2002). At the beginning stages, participant observation is used to develop rapport with key informants and stakeholders, whose assistance and approval are needed for the study to happen, as these relationships are what allow the researcher access to particular settings (Bonner & Tolhurst, 2002); to determine what types of questions will be relevant in other methods of data collection; and to figure out
effective methods for recruitment (Mack, Woodsong, MacQueen, Guest & Namey, 2005). My insider position as a community member meant that I was beginning this project with certain advantages that an outsider would not have. I was coming in with an intimate understanding of the community I was studying; I did not have to worry about altering group dynamics or social interaction unnaturally; and I already had established relationships with participants that would help facilitate access to community settings (Bonner & Tolhurst, 2002; Reed & Procter, 1995; Kennedy, 1999). As an insider, I already knew where to gather data, and I was familiar with and had already attended many key events in the community. This prior knowledge allowed me to gather rich and focused data and helped me to identify when something that was happening was unusual or different (Bonner & Tolhurst, 2002).

Yet with these insider advantages came challenges, which I had to work through to overcome. Throughout the project, I continued in my regular activities within the community, and I became so enmeshed in the study environment that it became difficult to step back and ask questions about the data in my role as a researcher. It became hard to distinguish between what was emerging knowledge and what was already established or to recognize relational patterns, because what I was observing was already so familiar to me (Lipson, 1984). I also found it hard not to get caught up in interpersonal dynamics when people in the community became upset, particularly when I was involved in an action that was related to conflict, which made it more difficult for me to analyze the situation. These issues posed challenges throughout the course of my research, but I found some ways to mitigate them. There were two key people to whom I would speak when I found myself getting upset about events in the community in order to help me regain focus. I would also check in with
participants when I was unsure if I was interpreting in a fair manner what they were
telling me, and I would use my supervisor as a sounding board to check if my
interpretations of group dynamics in antipsychiatry organizing were accurate from
her point of view, mostly to make sure I was not being overly critical of work in which
I was directly involved. Near the end of my data collection, I decided to resign from my
organizing responsibilities in the community so that I could get some distance from
what I was studying, remove myself from the emotional weight associated with some
of the events unfolding in the community, to take a step back to gain critical
perspective on my data. Taking distance from the community for one year helped me
to read my field notes and transcripts through a researcher’s lens, less clouded than
my heretofore habitual lens of community organizer who was deeply vested in
particular outcomes.

While there were challenges involved throughout the process of participant
observation, overall, being immersed in the community was extremely helpful in
understanding and interpreting data and provided a context in which I was able to test
hypotheses and hunches based on information emerging from other research
activities.

**Freirian codification group.** One of the first research activities I
conducted in this study was a Freirian codification group with psychiatric
survivors and mad people aimed at gathering information about their goals,
aspirations, and blocks preventing them from meeting these goals. A Freirian
codification group is a consciousness-raising group that uses visual tools called
codifications to help people examine their oppression and identify possibilities for
resistance.
This codification group technique, adapted from Freire’s approach to liberatory education, was designed to support oppressed people in becoming conscious of the nature and causes of their oppression and in developing strategies for resistance. It employs a problem-posing methodology, in which educators who are knowledgeable about the history and situation of the community hold meetings where community members are invited to identify their hopes and aspirations, the problems in their everyday lives that block them from actualizing these hopes and aspirations, and the systemic causes of the oppressive conditions in their lives (Freire, 1970). It aims at deepening people’s collective understanding of culture, and self in culture, so that they become more aware of their oppression, eventually come to reject the images of the oppressor housed within them, and find their own language to describe themselves and the world (Freire, 1970; 1973).

Freire describes the codifications themselves as objects (i.e. drawings or photographs) that reflect existential situations that occur in the daily lives of oppressed people. The codifications represent themes that are characterized by social structures that privilege some and oppress many others (Freire, 1970). The themes embody social contradictions, referred to by Freire as limit-situations, that denote both the hopes and aspirations of the people and any blocks that prevent fulfillment of these hopes and aspirations (Freire, 1970; Burstow, 1991). The themes and the actions that are needed to change oppressive situations are not depicted explicitly, but because the situations are directly relevant to participants’ lives, they can easily identify the blocks and work collectively to come up with tasks to get rid of these blocks to alter the oppressive situation (Burstow, 1991; Peckham, 2003). This process requires participants to become active in
developing ideas and actions for social transformation (Freire, 1970).

There are different approaches to constructing codifications, which can involve members of the oppressed group to varying degrees, but must always be founded on an intimate knowledge of the specific history and circumstances of the community. This knowledge can stem from living in the community, observing oppressed people’s day-to-day experiences, and interacting with community members. For example, Freire asked people in a village in Brazil where he worked to help him observe village life as they took pictures together of scenes of village activities that were familiar and common to most of the villagers (Farmer, 1972 cited in Craig, 1981). He then used these photographs as codifications in learning circles. Burstow (1989) and her colleagues used knowledge they derived from working closely with ex-prisoners, and in some cases, their own firsthand experiences of prison life to draw codifications that represented situations that would be familiar and common to most prison inmates.

In the present study, to design codifications, I worked in a team of three people (including a research assistant and thesis supervisor, Burstow), all of whom had intimate knowledge of the psychiatric system and the community. We constructed three codifications reflecting situations that we knew were familiar and common to many psychiatric survivors and mad people. After an initial discussion with my thesis supervisor, I worked with a research assistant to draft the first codifications and then I met again with both team members to critique each draft codification. We decided to make some changes in the final codifications to clarify what was being portrayed and sometimes to heighten
possible contradictions in the scene (Burstow, 1989). My research assistant and I then used a paper collage technique to build the three final codifications that were used with the group.

The three final codifications depicted the following situations: 1) psychiatrized people in a common area at a psychiatric hospital (see Appendix A); 2) a racialized woman on a community treatment order eating lunch at home with her male partner and young child (see Appendix B); and 3) activists holding a demonstration/meeting against psychiatric oppression (see Appendix C). Each depicted the particular situation in a way that could open up discussion in many different directions. While the last codification depicted a situation specific to active community members, the first two depicted situations that were familiar to many psychiatrized people who are not active within the community. This meant that people who had less experience in the community were eligible to participate in the group, thus making the codification group the only part of the research that allowed psychiatrized people who had minimal experience as activists to participate.

A total of nine people participated in the codification group, which was held as an event at Psychiatric Survivor Pride. In this group, we spent approximately 30 minutes co-examining and discussing the three codifications, described above. This led to some insightful dialogue about how participants identified with the situations being depicted in the codifications, the contradictions they saw between what was supposed to “help” people and what their lived experience of “help” actually entailed, of the power dynamics they had experienced both within the community and in larger
society. It also generated ideas about people’s needs in order to fulfill their healing and empowerment goals.

Initially, I was inspired to use Freirean methodology by Burstow’s (1989; 2003) use of codification groups with institutionalized prison populations. Burstow suggests that Freirian groups are an ideal method to use with people “who have been deprived of their freedom and blocked in their aspirations,” as they begin with people’s lived experiences, allow them “to gain a critical understanding of their situation,” and prepare them “for the job of transformation” (2002, p. 28). This usefulness was affirmed by my own administration of the group codification method. The group discussion gave me insight into the specificities of psychiatric survivor and mad experience within the community, including goals and blocks faced by psychiatric survivors and mad people. It also exposed information on power dynamics within the community and brought to light the different experiences of people related to their diverse social locations within the community.

As a community member and researcher, I was enthusiastic about using a method which promised to be immediately useful to participants, leading to a greater understanding of the systemic causes of some of the oppressive conditions in their lives, and that held potential to generate ideas about how to work towards much needed change.

Focus group with community activists. The purpose of the first focus group I organized was for community activists to identify their goals, describe the various strategies they use to pursue goals, share their experiences of creative resistance and empowerment work, recount their successes and challenges
resulting from different strategies, as well as name the obstacles they encountered. The focus group was open to all people who had been involved in formulating community goals and planning and executing community initiatives to meet these goals. My intent was to capture some of the rich experiences and expertise of community activists who had been involved in community initiatives spanning the past four decades. The following questions were used to help facilitate the discussion:

• What are your goals as a member of this community?

• What kinds of acts of resistance have people in this room been involved with? How is this work in line with your goals? Did this work move you closer to your goals?

• What are some of the successes that have come out of these actions?

• What were some of the problems with these actions? What could you or your group have done differently?

• What types of obstacles did you face within your action group?

• What types of obstacles did you face from external forces (i.e. government, doctors, families, friends)?

• Are there certain groups of people who are missing from the movement? If so, why do you think this is?

• Have you experienced or witnessed any kind of discrimination within the movement?

A total of 14 people participated in the focus group, which was held as an event at Psychiatric Survivor Pride. Each participant identified goals in the community that
were important to them, and we then discussed specific initiatives aimed at meeting these goals, including campaigns against electroshock and homelessness. Participants described obstacles, both internal to and outside of the community, which had caused them difficulty in meeting their goals. The group ended with a discussion about community membership, who is included and who is not, coalition building and ideas for how to work across movements and communities to further healing and empowerment goals. This discussion informed my understanding of ideologies, goals, and priorities within the community, various initiatives and strategies used to meet these goals, obstacles faced by community members, the politics and experiences of coalition building, as well as differences among community members in terms of ideology, preferred strategy and perceived obstacles, and how people might proceed in light of these differences.

**Semi-structured interviews.** I decided to conduct semi-structured interviews to fill in some information gaps that became evident after reviewing the transcripts from the two groups conducted at Psychiatric Survivor Pride. Based on my experience in the community and participant observation, I was aware that these two groups did not capture the full diversity or richness of perspectives that exist in the community and that I needed to speak to more people in greater detail in order to generate data more representative of community goals and priorities. I conducted the first set of interviews between November 2008 and August 2009, during which time I interviewed ten community members who either requested to participate in an interview format during recruitment for the two groups at Psychiatric Survivor Pride or who were recommended by other participants because of their extensive involvement and in-depth knowledge. The purpose of these interviews was to learn
more about key goals of community members and strategic initiatives, their reflections on the successes and problems associated with these strategies, internal dynamics in the community that have helped foster positive subcultures or that have posed challenges, and issues of exclusion related to gender, race, class, disability, age, and other factors. I used the focus group question guide to facilitate these interviews in order to elicit more information about goals until I reached a point of saturation. These interviews produced rich data revealing a diversity of goals and ideological differences emerging from this community, but I was finding very little emerging in terms of sameness among the various constituencies. I began to realize that it was going to be impossible to find goals that all community members prioritized to the same extent or to discover common rallying points that so many people hope to find. Yet, it also became abundantly clear that community members from diverse social and ideological perspectives shared the goals of being able to co-exist and work together more effectively across difference both within the community itself and with other political communities that share overlapping interests. These goals were shared in all constituencies, to varying degrees among individuals, and represented a starting point for discussing issues that are pertinent to the entire community. Because of this finding, the focus of my thesis shifted from examining sameness to examining difference.

I decided to conduct a second set of semi-structured interviews with community members focused on ideas and strategies for working across difference. I invited six people whom I had interviewed initially to participate in a second interview, plus seven other people who had either approached me to request being included in the research or were recommended by other participants. Between May
2010 and August 2010, I interviewed a total of ten people, focusing specifically on strategies aimed at building alliances and working across difference within and among constituencies and communities, as well as on challenges encountered by community members as they engaged in coalition building work. The following two questions guided the interview process:

- How do you see psychiatric survivors, mad people, and antipsychiatry activists working towards building stronger alliances with each other and with other social justice movements and oppressed groups?
- What principles or strategies do you see being used in other communities and social justice movements that might be helpful for psychiatric survivors, mad people, and antipsychiatry activists to consider in their attempts to build stronger alliances and coalitions?

These interviews gave me the opportunity to test some of the ideas I was developing around what people were thinking and doing in their coalition building actions, how they were meeting some of their goals in terms of working across differences, and what kinds of blocks they were encountering in their efforts to build bridges with other constituencies and communities.

**Focus group with research support team.** At the end of the data collection process, I was participating as the co-chair of a conference called PsychOUT: A Conference for Organizing Resistance Against Psychiatry, which had as part of its mandate the goal of building bridges among different constituencies and communities. This provided a unique opportunity to observe a community event that was dealing directly with the topic of the present study, and I did not intend to let this opportunity pass me by. Prior to the PsychOUT conference, I asked those in my research support
team who were also part of the conference organizing committee to make note of the
tensions, conflicts, or attempts at solidarity building that they observed at the
conference, so that we could discuss as a group what we had each observed. I
organized a focus group with these three individuals one week following the
conference. This was an extremely helpful process, particularly because we had each
witnessed different parts of the conference, which had three concurrent sessions at
any given time, and because we each brought to the task different academic, activist,
and professional backgrounds that informed how we understood what we observed.
Together, we were able to compare and contrast observations to see if we could
identify any patterns or trends. This process mirrored Freire’s (1971) process of
interdisciplinary analysis, in which a team of scholars from different disciplines study
the results of “thematic investigation circles” (p. 110) conducted by the whole
community in order to create a program of action aimed at engaging the community in
praxis.

**Conferences and public presentations.** Conferences and public presentations
proved to be another important information source throughout the data collection
process. Often, these presentations and the dialogue they provoked revealed
important insights into key community concerns, tensions, and controversies. I made
notes in my research journal about interactions that influenced my thinking, and I
have included these sources of data in the findings chapters of this dissertation. I
differentiate presentations from other primary data sources by referencing them as
academic sources.

**Demographics form.** A demographics form was used to collect information
about participant age, gender identity, sexual identity, racial and ethnic identity, class
identity, relationship to psychiatry, relationship to the community, disability, and physical impairments (See Appendix D). The purpose of collecting this information was to help contextualize participants in terms of their social locations and standpoints when representing their perspectives and experiences in the writing stage of the present study. I had purposely used open demographic questions to allow for people to describe how they perceived themselves in relation to identity categories. For example, instead of asking “Are you male or female?” I asked, “How do you describe your gender identity?” These open-ended questions made the collection of demographics a more involved process, sometimes leaving participants confused about what I was asking and sometimes resulting in lengthy discussions. However, in the end, the open-ended nature of these questions resulted in rich descriptions of participant identities that captured a broader range of how community members conceptualize their social locations and identities.

**Recruitment**

I drew on my position as a community member to bring my research into the community in an organic way, by integrating research activities into community events and recruiting participants through my activist networks, email listservs, and community organizations. Both the focus group and the Freirian codification group were advertised as workshops and were built into the Psychiatric Survivor Pride program. The programs were advertised through distribution at psychiatric survivor organizations, mental health agencies, other community events, websites of community and activist organizations, and email listservs. Two posters were used to advertise the groups and were distributed to numerous agencies serving psychiatric
survivors and mad people (See Appendix E and Appendix F). Other means of recruiting included facilitating a workshop at Sistering, a drop-in centre for women who are homeless and isolated, and speaking about my research as part of the opening remarks at Psychiatric Survivor Pride.

For the one-on-one interviews, I contacted individuals who either requested to participate in a one-on-one interview or who were recommended by other participants because of their extensive community involvement and in-depth knowledge. People wished to participate in one-on-one interviews for a variety of reasons, including their desire to provide more information than could be voiced in the focus group, their discomfort in speaking freely in a group environment, or their concern of experiencing sexism within the group. I also invited members of my research support group, who were part of the organizing committee for the PsychOUT Conference, to take part in a focus group following the event. All participants who were recruited for the Frierian codification group, the focus groups, or one-on-one interviews were given the opportunity to ask me any questions after they reviewed the information/consent form before they agreed to participate (see Appendices G, H, I, and J). Given my social connections to many members of the community, I was mindful that some people might find it challenging to say no to me, and so in the letter/consent form and in conversations with people, I reassured all potential participants that they did not need to participate and that their decision not to participate would cause me no difficulty.
Data Management

The first stage of data collection included the Freirian codification group, one focus group, and ten one-on-one interviews, all of which were digitally recorded and transcribed in their entirety. In later interviews and in the second focus group, I began to selectively transcribe parts that contributed to the emerging codes. All audio recordings were erased from my digital recorder and my computer once they were transcribed. In situations where I did not digitally record interactions, such as when I conducted interviews over the phone or when I had informal conversations with community members, I made notes in my research journal afterwards and sometimes during the interaction to highlight relevant information and insights. My research journal was kept with the interview transcripts in a locked filing cabinet in my home office.

Data Analysis

The present study developed into a combination of both description of the different goals and ideologies emerging from the community and a conceptual description of what is blocking community members from meeting the shared goal of developing stronger networks and alliances for resisting psychiatric and sanist oppression. The prior description, bearing on goals and ideologies, emerged during the first part of data collection and analysis and provided a necessary foundation for understanding what this community is about and the types of ideological approaches, desires, and priorities that mobilize each constituency. The latter part of this research, relating to tensions and conflicts that emerge in community organizing, developed
once I decided to focus on one goal prioritized by the various constituencies—the desire to work together more effectively in order to achieve community goals. The data analysis resulted in two levels of analysis: the first centres on the ultimate and broadly defined community goals of resisting psychiatric and sanist oppression and describes the various priorities and aspirations emerging from different constituencies within the community, and the second centres on the shared community vision of building stronger networks to achieve these broader goals and explores the various factors blocking community members from achieving the diverse networks they desire.

The first stage of data analysis began with coding transcripts and research notes to determine ideological and action patterns emerging from the community, as well as recurrent issues that came up in discussions with participants. Codes were initially derived from textual data and then applied to them, in order to dissect large documents into smaller and more manageable passages (Miles & Huberman, 1994). This initial examination of data was done in combination with an examination of other sources of knowledge, such as my personal experience and existing literature and research (Strauss & Corbin, 1990). These other sources were treated as a form of secondary data that helped elaborate on the categories that emerged from research transcripts and my research journal.

Next, I developed themes and refined them to make sure they were discrete from one another yet broad enough to capture related ideas contained in numerous transcript segments (Attride-Stirling, 2001). I then arranged the emerging themes according to the three community constituencies, which I had already conceptualized
based on my knowledge of different ideological, and strategic approaches and identities adopted by community members prior to beginning formal data collection.

Diverse themes associated with each of the three constituencies emerged, often overlapping with more than one constituency. Once I identified the goal of working together across difference as the primary focus of the dissertation, all data collection from this point onward helped to further develop an understanding of problems encountered and resources needed for various factions to work together in solidarity with one another. I used my ethnographic encounters to test hypotheses and explore gaps in information and ended the data collection process once I was satisfied that I had an adequate representation of various ideological and strategic perspectives within the community. I determined that I had achieved this once the information I was gathering became repetitive and added little new insight (Miles & Huberman, 1994).

**Quality of Findings: Trustworthiness and Transferability**

Quantitative researchers typically rely on terms such as validity, reliability, and generalization to demonstrate the accuracy and credibility of their research (Lietz, Langer & Furman, 2006). Many qualitative researchers argue that the epistemological assumptions underlying these notions are inappropriate when applied to qualitative research and should therefore be replaced by such notions as trustworthiness, transferability, or other concepts that ensure a certain standard of research (Lietz, Langer & Furman, 2006; Seidman, 1998). A number of measures were taken in this research project to ensure its trustworthiness and credibility, such as methodological
 triangulation, checking procedures, descriptive accounts of the research context and process, and self-reflexive practice.

Methodological triangulation is a procedure that involves the collection of multiple sources of information that help to build and check themes and categories in the study (Denzin, 1978; Creswell & Miller, 2000). It is a powerful technique that facilitates validation of data through cross verification from more than two sources. In the current study, I collected information from multiple sources, including one-on-one interviews and conversations with community members, focus groups with community members and other researchers, a Freirian codification group with psychiatric survivors and mad people, field notes from participant observation recorded in my journal, conferences, and public presentations. The process of cross-verification helped, on one hand, to determine which codes emerging from my data represented patterns or trends in community processes or, on the other hand, which initial codes represented specific events that were not part of regular community processes.

Related to the process of methodological triangulation, I found it necessary to check recollections about events that emerged in interviews, such as the players involved, dates, and locations, as well as more significant details about why certain strategies were used or how significant problems came to be. People sometimes had very different recollections of particular events, and it often became extremely difficult to decipher what actually happened. I attempted to verify facts by checking their accuracy with other community members and by reading historical records available through community literature. This process was difficult, however, as often I could not decipher whose recollections were more accurate, and most commonly, the details
were not recorded in any literature. In some cases, discovering factual information about what happened proved to be impossible, and in such situations, I either left out the recollections altogether or, when the differences in recollections represented larger rifts within the community, I explored how they were connected to other overarching issues. I consulted with participants for other types of help in ensuring the accuracy of data and findings. For example, after the first round of interviews, I invited participants to check the interview transcripts to confirm the accuracy of the transcription, to identify gaps in information, or to add or delete information as they wished. I did not do this with later interviews due to the process of selective transcribing and time constraints. I did, however, continue to check my hunches and understandings with participants and other community members in conversations to make sure that my interpretations fit with people’s experiences of community events and processes. This is in line with Hinds, Scandrett-Hibden, and McAulay’s (1990) assertion that the accuracy and relevance of research findings should be judged according to the perceptions of those who are most knowledgeable about the phenomena being studied, in this case, those who are engaged in community work.

I have also included the most relevant details about the research process in order to provide readers with a clear picture of the research context. In the first three chapters, I have included information relating to participant demographics, my own social location in relation this research, data collection methods and approaches to analysis, the emergence of categories and concepts, and a rationale for how the core categories were selected. In later chapters, I include details about events that characterize these categories, relationships between categories and existing theory, discrepancies in the emerging analysis, and explanations for analytic decisions.
(Strauss & Corbin, 1990). Strauss and Corbin (1990) contend that such descriptions are important in producing research that allows readers to assess the suitability and adequacy of research methods used and analytical decisions made by the researcher throughout the process of gathering and analyzing data and drawing conclusions. These types of information also help readers to determine the transferability of the findings—that is “the extent to which the reader is able to generalize the findings of a study to his [or her] own context” (Morrow, 2005, p. 252)—so that readers can figure out how the current study and its findings are applicable to other contexts with which they are familiar, for example, in other similar political communities resisting psychiatric and sanist oppression in locations other than Toronto.

**Study Limitations**

The initial intent of the present study was to better understand the goals related to bringing the community together and to figure out ways to overcome specific obstacles blocking community members from meeting these goals. The foundation of this research did not recognize the extent of heterogeneity within the community, the diversity of ideologies, or differences in priorities. As the research focus shifted from sameness to difference, and as I became more interested in understanding this heterogeneity and finding more effective ways of working across difference, the original sample selection and methodology became less appropriate. Through my ethnographic encounters, it became clear that one shared goal among the various constituencies was to build stronger solidarity networks with people who are not well represented in the community. Participants had all kinds of ideas about the reasons why these populations were largely absent; however, the ideas of those
people who are actively involved in community work alone are not what would lead to the strongest understanding of the perspectives and needs of those who do not participate. This problem pointed to a new research strategy – one that I did not have the time or resources to implement. It now made sense to interview people whom the community would like to mobilize, but has not. As Burdick (1995, p. 368) writes, “the voices, visions, understandings, emotions and experiences of such people must not be glossed over or explained away with facile labels such as ‘false consciousness,’ nor cast into that vast homogenizing category of ‘fear.’” The perspectives of those who have a vested interest in these issues, because of their own vulnerabilities to psychiatrization and sanist oppression, but who are not actively engaged in the community are missing from this research project, and this is a glaring omission given the research focus that emerged.

The shift in research focus led me to seek out interviews with some people who left the community in part because they were unhappy with certain dynamics they experienced. I did not make the same effort to interview people who left the community for reasons unrelated to dynamics within the community. Likewise, when the focus of research shifted to working across difference, I asked participants who left the community questions that would elicit information about the problems they experienced, while I did not focus in the same way on asking people who stayed why they continue to engage in community work. In making these decisions during the data collection process, I selectively gathered data that is useful in terms of understanding problematic dynamics in the community, but that very likely does not adequately reflect all of the community’s strengths. This represents an inherent limitation of my
findings, though not of my methodology as it elicited information that is most relevant to my research questions.

I was able to critically analyze the experiences and insights of differently situated community members to understand some of the processes and dynamics that render ideological and practical priorities and goals more or less relevant, engaging or alienating, and affirming or oppressive in people’s lives. This analysis, in part, is based on the insights of community members, particularly those who have experienced problems of alienation within the community or those who have left the community, because they felt hurt by community dynamics that did not appear to speak to their experiences. Additionally, the analysis draws from literature about difference, social movements, and political community, particularly the body of work emerging from parts of the feminist movement that have analyzed working across difference and building solidarity. Most notably, Black feminists, Womanists, working-class, lesbian, queer, disabled, and transnational feminists have contributed significantly to this area, by speaking about exclusionary and oppressive dynamics that occur between and among differently situated feminists – even among those who state they are committed to combating the oppression of all women – and by setting before us practices that foster the relationships and climate needed to build solidarity networks across differences. It is true that the data in this study is limited by the failure to include voices of those who do not participate in the community, despite the belief on the part of many community members that they should be active participants in these struggles. However, I have developed an analysis based on many sources of data which capture the following: the desire of active community members for building stronger alliances, as well as their reflections on why sought after alliances are not working as
successfully as they would hope; the perspectives of people who have been active in
the community but have withdrawn or have remained but are having difficulties with
current dynamics and processes within the community or within specific parts of the
community; and positions developed in other political communities about oppressive
internal dynamics, limiting community discourses, and processes for building
solidarity networks across difference.

Another factor that is important to acknowledge in the present study is related
to the prioritization of community goals. It became evident early on in the data
collection that there are diverse goals emerging from the community, some of which
contradict each other. While working across difference and building solidarity are
shared goals across the various constituencies, not all community members prioritize
them equally, particularly when they believe this focus will compromise other key
goals. So while the focus of this research emerged organically from my ethnographic
encounters, and the topic stood out to me as an important one to explore, I freely
admit that, in part, this choice was influenced by my own interests, emotional
reactions, and priorities. My political commitment to an integrated approach to anti-
oppression work and my deep empathy with others led me to important questions
about exclusionary discourses and practices within community organizing work.
While this is not problematic in itself, there were times throughout the research
process when my tendency to empathize with others’ pain made it difficult for me to
analyze problems in a manner that is fair to all sides. With this awareness, I took a
number of steps throughout the research process to help mitigate bias in my
interpretations. Nevertheless, it is important to be transparent about the fact that the theme of working across difference became the emphasis of this project, at least in part, because this is a goal that I prioritize and that other community members may have other priorities which they legitimately consider to be more pressing.

The final complication I wish to point out in the present study is an inconsistency between my methodology and the way I am theorizing the community. This inconsistency is particularly evident when considering the groups I conducted at Psychiatric Survivor Pride and the distinctions I draw among the psychiatric survivor, mad, and antipsychiatry constituencies. I advertised the Freirian codification group as open to “psychiatric survivors” and “mad people” and the focus group as open to “psychiatric survivors, mad people, and antipsychiatry activists” involved in community organizing work. This means that the two groups attracted people who identified with any or all three of these terms and who espoused a range of goals, priorities, and ideological approaches, making it impossible to attribute the direction of the discussions to any one of the three constituencies. Nevertheless, I do not regret the way I organized these groups, as to organize them along the conceptual lines I draw in my community model would have created divisions that do not actually reflect how the community functions as a whole. As explained in chapter 1, many people engaged in community work tend to identify with the ideological concerns and priorities of more than one constituency. There are no clear lines of membership, but rather distinct trains of thought and action that overlap, crossover, and interact with

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10 As mentioned earlier, I periodically checked in with community members and my thesis supervisor to discuss and hear critiques of my interpretations, and I eventually resigned from my organizing responsibilities so that I would not be immediately caught up in the pain felt by some community members while analyzing the data.
each other. This reality is reflected in the written research findings, where
constituencies are theorized according to key ideological concerns, goals, and
strategies, and participants’ contributions are included wherever they fit best, often in
more than one constituency chapter. I did not attribute characteristics to
constituencies based solely on the identities of participants, but rather on a
constellation of factors emerging from my own community engagement, participant
observation, ongoing debate in the community about the meanings of terminology,
interviews, and conversations with community members, the Freirian codification
group, the focus groups, and community literature.

The above description of methodology is meant to provide a level of
transparency that allows readers to actively evaluate the trustworthiness and the
transferability of the findings in this dissertation. It has introduced the participants to
the reader, albeit in a statistical manner that will become much more personal in the
chapters that follow. It has established that the overall methodological framework of
the dissertation is critical ethnography and has laid out how the data was collected,
how participants were recruited, and how data records were managed and analyzed.
Two dominant models that emerged from the data were introduced, the first
examining the goals emerging from various constituencies within the community, and
the second examining what stops community members from reaching their
aspirations of building solidarity across difference and strengthening networks to
politically resist psychiatric oppression and sanism. Limitations and strengths of the
research methods were made clear. My own social location was described in chapter 1.
It is hoped that all of this information taken together provides the reader with
confidence to move on to the next chapters where we meet the various constituencies in more detail, coming to know their unique and shared characteristics, goals, strategies, strengths, and challenges.
Chapter 4: The Psychiatric Survivor Constituency

Part I: Introduction

It is appropriate to begin the analysis of findings with an overview of the ideological concerns, priorities, goals, and tensions that define the psychiatric survivor constituency. This is the constituency at the heart of the wider community, representing those who are most deeply and personally affected by the practice of biological psychiatry and the pervasiveness of sanism in dominant culture. This constituency grounds the community in real human emotion, need, and desire. As described in chapter 2, the psychiatric survivor constituency cannot be easily defined through a common politic, because it is not organized around shared political ideology. Rather, from the very beginning, psychiatric survivor initiatives have prioritized connecting people who have experienced the psychiatric system and improving the conditions in their lives, alleviating pain and suffering, and finding ways to meet their needs. In this chapter, I first set out the explore what exactly these practical goals mean to various people who are connected to this constituency, how the overarching goal of improving the situation of psychiatrized people defines their ideological, philosophical, and strategic approaches to community empowerment work, and what tensions arise among those engaged in working towards achievement of these goals. Section II of this chapter begins with a brief overview of the key themes that emerged from my ethnographic encounters with participants. Section III goes on to examine findings related to how the ideological and social differences among psychiatrized
people in Toronto disrupt and challenge particular aspects of community organizing work.

**Part II: Major Themes**

There is a wide diversity of views, priorities, and goals held by psychiatricized people in Toronto, and participants in the present study recognized that this diversity can make mobilization efforts difficult. Yet, the vast majority of participants who identified as psychiatric survivor remained focused on the notion of common and shared experiences among them, whether those commonalities were based on experiences of incarceration, psychiatric drugging, other forms of psychiatric intervention, or discrimination. In exploring what priorities and goals psychiatric survivors can come together around, seven key themes emerged, including the need for peer support, community and alternative family; the central role of consciousness-raising as a precursor to community action; ending stigma and discrimination against psychiatric survivors; resisting coercion, abuse, and advocating for choice; creating access to healing alternatives and critical dialogue about recovery; creating decent housing and equitable employment opportunities; and developing a collective history. Each of these themes was immersed in a rich history of community building and political organizing and was contextualized by areas of contention and disagreement, aspiration, and challenge that surfaced in discussions about working across difference.

**The Need for Peer Support, Community, and Alternative Family**

Peer support and self-help initiatives emerged clearly as a central priority in the psychiatric survivor constituency. Almost all participants recognized peer support as the foundation of the community, out of which other mobilization efforts have
grown, beginning with the first meeting that took place in Cabbagetown back in 1977 when psychiatrized people in Toronto gathered in large numbers for the first time to hear about each other’s experiences. The power of peer support and self-help projects in the lives of individuals was abundantly evident in the words of participants. The following quotes from Mad Hatter in the focus group and Weitz and Innes in one-on-one interviews provide the essence of how many people felt:

Peer support, it’s a very valuable tool... We get together and support each other.

There are a lot of specific requirements and characteristics specifically about peer knowledge that can help us. (Mad Hatter)

It was just amazing...to me. That was a virtual miracle, in seeing how people started to change through that support that they got and from others. That’s how I became such a big fan of self-help, which actually should have been called mutual help or mutual support. (Weitz)

Some people have said that this work...has literally saved their lives. Now, that could mean any number of things. It could mean actually saved their lives or it could mean that they’ve turned their lives around because of it, and then that would have saved their lives. I see people more self-assured, more confident. Certainly there’s a sense of joy, which is a really positive thing, because, you
know, a lot of psychiatric survivors don’t have a lot of joy in their lives because of the situation they’ve been put in. I see a lot of people who are able to express themselves, and I see people becoming more active in the community. (Innes\textsuperscript{11})

Peer support was particularly important to psychiatric survivors who felt misunderstood by other people in their lives after experiencing psychiatrization, usually comprised of a series of events that left them feeling very alone in sorting through what had happened to them. Feelings of isolation were prominent in interviews and group discussions. For example, in the Freirian codification group, when we were examining the codification depicting a racialized woman sitting at the kitchen table with her husband and child, with a community treatment order and a bottle of pills in front of her, participants discussed the isolation they believed she was experiencing (see Appendix B). The following excerpt demonstrates how they connected to this woman’s situation:

Rachel: When I think of this woman, well, I don’t think that she knows anyone in the psychiatric survivor movement. I don’t think she has any ties to the community. I don’t even think that she might be aware of crisis lines... Not to upset anyone, but when I thought of a third option between taking the pills and not taking the pills, I thought what she might be thinking is just taking all the pills and being done with it.

\textsuperscript{11} Innes identifies as an antipsychiatry activist and is not a psychiatric survivor, but he has done a significant amount of work with psychiatric survivors and mad people with the Friendly Spike Theatre Band. In this quote, he is referring to what he has witnessed when psychiatrized people connect with each other and collaborate to create community theatre projects.
Farla: That’s a problem that there’s a lot of people in their homes who are isolated and who don’t have any connection to the outside and don’t have any choice.

Mad Hatter: ... This setting that is very stark and very lonely. You can almost hear how quiet it is for most of the day. You know, you can imagine how little there is for her to connect with in anyway. So she seems to be in a very awkward spot to fulfill what it is that she wants to fulfill. And yet has no apparent elements of choice or anything like that...

Jocelyn: My situation is almost the same. Only I don’t have children. But my husband takes away my life because of my weakness, emotional, so and that makes me more sick, because I am weaker and weaker, and I cannot get out of it. It’s very hard ... It’s unbelievable ... So he’s playing with me or he doesn’t understand. I don’t know what his game is, because sometimes, I feel he is doing games. So it is a terrible situation.

Shiva: I’m thinking the drug is not helping her, and she’s a victim. The man is forcing her to take a drug that’s not helping, and he’s complaining to her, but has no direct communication with that lady. He’s being just rude, and she’s a victim to that guy ....

This type of alienation from family members and friends was common, and in many cases, descriptions of support networks with other psychiatric survivors were much more meaningful than what is captured by the term “peer support”. As expressed by Mary in the Freirian codification group, “we need to belong. It’s very critical. We’re floating in the air like clouds, and when things happen to us, we become like storm
clouds... We need groups.” Some people spoke of other survivors as their “brothers” and “sisters” and emphasized the notion of “chosen family.” In one of the focus groups, participants discussed how the notion of family in the traditional sense was far too limited for them; they felt the need to expand societal definitions of what family means. Gray shared: “I haven’t seen members of my biological family since 1990, but there’s people in this room I count on as family...It’s chosen, but it’s none less than family as far as I’m concerned.” Xander added, “I think a lot of us have found problems in the nuclear family. Instead of maybe building on that nuclear family, building on alternative families and maybe peer support [and] wherever it is that we find love and understanding.” Developing strong social networks was viewed by many as a necessary precursor to escaping the box imposed on survivors by psychiatry and dominant sanist culture.

Numerous people also discussed the more formalized peer support programs offered through community groups, agencies, and within psychiatric settings. There was unanimous agreement on the importance of such initiatives, but people had differing ideas about the role peer support networks should play in the current organization of the psy-complex and larger society. For example, there were a small number who felt that psychiatric survivor organizing should remain completely independent from the existing psy-complex. They worried about the implications of other psychiatrized people taking peer support jobs in psychiatric settings and what this might mean for building solidarity among psychiatrized people. As Jackie expressed in an interview:
We should be keeping this [peer support] in the grassroots and stay away from psychiatry. I understand why people take these jobs. I mean, it gives them a way to live. But to oppress other survivors. You are an orderly. You listen to the head boss. I’m not comfortable with it.

Rora added:

They are working right in it. They are part of the coercive system. So I don’t know if they are in a position to decide for themselves what is right or wrong.

A few disagreed and felt that it was important to integrate peer support into existing psychiatric services, to provide much needed support to the most vulnerable people.

As Laurence explained in an interview:

If I am in there, am I making the experience better for some people? Meeting a compassionate person while I was locked up, somebody who understood what I was going through, would have made all the difference in the world.

Similarly, as explained in the focus group, Rachel believes that having peer advocates working in hospitals would make a significant difference in the lives of those who are incarcerated. She stated:

[We need advocates] to come onto the floor every single day and talk to every single patient, because if you’re going to count on the workers there, you might as well count on a two-year-old. You need advocates to come by every day to speak up for the patients.

These different perspectives represented a strategic divide among psychiatric survivors, between those who advocated for complete independence from the existing
system and those who either did not find this to be realistic or desirable and focused instead on reform and alleviating poor conditions.

Overall, participants were more comfortable with peer support initiatives that operate at arms-length from the psy-complex. Some were involved with activism in the late 1970s and early 1980s aimed at establishing survivor-run services with government funding and viewed some of the organizations that exist today as a major victory, a direct consequence of their efforts. There was a lot of hope in conversations about these organizations and the work survivors are doing within them to provide psychiatrized people with the support and services they need. Some people found these survivor-run alternatives to be so powerful that they envisioned the possibility of them replacing the current psy-complex altogether. As Madman explained in the Freirian codification group:

[Peer support] can provide a community option that could do away with the whole medical system in its entirety in a perfect world... We see studies that show we can do better than the system... Consumer-run crisis residential programs are more successful... So to me that’s a motivating factor for doing what we’re doing, but that third option is a very powerful option. It’s a very powerful pill, you know.

A few survivors, like Madman, expressed the hope that peer support could one day replace the existing psy-complex altogether, while others viewed such services as only complementary to other psy-services; but regardless of where they stood on this issue, all agreed that peer support currently plays a pivotal role in the lives of many psychiatrized people.
Consciousness-Raising

Most psychiatric survivors also emphasized the importance of consciousness-raising (CR) initiatives in the psychiatric survivor constituency. They identified many barriers that serve to keep psychiatricized people apart, such as messages from dominant culture promoting the desirability of fitting in as normal, and they pointed to CR as critical in helping people move past these messages to connect with others who share experiences of psychiatric oppression.

CR was viewed as an effective way of empowering psychiatricized people and mobilizing collective action. For example, in an interview, Bach explained:

[CR groups] are the most effective way to offer a new perspective and for people to gain a sense of empowerment in their own experience and develop a new analysis... People are acknowledged. People are offered something different... They learn to step outside themselves a little bit and see how their experiences are linked up to other people's experiences and analysis... The goal is empowerment through analysis of experience.

Many described how CR opportunities transformed their lives, when they had space to question the disempowering rhetoric they had been coerced into accepting. There was suddenly potential for them to recognize external circumstances that were intolerable and that had led them into the system. Below are excerpts from interviews and conversations with psychiatric survivors who felt that CR groups led to positive change and major shifts in how they understood themselves and the world around them:
There’s nothing like the experience of being in a place with only other survivors. In other places, you feel like you have to hide, but when you are with other survivors, you don’t have to be ashamed. You know that it’s not your fault. It was a huge change for me, and I need that in my life. I finally understood that it was not all my fault, and that the problem was not me…but what was around me. (Rudy)

That’s a really cool consciousness-raising moment and time period when people come and start to think that way. I think that’s really powerful and works really well and does give people a sense of strength and a voice to re-envision and rearticulate their experience. (Jackson)

CR groups were also viewed as a necessary precursor to any action or initiative aimed at changing oppressive conditions in people’s lives, providing the opportunity to explore and understand what kinds of action make sense in the community.

According to Jackson and Charlie, groups have sometimes fallen apart when members did not take the time to first develop a common vision, with people choosing to leave groups disappointed when their particular vision did not prevail; when irreconcilable political differences arose; or when groups embraced certain assumptions, without explicitly acknowledging the political position they were adopting. CR was understood by them as an ongoing process that was not only a necessary first step in building any initiative, but was also a critical ongoing component of the initiative, particularly in groups where people continuously join and leave, creating the constant need to (re)discover common ground and understanding.
While the ongoing need for CR was abundantly clear, striking a balance among peer support, consciousness-raising, and political action proved to be challenging. In different conversations, Jackson and Charlie acknowledged that many groups try to serve multiple functions, but often in the end, spend more time on peer support, sometimes even when their founding mandates are more oriented towards political action. There was recognition that many people continuously need peer support to help them feel heard, respected, and validated, and when these basic human needs are not being met, people may not have the energy or interest to work on activities aimed at systemic change. The words below demonstrate some of the struggles encountered in the community in trying to establish CR initiatives:

Some people who come to psychiatric survivor groups want support, want a place to talk, but aren’t necessarily interested in the political action part. You have to find a way to accommodate both those needs. What is happening in their lives right now... and getting what they need to survive now takes precedence over political organizing. (Charlie)

Groups can be problematic because of the history of how support groups have come down the pipe... A support group means that people come and perform for two hours, be supported and give support, and leave and that’s it... What I think is important around the format is having a group that teeters on being a support group and a political discussion group... [Sometimes] people are going on about a particular incidence in their life, and it gets to a point where people are offering advice or coping mechanisms. (Bach)
While Mary and Truly felt they needed space to come and talk about current struggles in their lives, others craved groups that moved beyond discussion to political action. For example, Jackson began to feel that he outgrew a group that was not politically engaged in the way that he needed. He explained:

> There was sort of this drop off period [in the group I attended]. Personally, I felt like it wasn’t what I needed anymore...once you get there [to a place of feeling better about your narrative], where do you go from there?

The importance of both peer support and consciousness-raising initiatives was widely recognized, but people struggled with how to meet the needs of a diverse population. They had different ideas about how to go about meeting people’s different needs, such as being flexible about the nature of a group, allowing it to change as its membership changes, or, on the other side of the spectrum, being very clear about the purpose of the group and sticking to its original mandate, whether that be primarily oriented towards discussion, support, or action, so that people know what to expect and have a clear basis for deciding if it is the right group for them.

**Ending Stigma and Discrimination Against Psychiatric Survivors**

Unanimously, participants agreed that action must be taken against the many forms of discrimination faced by psychiatrized people, discrimination that is rooted in negative attitudes, beliefs, and stereotypes about people who are labeled as “mentally ill”. In this study, survivors’ visions of addressing problems of discrimination were not vastly different from one another, and all who spoke to this issue were critical of the ways discrimination is being addressed by government and mainstream mental health organizations. In my research journal, however, I made notes about the diversity of
views on this topic that I encountered at community events that were not captured fully by my interactions with participants. Throughout my time in the community, I have met consumers and survivors who see nothing wrong with mainstream mental health initiatives dealing with the problem of discrimination.

Within mainstream organizations, discrimination against psychiatrized people is typically addressed using the concept of stigma (Mental Health Commission of Canada, n.d.; Health Canada, 2002). Sociologist Goffman (1963) defines stigma as “the phenomenon whereby an individual with an attribute is deeply discredited by his/her society and is rejected as a result of the attribute.” In a sense, it is the notion of a specific attribute common to psychiatrized people that is controversial among those involved in anti-stigma initiatives. In recent years, it has become very usual for mental health institutions and organizations sponsored by government and industry to put resources into launching anti-stigma initiatives, and it is clear from my research journal notes that the ways in which they address stigma and discrimination are different from how the issues are generally understood and addressed within the psychiatric survivor constituency. Mainstream campaigns are founded on the assumption that mental illness is a truly essential part of a person, that the individual's mental illness is the undesirable attribute at the root of rejection and discrimination. This view expounds that psychiatrized people are stigmatized because of biological differences that are identified as deviant, linked to negative stereotypes that engender prejudiced attitudes which are acted upon through discriminatory behaviour.

The majority of people in the present study did not base their understanding of stigma on a belief in mental illness, but rather approached the notion of attribute in a
broader sense to encompass the many ways in which survivors deviate from dominant expectations of how they should experience and behave. Attributes that are the basis of stigma were understood to be many different things, whatever causes the person to be viewed as crazy, including emotional and behavioural reactions that are viewed as deviant or the experience of being psychiatricized *per se*. Below are some quotes from interviews that capture some of the different ways that people conceptualized problems related to stigma:

There’s a real wave of anti-stigma for so-called mental health disorders... People don’t just develop bipolar disorder, and people just don’t develop a personality disorder. They have experiences, and they can shift those experiences and create a safer society, more fair, more just. (Laurence)

Unless you buy the medical model and accept the diagnoses and the treatments, they think you’re really nuts, that you’re not credible. There’s that bias deeply entrenched, with a few exceptions, but there’s that bias against us, and I certainly hold the psychiatric establishment largely responsible for the stigma and bias. (Weitz)

If I tell a friend that I believe that I’m being followed, what sorts of images are conjured up in my friend’s mind, and how do those images affect my ability to relate to that friend?...It’s a really, really difficult topic, because it’s so insider/outside... It’s just that there’s so little trust given to people who are confused, or especially in distress, let alone the people who are violent, not as a result of, but as part of that experience. (Fabris)
Over the years, I have seen many mainstream anti-stigma initiatives hire “consumers” and “users” to be the face of their campaigns. These campaigns attract a great deal of attention, because of the wealth of resources and funding provided by government and large mental health organizations to launch highly visible media advertisements. The faces and stories of psychiatristized people are plastered all over the public domain, advancing messages about the prevalence of “mental illness” and how “mentally ill” people are more than just their disease. Many survivors have pointed out that mainstream anti-stigma initiatives pay little attention to the issues that are of greatest concern to psychiatric survivors. In a presentation on anti-stigma initiatives, Bach (2007) explained that stigma... is only one aspect of the experience for people diagnosed with mental illness. It describes perspectives on how ‘society’ in general perceives a group, but it does not provide grounds to act against individuals and institutions who commit acts of ‘stigma’ through the law and legislation or political organization. The majority critiqued mental health organizations for being equally interested in naturalizing medical discourses on mental illness as they are in changing negative attitudes and discriminatory practices. While all were very concerned about changing negative attitudes towards people who have been psychiatristized, many were against doing this in a way that promotes the notion of mental illness.

As noted in my research journal, in public arenas and at community events, many survivors voiced concern about consumer participation in anti-stigma campaigns initiated by mental health organizations. These survivors have difficulty supporting initiatives that are based on conceptual frameworks and agendas that
come from the psy-disciplines. For example, Frado (cited in Bach, 2007) views consumer/survivor participation in such campaigns as radically different from the successful approaches taken by other equity-seeking groups. As Frado (cited in Bach, 2007) points out, “Rosa Parks refused to give up her seat and move to the back of the bus; she didn’t lend her face to a poster campaign. Gays, lesbians and gender minorities fought back against police brutality at Stonewall; they didn’t design a fridge magnet.” Frado (cited in Bach, 2007) noted that other groups of oppressed people have historically fought for their own rights, without depending on paternalistic organizations to do it for them. Similarly, Bach (2007) warned that survivors must be cautious about “inadvertently re-stigmatiz[ing] consumers and survivors by, on the one hand, espousing our rights and capabilities, and on the other, having the campaign designed and driven by individuals acting in our best interests.” There is a general feeling among many within the constituency that survivors are in the most appropriate social location to address stigma and lead these campaigns, and that it is inappropriate for psy-professionals to take the leading role. The following statements from interviews with Laurence and Reville capture some of the concerns community members have about professionally controlled anti-stigma initiatives:

There’s a real wave of anti-stigma for so-called mental health disorders. There’s the Mental Health Commission. It plays into the system, and over the long term, it’s going to be more damaging to people, more than the stigma was. I feel like we need a true commission for psychiatric survivors. I don’t want to kind of jump on the bandwagon. I think we need to seriously look at what this thing is doing and keep putting suffering back into context. (Laurence)
Now the problem is we have to fight the friggin’ Mental Health Commission, which has set itself up as the voice for crazy people, and it’s not. It’s a voice for psychiatry. (Reville)

Most agreed with these sentiments and believed that mainstream anti-stigma campaigns increase the problem of stigma by reinforcing difference and the notion of oppression as illness, while failing to address the daily lived experiences of psychiatric survivors who face discrimination, rejection, alienation, and negative material realities.

I noted in my research journal many occasions when survivors have tried to address issues of stigma through campaigns, artistic and theatrical endeavours, writing, online media, public speaking, and testimonials. In Toronto, some key anti-stigma community initiatives named by participants included artistic productions such as *Marked: Living with a Stigma*, a play put on by the Friendly Spike Theatre Band in 1993; responses to mainstream media coverage addressing stigma, such as the 2011 Toronto Star article, “Getting to the Root of Mental Health Crisis” (Bacque, 2011; Starkman, 2011); display of anti-stigma messages at psychiatric survivor and mad pride marches; and graffiti discrediting the messages put forth in CAMH’s 2009 anti-stigma campaign displayed at Toronto Transit Commission’s streetcar and bus stops. These and other grassroots initiatives provide messages relating to the real life experiences of stigma and discrimination faced by survivors and serve to raise awareness about what they need to change to improve the social and material conditions in their lives.
Resisting Coercion, Abuse, and Advocating for Choice

Choice was another recurring theme in conversations with psychiatric survivors in the present study. Participants were unanimously opposed to coercion or forced treatment in the psychiatric system, insisting that they should be allowed to decide what happens to their own minds and bodies. The following words demonstrate the importance of this issue to Costa, Weitz, and many others:

I think we can all agree that people should have a right to information so that we can make informed choices about what we want or do not want to happen with our bodies should they interlock with the medico-legal machine. (Costa)

I’m against the fraud, force, and fear that are consciously used and manipulated by the system to control... Force. Forced drugging. Electroshock. Damage and destruction of human lives. Under the name of we’re doing this for your own good. (Weitz)

Some viewed true “choice” in the contemporary psychiatric system as a “myth” or “an impossibility”. In the words of Jackie, “informed consent is a lie. How can somebody give informed consent when they don’t have all the information?” Weitz agreed that when people find themselves in desperate situations, and when a doctor tells them that there is a way to fix their problems, they will often follow doctor’s orders without fully understanding the associated risks. Jackie and Weitz wanted full disclosure of risks associated with various psychiatric interventions, so that people can make real informed choices. The message promoted by many was that there is no informed consent. People do not have real choice unless they are fully informed of all possible
risks, presented with other viable alternatives, and allowed the freedom to make their own decisions.

It is important to note that while most people who identify as psychiatric survivors are “pro-choice” and stand solidly opposed to laws and practices that further compromise control over what happens to one’s own mind and body, some psychiatric survivors and consumers take a different position. For example, I recorded in my research journal interactions I had at community events with survivors/consumers who agreed with the arguments of mainstream mental health associations and governments that some people cannot be trusted and therefore should be forced to comply with prescribed treatment; otherwise, they might make decisions that are detrimental to themselves and to others around them. These people advocated for greater input from individuals regarding their own treatment, but stopped short of demanding a total right to choose for themselves when their decisions contradict those of professionals. This position regarding “choice” was not held by any participant in the current study, and is not popular within the constituency in general, but still represents a particular standpoint in the constituency’s dialogue. Opposing positions on questions of coercion and forced treatment mandated by law definitely intensify the divisions among psychiatrized people, particularly now that the psychiatric system sometimes hires consumers to participate in teams of professionals who enforce legal sanctions on other psychiatrized people. I have witnessed emotions running high on this issue within the community. The right to control what happens to
one’s own body is so basic and central to the values of choice and freedom upheld by many psychiatric survivors.

Fighting back against coercion and violations of rights in the system was very important to many who took part in a wide variety of actions, including demonstrations, educational sessions, legal actions, and vigils. The purpose of fighting back was two-fold: 1) to empower psychiatric survivors and make dissenting voices heard, and 2) to change policy and regulations that systematically lead to harm, and in extreme cases, death. Jane Doe, a participant who has used the legal system in pursuit of justice, felt that speaking out about psychiatric coercion and violence was critical in community empowerment work. She wrote to me in an email:

I believe that it not only empowers the psychiatric survivor who pursues justice against psychiatric institutions and psychiatrists; it also helps other psychiatric patients who can’t do the same. I believe it offers the entire psychiatric survivor community hope and sends a very important warning shot to the psychiatrists and psychiatric institutions. Whatever the outcome, it is not about winning, it is about testifying. It is about speaking the truth to power with grace and dignity... Without the psychiatric survivor’s own story and their courage and willingness to share it (whatever the outcome), the narrative will be controlled by the powerful interests of the status quo, namely psychiatry and the pharmaceutical community... The living owe it to those still locked into
these abuses by psychiatry, and to protect those who may be duped into this “medical model” in the future.

Jane Doe and Jackie believed that legal actions had a real impact in bringing about positive change within the system even when they did not succeed in winning legal battles. They felt that at the very least, if survivors get their message out to the public, psychiatrists would fear repeating similar abuses. This was the sentiment, for example, after the Psychiatric Patient Advocate Office, with the support of many community members, brought to the public’s attention the problem of restraints used in psychiatric settings during the inquest following the death of inmate, Jeffrey James. Reville exclaimed in an interview:

I can tell you that anybody who runs and administers a psych hospital is going to be worried about people in restraints, because boy, do they not want to have that kind of publicity!

Six people made reference to how winning law suits or implementing concrete policy changes is a difficult feat that consumes are great deal of time, energy, and resources, but they nonetheless felt that these were necessary fights to take on whether through participating in formalized processes or direct actions that would bring their dissenting voices into the public realm.

**Access to Alternatives for Healing and Discourses of Recovery**

Recovery was a controversial theme that came up repeatedly in the present study. Given the rise of the recovery movement in the past decade and its crossover into the lives of psychiatric survivors, several people mentioned the need to engage with ideas and debates about recovery, considering, on the one hand, how it can be a
helpful concept, and on the other hand, how it can reinforce the medicalization of experience. A variety of reactions towards recovery were brought forward in the present study, ranging from hope and optimism to concern and anger.

On one end of the spectrum, psychiatric survivors maintained that “recovery” was in fact a progressive concept—that the very notion that psychiatrized people could “get better” directly challenged the most conservative psychiatric ideology, which does not espouse the possibility of “curing mental illness, only of managing one’s illness through drugs” and other physical interventions over a lifetime. Rora explained:

When I was in the hospital, they told me that I needed to take these pills for the rest of my life. I finally took a different route and proved to myself that I did not need to take pills not to be miserable.

While the hope of “getting better” was appealing to some, others viewed this as another reinforcement of the medical model, admitting that there is in fact something wrong within individuals in need of treatment or cure. Participants had different reactions to this analysis. A few wished to avoid using the concept altogether, emphasizing that the problems faced by psychiatric survivors lie in an oppressive environment that needs to change, not within individuals who have been psychiatrized. For example, Hope wanted to focus on the problem of psychiatric oppression and believed that the notion of recovery brings people away from this problem by insinuating that psychiatric survivors experience individual problems that they should work to overcome. Ricky shared this critique of recovery, but still felt the need to engage with the concept, given that so many psychiatrized people believe in
and are affected by recovery discourses in a myriad of ways. He expressed in a
conversation:

People keep on turning to the system because they need something when they
are in crisis. So we need to be talking about “recovery” at least, so that we can
figure out what people need, whether or not we end up using the word
“recovery” or not. People don’t like it because it says that you are sick, that there
is something wrong with you. But tons of survivors still buy into it, because they
need something, and that is the word they have right now.

Rudy was critical about the individualized and medicalized nature of mainstream
recovery discourses, but felt compelled to challenge and expand the term. He took
issue with how mainstream and professionally driven organizations consider recovery
to imply the need for individual treatment and adherence to treatment plans, including
unwanted interventions when professionals deem them necessary. In a conversation,
he spoke about the need to redefine such mainstream notions of recovery:

“Recovery” is still about doing what the professionals want when we are talking
about what they think “recovery” is. What we think recovery is can be very
different from that. The word is a problem, because of how it is understood by
most people. That’s not what we’re thinking about.

In the Freirian codification group, Rachel agreed that the mainstream idea of recovery
is utterly insufficient. She stated:

The visitors [at the hospital] are deceived into thinking that the person could
actually get well in that situation. They’re deceived by the whole hospital system
and the whole white coat thing. They thing that if we’re there, we’re going to get
better. So they come with their get well balloons or whatever. They really don’t know what’s going on.

Many participants wanted to include systemic change and collective resistance to the community’s understanding of what true recovery means. As Reville explained:

I don’t know what’s going to happen with this enthusiasm for recovery, because certainly...that’s big in the survivor movement... on one level, it downloads the responsibility for your health on the individual. And in fact the individual can’t deal with structural inequality, right? You have to deal with that collectively.

Reville was adamant that the concept of recovery needed to change to imply “collective” or “community” healing if it was going to be of use to psychiatric survivors. He did not want it to be used as a diversion tactic to keep people away from fixing the many systemic problems causing harm in the lives of psychiatrized people.

Redefining recovery was entwined with developing community-driven alternatives, which in the present study were vastly diverse in orientation, ranging from individualized solutions, involving nutrition, naturopathy, homeopathy, counselling or therapy, vitamins and body work, to collective community responses calling for the development of affordable housing, employment, peer support groups, and non-medical crisis centres. The vast majority of survivors felt it was critical to build community settings where psychiatrized people can discuss recovery discourses and alternatives, away from psy-professionals. For example, Rudy spoke of the importance of recent community events that allowed for such dialogue, including conferences such as the Psy"COZY"um event in 2006 and the International Recovery Perspectives conference in 2008.
Meeting Basic Needs: Housing and Employment

Poverty, homelessness, substandard housing, unemployment, underemployment, and exploitation in the workplace were named as major problems facing psychiatric survivors. These poverty-related issues were viewed by all as part of the cycle of psychiatricization, where people are unable to stay out of the psychiatric system when their problems in living are continuously exacerbated by not having their basic needs met or from being exposed to the world on the streets, making them more vulnerable to police intervention and involuntary incarceration. As Reville put it in the focus group, “If you can’t get first a job and a decent job, then what’s going to happen to you? You are going to end up back in the joint again.” While a number of participants were actively involved in setting up employment initiatives and housing opportunities for psychiatrized people, it was widely recognized that until these issues are dealt with in a large-scale systemic way, problems will continue to persist.

Many were enthusiastic about the gains made in the past few decades with regards to employment opportunities that offer decent wages and affordable, needs-based housing options to psychiatrized people. At the same time, there were tensions underlying many of these victories, particularly regarding professionally controlled programs designed for survivors. For example, Reville expressed his frustration with the amount of funds the Mental Health Commission was receiving to address problems related to homelessness. In an interview, he explained:

I think the Mental Health Commission has sucked the air right out of the room.
There is no conversation room left, because they got it all, and they’re fixing it.
And the little Senator Kirby, he’s almost like Mother Theresa for those poor crazy
people, and it’s going to be okay now. He’s going to fix it!...they got all that money! A Gazillion dollars! And now the government thinks, well, we’ve got that done, because we put out all that money! And you know who gets the money? The Toronto money, the City of Toronto and St. Michael’s hospital scooped up 22 million dollars to do a study about homelessness\textsuperscript{12}! It’s just nuts! They certainly will keep researchers busy, and they’ll come up with stuff. Well, we should have one this big, or we should have one that’s green, or these people didn’t work out so well, I don’t know why. And it’s all the same people too... sitting on tens of millions of dollars for researching! It makes me so cross-eyed.

Similarly, two survivors, who wished to remain anonymous, expressed concerned about how funding bodies influence employment initiatives and were discouraged with what they had observed. In separate conversations, they cited instances where managers in consumer-run businesses told their employees not to attend certain radical psychiatric survivor and antipsychiatry events. They speculated that these managers acted out of fear of losing funding in case they were seen to participate in activities that veer too far away from the acceptable, as defined by the mainstream standards of the psy-complex.

At the same time, Xander, Weitz, Hope, and many others recognized the benefits of projects that address problems of homelessness, unemployment, and poverty, even when they are not completely survivor-controlled, and even when they are housed in

\textsuperscript{12} Shelter, Support and Housing Administration (SSHA), in partnership with the Centre for Research on Inner City Health at St. Michael’s Hospital (CRICH), was selected to conduct a four-year, approximately $22,500,000 research demonstration project, under a national program of the Mental Health Commission of Canada (MHCC), to examine the benefits of certain service models on the well-being of psychiatrized people who are homeless (City of Toronto, 2009).
organizations that run counter to values emerging from the grassroots community. In a conversation, Hope commented about the Mental Health Commission’s Chez Soi project:

It’s far from perfect, but people get to choose their own apartments and have people there to help them get what they feel they need to get their shit together...

Housing all those people... That’s a good thing.

Similarly, the vast majority felt that consumer employment initiatives offered many psychiatrized people a sense of independence, self-confidence, and control over their lives, and sometimes even acted as an entry point into community organizing. While some people were critical of government-funded and consumer initiatives, the general sense among most participants was that, in the contemporary context, they offered more good than bad, acting as band-aid solutions, helping to deal with many of the everyday problems faced by psychiatrized people in Toronto. Understandably, the majority felt the need to make compromises with those in power in order to secure resources that ensure opportunities for survivors, even when such initiatives fall short of offering the types of solutions many survivors ultimately seek.

**Building Psychiatric Survivor History**

Constructing a psychiatric survivor history was deeply meaningful to several participants in the present study. To them, survivor history provides people with a sense of pride and a way of looking at themselves in a different way than how they have been defined by the psychiatric system and other hegemonic forces. Here is what Reaume and Costa had to say about the role of psychiatric survivor history in the community:
It gives people a sense of ownership, that we have some real legitimate history that’s out there, that has been so often ignored and to understand all of the struggles people have encountered fighting for their rights…. It also becomes a testimonial to their abilities as well, which of course can be used to say to people. (Reaume)

[It is important] to ensure that there is some way to bridge the past work of c/s/x [consumer/survivor/ex-patient] community to younger generations of people who will or might have contact with the psychiatric/therapeutic system(s). There’ve been so many individuals who have contributed and worked hard over the years to ensure that people with “psychiatric disabilities”—or whatever you want to call it—have the same rights as all citizens. Our history disappears very quickly and although we do have archives and other means of acknowledging our history, I worry about the things that we haven’t documented that will be gone and lost forever. I think it’s important to know where we’ve been in order to understand where we should go in the future. (Costa)

It is clear from these observations that the historical location of community has been an important part of the process of reconstructing understandings of self, experience, and community, through public access to the enduring strength of psychiatric survivors in resisting their placement within society and the treatments to which they have been subjected. By discovering earlier resistance efforts of psychiatrized people, some survivors feel they can provide themselves with history and analysis and claim a positive ground for self-understanding and meaning.
According to Reaume, Costa, and Nat, the development of psychiatric survivor history reveals the richness of the community, breaking down feelings of isolation and alienation, and provides opportunities to learn from the past actions of people who struggled for similar rights and freedoms. In a conversation, Nat shared the following narrative about how learning about psychiatric survivor history affected her:

It is so great hearing what Geoffrey [Reaume—professor, historian, and community member who gives tours of the CAMH wall built by psychiatrized people] has to say. There is such a rich history here, and I think uncovering stories of how people resisted in the small day-to-day ways, before there even was a survivor community, is an inspiration to the people who are here today, who are fighting for their rights together.

Since 2001, a group of psychiatric survivors and some non-survivors have worked hard to establish the Psychiatric Survivor Archives of Toronto (PSAT), a project dedicated to preserving the community's history from the perspective of people who have experienced the psychiatric system. Co-founder Reaume explained in an interview that the archives are building steadily, even without consistent funding or adequate resources, running on the energies of volunteers and resources from the Gerstein Centre and Sound Times, both of which donate storage space. In the past decade, PSAT has become a community initiative that many people truly care about; its events are always well attended and, according to many, foster a sense of community.

As I noted in my research journal, there are also historical monuments that have become significant markers of psychiatric survivor history in the Greater Toronto
Area. One key monument is the wall surrounding the Centre for Addiction and Mental Health in Toronto, Ontario, which was built by unpaid labourers who were incarcerated in the psychiatric institution. People from within and outside the community gather for wall tours regularly to hear Reaume recount stories of patients past. The Lakeshore Psychiatric Hospital Cemetery in Etobicoke, Ontario, where 1511 people incarcerated in the hospital were buried without markers, is another important memorial site that psychiatric survivors use to educate others about the history of psychiatric abuse and neglect. Reaume and Nat described both of these monuments as important symbols of the oppression and discrimination faced by psychiatricized people in the region.

I made note in my research journal of the many occasions when psychiatric survivor history was showcased at cultural events within the community, such as Psychiatric Survivor Pride and Mad Pride. Survivor history has also been made accessible in other formats, such as a play produced by Friendly Spike, *Angels of 999*, based on the Reaume’s research, and through various presentations and workshops covering personal, familial, and community histories of oppression and resistance (Shimrat, 2010; Weitz, 2008; Fabris, 2009; Gorman, 2009).

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Psychiatric survivors raised many themes that demonstrate the importance of community and connection among psychiatricized people. The following section will explore in more detail the complexities that have arisen from organizing in the psychiatric survivor community. It will look at where psychiatric survivors have
managed to find ways of connecting across differences, as well as where conflicts, tensions, and barriers remain unresolved.

**Part III: Working Across Difference in the Psychiatric Survivor Constituency**

Given the constituency's focus on improving the situation of all psychiatrized people, it was interesting to explore with participants how they worked in solidarity with differently situated psychiatrized people. In relation to this, there were three major themes that emerged from conversations. The first was related to ideological and strategic differences among those who are already engaged in community work; the second was related to accessibility and community outreach; and the third was related to how differences in social location disrupt the notion of shared experience and interfere with psychiatric survivor identity politics. The discussions around these themes shed light on why certain marginalized groups of psychiatrized people are underrepresented in the constituency and provide some insight into how to move forward with solidarity work in light of contemporary divisions.

**Collective Representation and Difference**

Identity politics have been a hotly contested area since this community came into being. In the early days of the Toronto community, identity debates were centered on terminology such as “*patient,*” “*ex-patient,*” “*psychiatric prisoner,*” “*psychiatric inmate,*” and “*ex-inmate.*” Weitz was engaged in community organizing in the 1970s and 1980s and shared memories about these variously contested terms. He explained in an interview:

People like Judi Chamberlin were saying mental patient this and mental patient that. I was fucking upset about it. Not at first. She used it in her book *On Our*
Own. Okay. Politically it didn’t make much sense. I mean come on! If you are locked up, you can’t leave, you are not a patient! ... By definition, a patient can leave at any time, against medical advice, or discharged, that’s a patient...When she was talking, and others like Judi Chamberlin, were talking about the injustices, they were talking about represssionist tight restrictions and abuses of rights, violations of people’s freedom. People were not free, and if you are not free, you are an inmate or a prisoner. It’s as simple as that.

The terms to which Weitz is referring are still in use to varying degrees in the contemporary community, but new terms, such as psychiatric survivor, mad, and consumer, have become much more common. Even with changing terminology, I observed many of the same underlying tensions persist, rooted in different ideas about institutional psychiatry and one’s position in relation to the institution.

**The consumer versus survivor debate: Language and identity.** The development of the consumer constituency in the last thirty years has had an enormous impact on the psychiatric survivor constituency, and in the present study, mixed reactions to this development came through loud and clear. With the development of government-funded consumer initiatives and consumer positions within mental health organizations, the term has become widespread and is now used by many who are associated with psychiatric survivor initiatives. Weitz was protective with regards to the use of language and was upset about how commonplace the term consumer has become within the constituency. He explained in an interview:

I think we have to be very, very political when we are talking about identity and movement. Very. I think words and language that the movement uses, those of us
who call ourselves activists, have to be very conscious and critical of how
language reflects our identity.
Survivors like Weitz fought to have the psychiatric survivor identity recognized since
to them it represents an acknowledgement of the abusive nature of psychiatry. It was
upsetting to see the rise in popularity of the term consumer, a term that does not
communicate psychiatric violence or coercion, but rather evokes notions of choice and
freedom.

On the flipside, a few people resented the stance of some psychiatric survivors,
which was perceived to be harsh and critical of psychiatrized people who identify as
consumers in the community and who do not relate to the more radical terminology.
Below are some quotes from participants who felt that psychiatric survivor identity
politics could be counter-productive:

Explicitly, there are those who do exclude people who identify as consumers
from work, and if they do find out that they identify as a consumer, they won’t
work with them in any kind of way... People don’t even get to have a
conversation, because as soon as they identify in any space as a consumer, it’s
completely shut down. To me, that makes no sense at all, because whether you’re
a consumer survivor, ex-patient, mad person, we all face the same oppression.
(Bach)

People I know... felt either really not able to access peer work groups because
people are so antipsychiatry or anti-psych meds or both, so they feel like they
want a supportive critical place that’s still part of psychiatry or of medication, if
that’s what the person thinks they need. So I guess that’s my main experience of
that, of people being really frustrated with a sort of emphasis on survivors rather than consumers. (Jackson)

**The fluidity of language.** In debates over language, survivors have correctly understood that they are fighting partly over understandings of themselves and the context in which they live. Yet, as Reaume (2002) points out in his article about community terminology, while some psychiatrized people involved in the community continue to grapple with which terms best represent collective and individual experiences of psychiatric survivors, in practice, the meanings of terms are fluid and change in different contexts. For example, Reaume (2002) points out that while the term *psychiatric survivor* originated with a radical critique of the psychiatric system, now many people who are not as radical in their vision embrace the term, sometimes even attributing different meanings to it, such as the implication that one has survived mental illness rather than the psychiatric system. Likewise, in an interview, Bach pointed out that many people use the term *consumer*, not because it necessarily fits with their ideological perspective, but because it is the term they are most familiar with because of where they are situated *vis-à-vis* the community. It became clear to me during the data collection process that, while there are specific intentions and meanings behind terminology, language is used in multiple ways by psychiatrized people reflecting different perspectives and experiences of psychiatry.

**Moving beyond consumer/survivor divisions.** Jackson, Rudy, and Bach had grown tired of the division between survivors and consumers and were interested in finding ways of building solidarity across differences in identity. Rudy proposed as a solution using the term *consumer/survivor*, which is now widely used within the
constituency; he understood this to be a compromise that acknowledges both survivor and consumer camps. Weitz was not comfortable with this compromise, however, as he felt it stripped both terms of their implicit meaning and ignored the reality of psychiatric violence. Another trend among some psychiatric survivors in Toronto, which I made note of in my research journal, was the softening of their stance on the importance of language people use to describe themselves. For example, even though Shimrat (1997, p. 45) expressed in her earlier work how she found it to be very difficult to communicate and work with less radical survivors, she stated in a recent presentation “that it’s important to try to communicate with the people who are still within the psychiatric system [as]…they are the ones who need the information most” (Shimrat, 2010). Similarly, Weitz, who has a reputation as a very strong and outspoken antipsychiatry psychiatric survivor, explained to me during our interview,

people have the right to identify however they like, and I will never criticize someone. Even though I don’t like the word consumer, I will never say, “oh, you call yourself a consumer; you’re wrong.” I will never say, “you’re wrong,” I will only say, “I just don’t agree”. I will never publically criticize…a brother or sister, but personally, I just don’t think it [the term consumer] does justice.

As evident from Shimrat’s and Weitz’s comments, even survivors who are known to be very passionate about the words they use to describe themselves agree that the principal focus should be on a common oppression and cause. In line with this, Bach advocated for groups to focus less on identity and more on experience in order to give priority to what survivors have in common with each other. He explained in an
interview that it makes no sense to him that some people are excluded from certain
spaces because of how they identify. He stated:

When we’re speaking about people who face the same oppression, I think we
have to be a lot more inclusive of people's experiences... Consciousness-raising
is a long hard process, and you have to be willing to engage with people’s
experience in order for that to happen. And that has not happened...I think
because the [consumer/survivor] binary has been laid down.

Rachel, Xander, Gray, Starkman, and Bach agreed that in order to build a strong
constituency, it is important to bring together psychiatrized people from different
social locations so that people have the opportunity to share experiences, raise
questions, discuss language and ideology at their own pace and in a way that makes
sense in their own lives. For Bach and Rudy, this meant remaining more flexible about
language and the meaning of words in order to increase opportunities for meaningful
communication.

**Beyond identity: Strategic concerns behind the consumer/survivor divide.**

Weitz and Reville recognized that the identity debates represented much more than
language. The term *consumer* was also linked to particular strategies and connections
to government and the psychiatric system. Slightly more than half the survivors who
participated in the present study acknowledged the consumer development as an
opportunity for survivors to influence change from within the system by participating
in forums where real policy, program, and funding decisions would be made while
getting paid for their labour. For this reason, they viewed the consumer development
as a step towards gaining power and influence with government and the mental health
system where they could implement real change. For example, in an interview, Reville explained:

I call that getting a seat at the table. It’s not your own table, but you’re in the game now, and now you can say what you need to say. There’s still problems obviously, because they’re [government officials and psy-professionals] still more powerful, and they frame the discussion. But at least you can put your point of view forward.

At the same time, several people viewed the consumer development as a threat that has in some ways diluted the collective vision and energies of psychiatric survivors. They viewed the creation of consumer initiatives and work positions as a strategic action taken by governmental institutions to make them appear accountable to psychiatric survivors without really addressing underlying problems and remained skeptical about the changes that would come with survivors becoming part of the system. They feared co-optation and worried that consumer initiatives would further divide psychiatric survivors, thus weakening grassroots initiatives. Even though overall, Reville saw government-funded consumer initiatives as beneficial, he too recognized the problems it caused for the grassroots survivor constituency, stating in an interview:

I think on the flipside, it [the consumer development] took a lot of activists out of action for sure, because you got a couple of thousand dollars to manage, and way more demand than you can meet, and a lot of your time is spent reporting to the government and trying to decide the things you’re gonna do and things you can’t do.
The concerns of a few participants were based on specific examples of how consumer involvement in the psy-complex has countered some of the values central to the grassroots community. As seen throughout this chapter, among these concerns were consumer/survivor business managers discouraging the political involvement of their employees; the stranglehold that operations like the Mental Health Commission of Canada now have on funding for survivor housing initiatives, which include consumer input, but are not survivor-organized or run; the use of psychiatrized people in the promotion of psychiatric ideologies in mainstream anti-stigma campaigns; and the appropriation of peer support within the system in ways that counter values such as choice and independence.

These tensions were not easily resolvable, and the vast majority recognized that any approach to the consumer issue had its trade-offs. Xander, Weitz, Reville, and Starkman recognized that the benefits that have come from the consumer constituency are very real, such as the development of employment and housing options and alternatives to traditional psychiatry. Yet, Weitz and Reville expressed their concern in separate interviews about the effect the consumer constituency has had on radical political action. Despite the fact that psychiatric survivors want to work with others who share experiences of psychiatric oppression, the conflicts that arise in the constituency around different ideological and strategic approaches persist, and the way forward was not clear to participants.


Many survivors were clearly grappling with ways of being more inclusive of consumers and other psychiatrized people who did not identify with terminology such
as psychiatric survivor, but I wanted to understand how they viewed issues of
difference that went beyond the consumer/survivor divide. As central priorities
emerged within the constituency, I asked participants to consider how people from
diverse social locations were situated within initiatives addressing psychiatric
survivor concerns; if they had witnessed any exclusionary acts or forms of
discrimination within the community against particular groups; and if so, why people
thought this might be. In response to these questions, survivors mostly spoke about
the underrepresentation of people with disabilities and racialised people and
speculated about why these marginalized groups were missing. Some also noted that
younger psychiatrized people were rarely involved in psychiatric survivor initiatives.
While some people raised concerns about sexism, homophobia, and transphobia, most
felt that women and queer people were generally well represented in psychiatric
survivor groups and initiatives, and some noted that many trans people are organizing
around issues specific to the trans community without making strong links with other
psychiatrized people. In the following section, I will explore findings about barriers to
working across difference from the viewpoint of psychiatrized people who
participated in the present study.

**Accessibility issues and community outreach.** Several people named logistical
problems that organizers frequently encounter as barriers to engaging differently
situated psychiatrized people. For example, in various research activities, Reaume,
Blaser, Erlich, Rachel, and Rhisiast pointed out that events and meetings are often held
in English without interpretation in different languages, including sign language;
events and meetings sometimes take place in locations that are not wheelchair accessible; meetings and events are often held and advertised in the downtown core, in locations only known by people already involved in the community; and language used in event descriptions often appeals to those who already identify as psychiatric survivors, but may be intimidating or unfamiliar to others. Lack of funding for grassroots initiatives was viewed by Reaume as a major problem, making it difficult, for example, to hire interpreters or find accessible space. He believed that this puts community initiatives at a disadvantage compared to state-sanctioned programs for psychiatrized people that are developed within the mainstream psy-complex.

**Differences in priorities and needs.** Another observation made by a few participants was that some consumer/survivor initiatives appeared to be attended by more racialized people than did grassroots psychiatric survivor initiatives. For example, as Reville and Starkman pointed out, while the crowd at Psychiatric Survivor Pride in Toronto is overwhelmingly white every year, organizations such as Sound Times or businesses like Out of This World attract a much more diverse representation of the psychiatrized population in Toronto. When I asked why they thought this was the case, Starkman and Reville responded that many consumer/survivor initiatives are more focused on responding to the immediate material needs of psychiatrized people, such as, for example, providing them with employment or helping them navigate through the welfare system. Others, such as Rora, Hope, and Bach, responded that these organizations do not try to push particular types of identity politics, analyses of oppression, or political actions. They emphasized
the importance of avoiding paternalistic attitudes towards racialized people. Xander agreed and stated in an interview:

Trying to engage racialized people, you have to be careful, because you don’t want to send the idea that racialized people need to be educated about the dangers of psychiatry. That would be horrible.

Xander spoke of Aboriginal psychiatrized people whom she knew through consumer initiatives who were politicized about their experiences with psychiatry, but did not identify strongly with psychiatric survivor groups. She stated:

The Aboriginal folks who I’ve spoken with, who have been part of this group, have really great analytical understandings of how the history of psychiatry is deeply dependent on the history of colonization.

Both Xander and Rora explained that many racialized people who are organizing outside of spaces designated as psychiatric survivor are politicized by their experiences, but do not necessarily share the same priorities or understandings as the predominately white psychiatric survivor constituency.

**Responding to Difference**

When I asked how psychiatric survivors should respond to the differences in conceptualizing experience, systemic problems, and material needs, several people felt that consciousness-raising (CR) initiatives were the best solution. This is in line with what Chamberlin (1978) espoused in her book *On Our Own*, where she explained that if CR groups are run well, and particularly when groups include survivors from diverse social locations, survivors may come to understand ways in which they are complicit in recreating oppressive relationship dynamics with other survivors. Ricky and Bach
hoped that CR groups could be a place where survivors will begin to analyze
hegemonic ways of relating based on sexism, racism, classism, ableism, and other
forms of oppression, invent new ways of relating to each other and to the world
around them, and manage to create safer spaces for themselves and others.

**Difference in consciousness-raising and peer support groups.** Several
participants whom I interviewed believed that consciousness-raising groups could
offer a place for survivors to come together based on shared experiences of sanism
and psychiatrization regardless of other differences. For example, Bach stated in an
interview:

> As long as people want to be in a group setting, it can work for a lot of different
> needs and people, and I've seen that happen, from the people who are just trying
to get by to people who are in university...

For many survivors, having the opportunity to connect with others who share
experiences of psychiatric oppression was very powerful, representing one place
where they could “speak freely” about their experiences without fear of judgment from
non-survivors. Yet, the claim to commonality could also create what Bach referred to
as “false situations of support” where people come together advocating for mutual
understanding and safe space, when in reality, only some people who see themselves
reflected in the ideology and spoken experiences of other group participants feel
supported, while others feel further marginalized as the reality of their experiences
are ignored and power relations based in dominant culture go unacknowledged.

This dynamic was evident in one focus group I facilitated where I was the only
non-survivor in the room. One man in the group, Reville, noted: “I just feel like the
women are talking a lot less about their experiences. It’s just weird. You always feel that anyways, wherever you are.” Xander responded: “It’s an old history of old white men talking more than women.” Rachel then explained:

We have something to say, too. But I think that our experiences are so different, it’s sort of hard to get into the conversation. Our experiences are just so different. What happened to us is different. It comes from a whole different place, and it’s almost hard to blend the two together. It’s almost like we’re talking about two different things. Two different perspectives on the same thing.

Truly, another woman in the group, had shared her experience of a man who was incarcerated in the hospital at the same time as her crawling into her bed when she was very disoriented and sleepy due to the effects of psychiatric drugs. Rachel used Truly’s experience of male violence in the psychiatric ward as an example to demonstrate her point:

Even what Truly said about being in the hospital in a coma state, and this guy coming and laying next to her. As a woman, you’re dealing with so much more. You’re not just dealing with the doctor and the nurse, you’re dealing with other male patients, too. You’re just victimized by so many things, and that’s why it’s such a different experience. There’s nowhere to run from that. Even from your own family you are getting it.

While this was not universally true, like Rachel and Truly, approximately one-quarter of the women survivors described that their experiences of patriarchal violence did not fit within some aspects of psychiatric survivor discourse about psychiatric oppression, despite the fact that such experiences were key to their
oppression. Similarly, Blaser explained how Deaf people’s experiences of psychiatrization have different elements of oppression involved, which might not be readily understood by other survivors. She stated in an interview:

I think that once you are involved with the psychiatric system, your experiences are going to be vastly different if you are Deaf. For example, most of the assessments I was forced to undergo were done without interpreters, regardless of me asking for it, so it was not linguistically accessible. They denied my request for interpreters, and a lot of the assumptions that they made would have been different had they had a more linguistically accessible environment. I think there’s a lot of oppression of the Deaf community within the psychiatric system.

Other examples of oppressive dynamics came up in interviews and conversations I had with women and genderqueer psychiatric survivors. For instance, two people involved with the Deaf community, Blaser and Erlich, explained that often they would not come to events because of lack of sign language interpretation. Rora who is a survivor of male violence characterized the men in an organization that she used to belong to as loud and angry, behaviours which caused her to feel unsafe at times, so much so that she ended up leaving the group. She explained in a conversation: “The approach taken was not fitting with my worldview of how to make changes in the world. I found the meetings to be chaotic often and loud... It didn’t feel safe for me.” Similarly, two women psychiatric survivors whom I spoke to during the recruitment stage of my research told me that they did not want to attend a group with men who would monopolize the discussion; they had already experienced this type of dynamic in survivor groups and were not interested in repeating the experience. Clearly, for some
marginalized people, taking part in peer support or CR spaces with other psychiatric survivors did not guarantee mutual understanding, safety, or a sense of connection through lived experience due to power dynamics based on sexism, racism, ableism, and autism.

**Difference and power relations within psychiatric survivor spaces.**

Experiences of marginality in psychiatric survivor spaces were not at the forefront of all participants’ minds. Many were much more focused on the positive aspects of these spaces and how the existence of such spaces “saves lives” in a world that despises those deemed as mentally ill. In many cases, white survivors would speak about the connections among psychiatrized people in an idealized way, particularly in reference to peer support and CR initiatives, until I asked questions specifically about discrimination or exclusionary practices in the community, or raised concerns that were expressed to me by other participants, at which point they began to share observations and worries about why certain groups are underrepresented in psychiatric survivor initiatives. People who experienced other dimensions of marginality, for example, racialized survivors, disabled people, trans and genderqueer people, and women, tended to be more cognizant of dynamics that posed problems within psychiatric survivor groups and brought up related issues more readily.

Two commonly held beliefs about why racialized people are proportionately underrepresented in the psychiatric survivor constituency came up repeatedly. The first was related to how problems of racism in dominant culture make it more risky for racialized people to identify as psychiatric survivors. The following are some anonymous quotes from interviews:
If you’re an immigrant and you’re just getting settled in, it’s almost like taking on another huge public burning.

Racialized people are already vulnerable enough, and they don’t want to play ...white identity politics games around organizing around psychiatry. They don’t want to put themselves into some kind of further jeopardy.

People who have dealt with marginality in different ways than white people might not want to enter into a social movement that is going to mark them up in different ways.

The second related to how biases and stigma against people diagnosed with mental illness in racialized communities make it too risky for racialized people to associate with psychiatric survivor groups.

The prejudice in racialized communities is very widespread against psychiatric survivors.

Many were clearly worried that racialized people are not taking part in large numbers in psychiatric survivor initiatives and identified this as a problem. Yet, there were others who were skeptical about how some psychiatric survivors address issues of inclusion and exclusion. For example, in a conversation I had with Tam, she voiced concerns about how statements similar to those cited above can be used to avoid accountability when it comes to racist and otherwise oppressive dynamics that exist within psychiatric survivor groups. In the same vain, an additional worry that arose for me was the tendency towards making generalizations about racialized communities in ways that depict them as somehow more oppressive than dominant (white) culture. This seemed to underlie some statements made by community
members, despite a widespread awareness that psychiatry emerged in dominant (white) culture along with many images and stereotypes of those labeled as mentally ill. These negative portrayals are propagated by government, popular culture, and the psy-industries in ways that are extremely damaging, stigmatizing, and serve to justify many kinds of exclusionary practices and violence.

The points brought forth by participants are nonetheless important to consider, and there was evidence from my encounters with racialized women who were psychiatrized that psychiatric survivor identity politics did not always fit with their experiences of the world. This was clear in a conversation I had with Rora, a racialized woman who understood that she was oppressed by psychiatry, but viewed this oppression as deeply intertwined with the racist and sexist violence she endured throughout her life. She knew about the psychiatric survivor constituency, but felt more connected to a community of racialized women who she believed understood her experience in the context of racist-patriarchy. She commented in a conversation:

[Psychiatric survivors] need to take more of an intersectional approach and call people on their sexist and racist shit. If you don’t, it’s going to be a group for white guys. I rather work with women of colour who understand that. Additionally, through my experience in the feminist community, I have encountered feminist and anti-racist initiatives that deal with issues of psychiatric oppression within the larger context of combating racism and patriarchy, without necessarily having any strong ties to the psychiatric survivor constituency. For example, the Toronto Women of Colour Collective has included issues of psychiatric violence in events about violence against women, without forging more formal connections with
other psychiatric survivor groups. Another event I was part of in December 2010 was organized by THRIVE, the Multicultural Women’s Coalition Against Violence and Oppression, to address violence against racialized women, where I facilitated a group about psychiatric violence against women. Most of the women who attended were psychotized and understood their experiences of psychiatric oppression as inseparable from issues such as immigration, motherhood, domestic violence, and racism, yet most did not identify with the psychiatric survivor constituency.

Recent discussions that took place at the 2010 PsychOUT conference also pointed to problematic power dynamics, as some people with disabilities expressed frustration about what they viewed as ableist ideologies left unquestioned in certain psychiatric survivor spaces. For example, in his presentation, Withers noted how frequently disability is framed as a negative effect of psychiatric interventions, such as drugging and electroshock (Withers, 2010, p. 2). He explained that disability is viewed by many psychiatric survivors as negative impairment, rather than a “social construct” used “to invent and describe deviance from a conscripted, historically-contingent norm,” and due to this hegemonic understanding, many survivors do not want to identify with disability, regardless of the fact that psychotized people are medicalized and rendered disabled within dominant culture (Withers, 2010, p. 2). Withers commented on how he perceives such attitudes:

One commonly heard affirmation by psychiatric system survivors is something like “I am not disabled, I was targeted by an oppressive system, and there is nothing wrong with me.” As a disabled person, when I hear statements like that, I
hear, “There is nothing wrong with me, but there is something wrong with you, and I do not want to be associated with that.”

As Withers explained, when survivors fail to see how psychiatric oppression parallels other forms of ableism, people who identify as disabled are faced with the same ableist attitudes in psychiatric survivor spaces as they are within dominant culture.

I do not wish to overstate the presence of racist, sexist, ableist, and otherwise oppressive attitudes and dynamics within psychiatric survivor organizing, for as in comparison to other realms in society, many psychiatric survivors strive to be inclusive, aim to embrace difference and diversity, and at the very least, are well-intentioned in their work. Nevertheless, it was evident from my encounters with differently situated psychiatrized people that awareness about marginality within psychiatric survivor spaces varies a great deal among community members and that sometimes, a general lack of awareness allows for the reproduction of hegemonic power dynamics, even within spaces that are constructed to challenge the dominant social order. I recorded reflections in my research journal about the importance of recognizing, acknowledging, and changing the ways in which dominant cultural values are left unquestioned or unchallenged within spaces that strive to be anti-oppressive and inclusive to all psychiatrized people. Challenging such values would mean examining our own ways of thinking, behaving, and relating to others in demanding and difficult ways.

**Joining the efforts of other marginalized communities.** One suggestion offered by Reaume, Rhisiast, Xander, and Madman was to join the initiatives organized within other political communities. Some participants were already engaged in cross-
community work, such as with Disability Action Movement Now (DAMN 2025), a radical cross-disability alliance that organizes around a variety of issues such as poverty and immigration and actively tries to build bridges among various people affected by ableism. There were professionally driven organizations that some people were more cautious about joining, while simultaneously recognizing the potential benefits for building relationships with various groups of psychiatrized people. For example, Across Boundaries, an “ethno-racial community health centre” which houses peer support initiatives for racialized consumers and survivors was widely known, but two people voiced reservations in interviews about seeking alliances with an organization that was professionally run. Others felt that it was important to foster stronger connections with the organization, to learn from their anti-racist analysis and make connections with racialized survivors who are using their services. As Xander stated in an interview:

Across Boundaries is traditional in many respects, but then they also offer culturally sensitive and alternative treatment as well, right?... Who are you willing to work with in order to include, in order that you don’t exclude?... your priorities are that you will exclude racialized people because it is your priority to exclude the psy-disciplines... or I’m will to work with the psy-disciplines in order to make sure that we include racialized parties. It’s really like that choice, right? It may not be as straightforward as a choice between working with professionals or alienating racialized people with psychiatric histories, as I did encounter initiatives organized within racialized communities that were not professionally-run. Nonetheless, Xander raises critical points about the importance of broadening
frameworks and questioning the boundaries common in the constituency, in order to include more people who do not identify with the current frameworks that fail to encompass how they view their experiences.

In line with this sentiment, some participants, including Xander, Bach, Rora, Rachel, and Jackie, emphasized the importance of psychiatric survivors challenging their “comfort zones” meaning that they should try working outside of psychiatric survivor spaces to broaden their social circles with people outside of the constituency. They viewed this as an organic way of nurturing relationships with people who might not already be connected to the community and fostering ties among different groups. Xander talked about how she was able to nurture relationships that led to stronger alliances with people in racialized communities:

I have a lot of racialized friends who aren’t necessarily psych survivor identified, but through the process of our friendship and our love for one another... [we were] radicalized through the process of friendship...

She speculated that this was not an easy task for white psychiatric survivors who like many other white people often do not feel comfortable acknowledging their white privilege and find it easier to stay within predominately white circles where power dynamics based on race are ignored. She considered this to be a problem blocking white psychiatric survivors from forging meaningful connections with racialized people with psychiatric histories. She stated:

It’s your duty as somebody who has been bestowed with white privilege through incidents like genocide and histories of colonization and violence, it’s your duty to travel outside your white comfort zone and do the work of negotiating
relationships where you are an oppressor. I think that is the work that the
predominately white psychiatric survivor group should do... As psych survivors,
we certainly occupy and identify as people who have been oppressed... It places
us far outside our comfort zone when we are forced to acknowledge when we
engage with racialized people that we as white people are also people who have
a lot of power... the power to oppress. It’s that willingness to understand that as
much as we’ve experienced our own systems of oppression, we can also take on
other ones.

Xander’s call for white psychiatric survivors to do individual and collective work
aimed at broadening their understandings and ways of working is important in the
process of challenging insidious manifestations of racism in survivor spaces.
Nevertheless, doing the work of acknowledging privilege and power dynamics shaped
by compound oppression, in a constituency consisting of people who come together
based on a shared consciousness of their oppression, comes with both benefits and
challenges.

Throughout the data collection process, I spent some time reflecting on this issue
in my research journal. On the positive side, I observed that psychiatric survivors who
are engaged in community organizing work are aware of the many ways they are
oppressed within dominant culture, which can represent a focal point for people to
begin examining themselves and their communities for other insidious manifestations
of oppression. On the other hand, critically examining oneself and one’s community
requires a great deal of emotional energy and openness to changing problematic
dynamics within, which can feel threatening to people, and perhaps even more so for
those who are already vulnerable. Within a constituency that includes many individuals who feel vulnerable, finding ways of doing anti-oppression work in meaningful and transformative ways without infringing on some people’s sense of safety is a challenge. This is complicated, as leaving current dynamics unchallenged maintains norms where only those who already “fit” within the constituency will feel a sense of safety, while others will continue to feel further marginalized. While bringing awareness to how white privilege works in psychiatric survivor spaces, some individuals might feel they are put in a more vulnerable position, but ultimately, if done well, this type of engagement should bring a greater sense of safety for a larger number of psychiatrized people coming from different social locations.

Another difficulty raised by Gray, Reville, Erlich, and Blaser was the sanism that psychiatrized people face within other social justice movements. For example, Blaser and Erlich described the problem of sanism within the Deaf community. The following discussion unfolded in a group interview:

Erlich: The interesting thing with the Deaf community is the stigma around mental health... If you think that stigma is bad in the hearing community, it’s five thousand times worse in the Deaf community...

Blaser: The Deaf community itself has such an issue with labels and being labeled with having things. There’s a lot of people in our community who have been diagnosed with autism, before being diagnosed as being deaf, because the behaviours stemming from their inability to communicate effectively are some of the same ones associated with autism spectrum disorders. Just along with the cultural identification of the Deaf community—there are two separate models to
look at in the Deaf community, which are the cultural and medical, or the cultural and disability, as I tend to separate them. So the cultural is saying that we have our own culture, our own language, our own beliefs, our own values, we have art, we have history, we have all the same things that creates a cultural group. And then there’s the disability model, where the person is broken, their ears don’t work, they need to be fixed, basically. And so, from the cultural perspective, any sort of pathologizing or labeling that happens is generally frowned upon in any sort of sense, just because we are so used to battling the labels of disability or that perception within the community. When you add mental health into that, it can be really tough... The Deaf community is pretty strongly rejecting this community. They won’t even identify with the disabled community or the radical disability movement. Now it’s starting to happen, because of the discourse coming out of the radical disability movement, shifting the discourse into more of a cultural paradigm, I guess, so that is starting to come together. I doubt that specific collaboration [with psychiatric survivors] could happen on a large scale anytime in the near future.

This discussion demonstrates how sanism is reproduced within marginalized groups whose members are struggling to be viewed as “normal” within dominant culture. To them, it feels risky to associate with psychiatrized people, as they do not want their own experience to be further pathologized.

A small number of survivors did not feel safe organizing outside of groups designated for psychiatric survivors, because of the prejudice they face on a day-to-day basis. This was an issue that was touched upon in one of the focus groups. Gray
stated that he found it particularly difficult to engage with people who are supposedly “politically aware” but do not have an analysis of psychiatric oppression. He stated:

This is certainly a problem in the broader community, but I think that a lot of activists ... fall way short of this too. Sometimes they’re harder to talk to than the general public... It [is challenging] to make links to other oppressions and prejudices and broadly educating on this.

Reville added:

Sanism, what you do with that, is one of the difficulties. The point you make, Gray, I think is good. This is part of the anti-oppression project. The problem is that some of the other people who see inequity are influenced by sanism in our society. So we need to get past that somehow before we can ally.

In addition, Reaume noted other limitations based on personal energies and resources in cross-community organizing. He explained that such limitations can make it difficult for individuals to stay consistently engaged in the many important issues groups are organizing around. He stated in an email:

Part of the problem is most activists are over-committed, and we all only have so much physical and emotional energy to go around - at least I do. Thus there are plenty of worthy causes people may support, in thought but not in deed, on a consistent basis simply because most of us pick and choose what we will and won’t be involved in. How to go about building alliances in more practical terms would entail going to events organized by various groups, but then that needs to be done consistently too or it could seem tokenistic. It all depends again on the circumstances and who is able to do what.
While acknowledging limitations in time and energy, Reaume stressed the importance of taking initiative within psychiatric survivor spaces to bring in understandings and concerns that are being addressed within other marginalized communities. He further explained:

We can also support causes which we may not be involved in regularly by speaking about issues within our own groups, to ensure people from other marginalized groups aren’t marginalized within our own communities - we all have a responsibility to do that.

As seen in this section, psychiatric survivors have many ideas about what they can do to build a more inclusive and anti-oppressive environment that would be more conducive to effective solidarity work among differently situated people. Their insights suggest that the community needs to look more toward compound manifestations of oppression; continue to address issues that affect psychiatrized people who are not necessarily currently active within psychiatric survivor spaces; challenge power dynamics based on race, gender, ableism, and class within psychiatric survivor groups; remain open to different understandings of psychiatric oppression; understand that differently situated people may have legitimate, different priorities; and step outside their comfort zones to engage in the work of other political communities. The marginalized position in which all psychiatrized people find themselves was viewed as a potential starting point for psychiatric survivors to understand how differently situated people experience psychiatric oppression within the larger matrix of domination. Undoubtedly, moving forward from this starting point would pose a challenge, as already vulnerable people would engage in difficult self-
reflexive and cross-community work where they are likely to be subjected to
discriminatory and prejudiced attitudes towards people who are viewed as mentally ill.

Closing Remarks

Psychiatric survivors have worked hard to build empowering spaces for people
who are stigmatized and oppressed as “mentally ill”. Many have been active in social
justice work aimed at changing oppressive conditions in the everyday lives of
psychiatrized people, focusing on anti-discrimination and anti-stigma work,
developing housing and employment initiatives, doing consciousness-raising and peer
support work, building community history and identity, and challenging laws and
policies that infringe on people’s right to choose what happens to their own bodies.
They have won some exciting victories and have carved out places where
psychiatrized people can explore the meaning of what has happened to them away
from the gaze of psychiatric authorities. Through all of these amazing feats, however,
participants in the present study acknowledged that the process of building anti-
oppressive spaces, inclusive to all psychiatrized people, is an ongoing challenge that
leaves many organizers feeling stuck in how to proceed in their solidarity building
efforts. Some participants acknowledged the need to remain open to change as they
engage with psychiatrized people who offer different perspectives that sometimes
contradict their own. The reality is that the more successful survivors are at reaching
out to other psychiatrized people, and the more perspectives that are brought into the
constituency, the more transformed the constituency will become. The next chapter
will visit the mad constituency, a more recent development than the psychiatric
survivor constituency within the wider community. Having looked at the psychiatric
survivor constituency and having identified its self-perception, goals, victories, and
outstanding challenges, including divisions within, this dissertation will now turn to an
exploration of how the mad constituency approaches similar and different dynamics
that emerge from its politics while trying to find common ground among those
oppressed as “crazy”.
Chapter 5: The Mad Constituency

Part I: Introduction

As explained in chapter 2, the mad constituency is a newer phenomenon within the community and reflects the contemporary complexities, divisions, and theoretical trends of today. It does not represent a unified vision, any more than the community as a whole does, but rather in some ways can be seen as a response to the lack of unity and an attempt to bridge some of the political differences among members of the community, particularly those who have been oppressed as crazy. It evolved out of the psychiatric survivor constituency and is often viewed as one and the same, but it can more accurately be considered an extension of that constituency, formed in response to concerns emerging from psychiatric survivor politics. *Mad* is also frequently used as an umbrella term to represent a diversity of identities and is used in place of naming all of the different identities used to describe people who have been labeled and treated as “crazy”. While there are many different interpretations of what *mad* means and what the mad constituency is about, there is a common emphasis on the oppression faced by people who have been oppressed as “crazy”. *Mad* is a term that crosses the spectrum of politics within the community, in terms of discourses about madness and liberation. This constituency has existed for a relatively short time and, as such, has not yet been theorized much in writing as a separate entity from the psychiatric survivor constituency; but based on the perspectives of participants and what I have observed in recent years, I feel that this distinction is merited.
In this chapter, I set out to explore the characteristics that define the mad constituency, various emerging approaches to understanding what mad identity and culture are about and tensions that arise around mad ideology and practice. Part II of this chapter explores the major themes that developed out of my ethnographic encounters with participants who identified as mad or who were involved in mad initiatives within the community. This is followed by part III, which grapples with differences among mad people that emerged in relation to the various themes in Part II.

**Part II: Major Themes**

Many of the themes that emerged from the mad constituency overlapped with themes in the psychiatric survivor constituency, particularly in relation to material concerns, such as housing and employment, stigma and discrimination, access to non-medical alternatives, and developing community history. This overlap reflects the fact that in many ways the mad constituency can be considered part of the psychiatric survivor constituency. However, there were five themes that emerged specifically in relation to mad thought and practice that support it being considered a constituency in its own right: the importance of pushing psychiatry to the margins; developing mad pride, identity, and culture; exploring mad experience and establishing mad support networks; creating mad science; and fostering mad studies in the academic realm. Each of these themes introduced a new set of complexities, challenges, and hopes in relation to the goal of working across difference.
Pushing Psychiatry to the Margins

The primary characteristic that differentiated the mad constituency from the psychiatric survivor and antipsychiatry constituencies was its focus on decentering psychiatry. Many of those who identified as mad were not as focused on abolishing or changing institutional psychiatry, but rather rallied around creating and fostering identity and culture that is not in any way defined by psychiatry. There was a belief, among some participants, that mad people will never achieve liberation or freedom from oppression without extending the focus beyond liberation from psychiatry.

Those who supported the mad direction within the community argued that even if somehow it came to be that psychiatric institutions, psychiatric drugs, or electroshock were no longer threats to mad people, there would still be other tools in society used to control and keep mad people in their place. Defenders of this claim emphasized that the root of the problem is a widespread basic distrust and hatred towards mad people, and they believed that as long as these underlying attitudes and values persist, others in society will continue to produce tools aimed at controlling and eliminating madness and mad people.

To back up this perspective, in a conversation, Ricky pointed to the long history of oppression mad people have endured, traced back to ancient times. He drew on historical works that point to the early period up until the end of the Middle ages, when madness was understood as a spiritual phenomenon, often viewed as demonical possession, and was controlled and suppressed using such methods as torture, exorcisms, and judicial murders (Porter, 2002); the 17th and 18th centuries, when madness was re-conceived as a loss of reason, and mad people were relegated to
workhouses, prisons and poorhouses (Leslie, 2000); and towards the end of the 18th century, when mad people “formed part of a growing class of the dispossessed” and madhouses were established far away from town centres to afford “greater isolation and concealment of those called insane,” where mad people faced cruelties such as chains and whips used as instruments of control and punishment (Porter, 2002; Leslie, 2000). As I noted in my research journal, historical records back up this perspective; the medicalization of problems in living was widespread, dating back to ancient Greece, but it was not until the late 18th century that biological psychiatry began to establish dominance (Szasz, 1987). Ricky and Bach expressed, in separate conversations, that they understood in the contemporary era of globalization that psychiatric discourses are beginning to represent dominant conceptualizations of madness around the world, but they believed that, even if the time of biological psychiatry passes, new discourses about madness will emerge and the mad will continue to be an oppressed class. The following quotes from interviews with Bach and Fabris capture insights about the trans-historical nature of mad oppression:

Mad is what people were called before psychiatry, so in that way it removes itself from psychiatry in a historical context. And also it retracts from the separation or the problematic binary of the madness from the madman, or the mental illness from the person. Mad is what people were called before, and people were seen as mad... What does the world look like if say we do ban electroshock? What happens then? Does that necessarily improve the lives of people? Does it mean that there’s just going to be another form of psychiatric oppression instituted? (Bach)
I think that in 20 years, things will be completely different then. I mean look how
drugging has almost completely replaced the asylum. That’s the thing. The
institution continues to evolve and change. (Fabris)

Jackson, Fabris, and Bach offered another more pragmatic reason for decentering
psychiatry. They believed that taking the emphasis off psychiatry could help diffuse
tensions that exist among those who identify as psychiatric survivors and those who
identify as consumers within the community. As seen in chapter 4, many people
consider this identity struggle among those who have come into contact with the
psychiatric system to be a very divisive issue within the community. As Bach explained
in an interview, there is a perception in the community that

community activism is so centred around being either part of the psychiatric
system or outside of the psychiatric system...that when somebody is taking
psychiatric drugs or is using the system in some other way...there is a barrier

[for her/him] to feel political or that [she/he] can do activism outside the system.

Jackson echoed Bach’s point, as he shared that “a number of people...wouldn’t identify
as part of the community... and don’t feel that they can access peer groups because
people are so antipsychiatry or anti-psych drugs or both.” Due to these perceptions,
some viewed the use of the term *mad* as a way to overcome the conflicts and
differences between survivors and consumers, so that they can get on with building
mad identity and culture, de-emphasizing the importance of connections to the
psychiatric system.

There was also a sense that while the psychiatric survivor identity has an
important role to play in the community, for many people it is too limited in what it
represents. Laurence explained this in an interview, stating that “there is...a time to
say that I survived the system, and I can be proud... There’s a strength in me that helped... but it’s limited... survivor means that I was a victim.” In another interview, Bach agreed that these terms are “formed in relationship to psychiatry and in many ways are institutionally based.” He elaborated that he uses the term mad “because it is based on my experience...not in relationship to an institution.” Similarly, Fabris explained in an interview:

psychiatric survivors and even consumers had identities and maybe even ideas about what that identity is, that it can be quite wonderful, but that they couldn’t embrace the thing that made them different... in the mad movement, at least there’s a hope that the thing everybody hates... has significance or value.

These quotes capture the sentiment of some community members who believe that defining oneself solely in relation to surviving one oppressive system represents only one part of the self, leaving out important elements of self-determination and many other dimensions of life experienced by mad people.

**Mad Pride: The Development of Identity and Culture**

According to the groundbreaking book *Mad Pride*, the essence of the mad constituency is about “reclaiming the experience of madness and the language around it,” valuing and celebrating the experience of madness, and figuring out how to “change the world into a fit place for us to live” (Curtis, Dellar, Leslie & Watson, 2000). Likewise, in the present study, the theme of reclaiming language and developing mad identity and culture was a major priority for many mad participants.

In an interview, when I asked Ruth, a key organizer in the mad constituency, how she viewed the primary goals of the mad constituency, she explained that goals
are antithetical to the mad project. She compared the mad project to a chicken, explaining: “a chicken has no goals. A chicken has tasks [to produce eggs]...and the eggs hatch to become who they are, but that would be who they are, not who I decide they are”. From what I have observed in the community, I would agree that this is indeed a good analogy to explain how the mad constituency functions as a whole. It provides venues and equips people with tools to create ideas and projects. Yet, the ideas that have emerged about what it means to embrace one’s madness and what creating mad culture looks like remain extremely variable. From my encounters with community members, it appears that many people who identify with the mad constituency have tried to avoid defining a specific group identity and exclusive group culture in favour of emphasizing inclusion and diversity as paramount.

Still, specific ideas are emerging about the meaning of mad, as people pose questions asking who mad people are or what mad culture is about. In the present study, these questions were met with many different answers, ones which tap into a wide range of theories and discourses, ranging from biological determinism to postmodern critique.

**Mad as mentally ill and proud.** One mad perspective that I made note of in my research journal was focused primarily on countering stigma and fostering greater inclusion within dominant culture of those who are labeled as mentally ill. While this perspective was not espoused by participants in the present study, I have written records of interactions I had with people at mad pride and other events who generally accept the biological notion of mental illness and reclaim “mad” in the spirit of being proud of who they are, in spite of their mental illness. In my discussions with these people, what was often emphasized is that people labeled with mental illness are
human beings who represent much more than their mental illness, as they too have hopes and aspirations, social relationships, careers, and families. For example, one woman I met proudly carried a sign from the Schizophrenia Society of Ontario that read: “I am a student. I am athletic. I am dating. I am your neighbor. I am successful. I have schizophrenia.” This woman accepted her mentally ill status, but demanded to be treated with respect and dignity as a human being. She believed that the essential purpose of psychiatry is to help people, but also recognize parts of the system as corrupt and was interested in reforms to make it more humane. Mad people who share this woman’s perspective might participate in anti-stigma campaigns launched from within the mental health system, or they might belong to mental health organizations, such as the Schizophrenia Society or the Canadian Mental Health Association, and they do not view these activities and affiliations as contrary to their empowerment vision.

I noted in my research journal that this type of approach tends to have a more neutral vision of societal institutions and the roles people are expected to adhere to within these institutions. While this is not always the case, it is a position that seems to accept the power relations and structures in society and tries to determine how mad people can find a more comfortable place within these structures. In my research journal, I drew comparisons between this perspective and social liberalism ideology, as there is an acknowledgement that people labeled as mentally ill often suffer under capitalism, and the perceived solution is to develop state-sanctioned programs to help mad people mold themselves to fit a normalized ideal of citizenship. Such programs include psychiatric interventions, welfare and disability support programs, accommodations in employment and education, as well as specialized programs to help mad people gain access to employment and education. While this approach
celebrates the individuality and creativity of mad people, many dominant cultural assumptions about madness are left unchallenged, and the suffering associated with madness is viewed primarily as a problem based within individuals and as a stable part of who they are. It is important to note, however, that some people who identify as mad in this sense have a more radical analysis than what is described above. For example, I have encountered a few mad people who accept biological understandings of mental illness, but who also have a radical analysis of structural oppression and believe that social transformation must go deeper than a social liberal strategy.

**Mad beyond surviving psychiatry.** A more common usage of the term *mad* among participants in the present study signified a continuation or elaboration from where the survivor standpoint ends. Like survivor or consumer, mad identity was used to describe people in the community who have in some way experienced the psychiatric system, without in any way presuming a belief in mental illness. This mad approach advocates for shifting community focus away from psychiatry, while simultaneously recognizing the critical importance of the critiques of psychiatry offered up by the psychiatric survivor and antipsychiatry constituencies. As Fabris expressed in an interview, “the mad movement would have no importance if it wasn’t for the survivor movement. It would just be another chapter in what sane people do with madness.” Ricky similarly explained that the survivor constituency “helps define the mad constituency,” creating boundaries around what defines the experience of being mad, ensuring that “mad has meaning” beyond what is attributed to it by dominant culture. There was still a recognition, however, that there is more to people’s lives than the experience of being psychiatrized and that people need spaces to explore emotional/perceptual/behavioural experiences that are complex, have
positive aspects to them, and can at times reach levels of intensity that put people at higher risk of ending up back in the system and losing social and material benefits, such as support from family and friends, employment, and education. This sentiment was captured in an interview with Fabris, who stated:

[Mad activists] are focusing on the experiential which the survivor movement, they had a lot of narratives about their experience--I’m not denying that--but I don’t think that they answered the world’s question, what goes on in your mind when this happens. And they shouldn’t have, of course. I’m not saying they should have. But the mad movement has that possibility.

Participants who shared this analysis varied in their political perspectives, but were critical of institutional psychiatry and questioned its role as an institution of social control. As Madman shared in the Freirian codification group:

You might say that broad society is being served [by psychiatry] in the sense of having predictability and stability in society or whatever, which seems to be what most people want. But maybe they’re not being served, because some very unusual and creative people are not out there interacting and their ideas are not getting out there.

All mad participants were involved in survivor and consumer activities advocating for state-sanctioned programs to support mad people in surviving current oppressive conditions, but many viewed this as working towards short-term band-aid solutions. Their critique generally went further, essentially questioning the current social and economic regimes and their roles in suppressing madness and oppressing those who are unable or refuse to conform to sexist, racist, ableist, and classist ideological roles. As Rudy expressed in a conversation, the suffering associated with madness is
generally viewed as “caused by oppressive systems” rather than “an individual problem caused by madness”. In line with this understanding, Rudy, Bach, Starkman, and Ruth emphasized the importance of making connections to other social movements and were actively involved in disability rights, anti-war, and/or anti-poverty initiatives. They considered involvement in other movement struggles to be a necessary part of achieving the liberation of mad people. Hope stated in a conversation, “if we are going to liberate mad people, we need to focus on the struggles of all mad people... including the struggles of poor people, gays and lesbians, women, black people, and all people who are treated as mad.” In accord with Hope, many who espoused this approach were interested in a longer-term vision towards developing communities that are “mad-positive” and based on values of equality, acceptance, and support.

**Mad within the matrix of domination.** In the present study, there was also a critical (poststructuralist) train of thought that emerged that rejects madness as an essential category and views it instead as a category that is created and maintained through various institutional/cultural discourses. As Rudy explained in a conversation, the mad person and the sane person are archetypes designed to maintain power relationships. He did not view “sanity” as an actual state of being, but rather described it as an imaginary standard of how people are expected to feel and behave. It is a standard that is variable, depending on the cultural and historical context as well as on the social location of the individual.

This understanding of mad identity was an interesting one, espoused by only a few participants, as it has the potential to open up this constituency to all people who consider “normal,” as defined by dominant culture, to be oppressive. As Fabris noted
in an interview, “the mad movement will absorb people who have hardly any experience with psychiatry.” This is a perspective that decentres psychiatry more successfully than other mad approaches, as it views psychiatry as an institution that plays a key role in perpetuating medical discourses of madness, legitimizing power relationships and social control of people, while disentangling mad identity from the experience of being psychiatrized.

Rudy and Fabris, who took this approach, believed that every person is affected by the dichotomous power relationship between the sane and the insane, as they try to meet the imaginary standard of sanity. Fabris described the performance dimension of sanity in an interview. He stated:

I guess you have to put on an act all the time. Everybody's doing this. It's not just the crazies that are doing this. Sane people are doing this all the time... As long as you don't appear crazy, you're probably going to be trusted more often by whoever is around you.

In a conversation I had with Rudy, which I recorded in my research journal, we linked insights about how culture regulates people both externally and internally to critiques associated with Foucault’s (1977) examination of prisons. Foucault’s (1977) analysis determines that control through fear of punishment (i.e. being incarcerated in a prison or psychiatric prison) has largely been exchanged for control through fear of being abnormal (Foucault, 1977). The fear of being labeled and treated as a criminal or a mad person forces individuals to police themselves, even when they are not under the direct gaze of authority. Rudy and I drew on this analysis to examine how all individuals are oppressed by normalizing discourses and disciplinary systems and are forced to repress parts of themselves to gain privilege as a “normal,” and that those
who deviate too far outside the bounds of the “normal” standard are labeled and
treated as mad. As Hope explained to me in a phone conversation, “everybody is
affected by this stuff through the media, through education... it’s impossible to
escape... and it shapes our self-image... and instills fear of ourselves”.

**Mad Focus on Experience, Consciousness-Raising, and Support Networks**

The mad constituency has continued the tradition of peer support and
consciousness-raising (CR) groups first popularized within the community by
psychiatric survivors. It is a false divide to associate such groups exclusively with
either the mad or psychiatric survivor constituencies, as people who identify with one
or both of these constituencies tend to attend the same groups. However, with the
emergence of mad identity and culture, the focus of such groups has shifted somewhat
away from focus on psychiatric oppression to exploring experiences of madness and
how these experiences play out to enrich life and/or to cause problems in living. As
Fabris explained in an interview,

> Historically, they [psychiatric survivors] chose to stay clear from that path... we
> have a completely different way of orienting ourselves in terms of society... this
> inner experience, or this personal experience is being pressed home.

Along with this focus on subjective experience, a few participants emphasized the
importance of developing visions of mad culture and an analysis of mad oppression
organically based on discussions of people's lived experiences. As Rudy stated in a
conversation:

> As we explore mad experiences, we can begin to imagine what we need to create
> environments and cultures that can embrace our differences.... our madness.
Sometimes political actions develop from such groups, but this was not necessarily a predetermined goal. As Bach explained in an interview:

> There’s no ultimate goal. Some people just want to talk and not having that agenda to engage somebody in the community helps, because there’s no expectation. Just come talk. And when you have that as the important thing, and it’s grounded or whatever, that’s what gets people involved. People don’t necessarily want to take on the mad identity or what have you, but it does create a space for people to come together and talk about things.

As I recorded in my research journal, groups that identify themselves as either mad or psychiatric survivor are usually organized around identity and assumptions about shared experience, and currently, membership to such groups tends to be defined in relation to experience with the psychiatric system. Among mad-identified people, however, there was some questioning of this, and it appears that some community groups are shifting the identity boundaries. For example, in Toronto, the Mad Students Society is described as “an inter-university group organized for and run by students who have experienced the psychiatric system”; however, they also state that they “work to create a community to empower, support, and mobilize students who are currently or may in the future experience the psychiatric system.” Rudy explained in an interview that he believes there are limitations associated with the exclusion of people who have experiences deemed as mad within dominant culture, but who have not (yet) experienced the system. He believes that other kinds of shared experiences such as being labeled and treated as mad should matter in the realm of mad identity politics. The message here was that experiences other than psychiatrization can represent enough common ground for connection within a group.
There are some groups that have formed around a different kind of identity
politic, defined by specific experiences of madness, rather than experiences with
psychiatry. In Toronto, such groups were inspired by the Hearing Voices Network,
founded in 1988 in Manchester, England, and Intervoice, a similar group that was
founded in 1997 in Maastricht in the Netherlands. Intervoice has now evolved into a
global network of groups worldwide with initiatives in both Ontario and Quebec, and
in 2010, Intervoice convened a groundbreaking conference in Toronto. This
conference was called Do You Hear What I Hear: Alternative Perspectives on the Voice
Hearing Experience and provided a forum “focused on creating a better understanding
of the voice-hearing experience and discussing alternative perspectives and coping
strategies” (www.intervoiceonline.org, 2010). According to the Intervoice website, the
goal of such initiatives is to provide venues where people who “share the experience of
hearing voices... [come] together to help and support each other” and “exchange
information and learn from one another” (Hearing Voice Network, 2010). In an
interview, Starkman added that these initiatives help “to raise the consciousness of the
phenomena of hearing voices, such that voice-hearers can come out of the closet” and
to support “voice-hearers who get emotionally upset.” As is usual within the mad
constituency, groups organized around the voice-hearing experience acknowledge and
accept that some people take psychiatric drugs as a means of coping while others
choose not to do so, although as Starkman noted, “those who already are out of the
closet don’t necessarily partake of a medical model approach.” Through the sharing of
experiences, Starkman explained, “people think of alternative strategies” to help
themselves and each other.
Members' connection to and involvement with the psychiatric system is peripheral in these groups, and people who do not necessarily have much experience with the psychiatric system are welcome. As Starkman explained,

there are percentage-wise more voice hearers who have never been through the psychiatric system. Percentage-wise... something like 18% of people hear voices or claim to hear voices, and 53% or 54% of those have never been in the psychiatric system. So this is a very interesting phenomenon.¹³

Ricky and Starkman emphasized the importance of fostering safe and accepting environments where people can explore how to accept and live with their voices. As explained in a conversation, Ricky perceived commonality based on having experiences that are recognized as different from what would be considered “normal,” and people come together to acknowledge and celebrate experiences without framing them as sick or deficient. As Bach explained in an interview, the ways in which people process the world “does align with a certain group of people's experiences...and the connections you can make with other people is amazing.” Bach, Ricky, and Starkman

¹³ Although I could not find figures that matched the statistics reported by Starkman, I came across research findings that supported his main points. Several student and community surveys have demonstrated that more people have experiences that would be labeled as psychotic (according to the psychiatric paradigm) than come into contact with the psychiatric system (Johns & Van Os, 2001; Posey & Losch, 1983). For example, Posey & Losch (1983) found that more than one third of college students reported having clearly heard their name called when no one was present; 5% reported having held conversations with absent or deceased people; and approximately 10% reported having heard a comforting or advising voice. Likewise, Morrison, Wells, and Nothard (2000; 2002) found that the meanings and understandings associated with “unusual perceptual experiences” are a predictor of the level of distress experienced by individuals. This could indicate that those who attribute positive meaning to hearing voices might be less likely to come into contact with the psychiatric system.
agreed that such groups can help people feel less alone and act as supportive community.

The majority of support and CR groups organized around madness are open to people who have experienced a wide range of emotional and perceptual experiences. In the present study, the vast majority of participants placed great value on having spaces to share and explore experiences with others in a non-medical, non-psychiatric environment. People felt the need to bring their experiences out into the open without shame. As expressed by Fabris, it is important to talk about “where we go in our fantasy lives and what good [and] value that has...[and recognize the importance of discovering] yourself in many different ways, imaginically, imaginally, however you want to.” Bach felt that having such spaces can help people overcome their fears of the “wild, wild places your brain can take you” and help people to “not be afraid of experiences you have had as a result of something that happened or as something that just happens for you.” Sometimes, participants found valuable insights into what a mad-positive culture would look like when exploring their madness. For example, Fabris described how his experiences led him to a deeper understanding of how environmental responses to madness affect mad people:

I was in university, and I didn’t have any responsibilities because I had classes, and stuff like that, you could basically walk around for about two months acting in ways that appeared irrational and wouldn’t upset the orders that be. You would basically step in the way of things being done the way they normally are done. But it went okay, because I was in university. And I was in the fine arts, and I had all kinds of friends who were crazy in some way or another. None of it mattered. And so it was fine. I’m not describing the experiences, because I’m still
looking at them and trying to understand them, in this kind of more reflective framework. But needless to say, it was certainly delusional, and it was certainly half way to hallucinatory. And again, the way I would picture it is very relaxed with the kinds of associations that came to be, you know, in my mind, were poetic by accident. Not intending any kind of poetry, but it just sort of was, because that’s what happened.

But then I was 24, I had a job, and when this starts happening, and I encourage it and welcome it, because I want to be back in a situation where I’m with me, where I feel like myself, the hammer comes down, because...you can’t go to work and be looking across the counter at the people who you are doing business with, and you smile at them because they look like angels to you. It’s just not appropriate. All that happened with me is that people started to notice that I wasn’t doing my job right, and the people who I worked with suggested that I go with the guy in the ambulance... After that, [I realized] that’s what they do to you? Like holy shit.

Like Fabris, Hope had experiences that led her to understand problems as being rooted in the way society is structured and in the absolute intolerance for madness within the a capitalist system that demands productivity at all costs and undermines qualities such as nurturing and support. She stated:

There is no place for me when I am crazy... no place at work, no place at home. I need to suppress parts of myself to fit into this world.

Bach, Fabris, Hope, and Ricky all recognized that for people to be able to live freely would require a re-working of society and that this cannot be achieved at the individual level. Sharing common personal experiences and insights with other mad
people seemed to help them connect their personal experiences of madness and oppression to larger questions of political struggle and community building.

**Mad Science?**

Many participants who identified with the mad constituency viewed contemporary science as a major barrier to mad people’s liberation. They have watched those involved with the antipsychiatry constituency, and to a lesser extent with the psychiatric survivor constituency, critique the science of psychiatry. These critiques point out the false assumptions made and the problematic theories developed to support theories of mental illness; they expose the weak methodologies of studies that claim successful outcomes of psychiatric drugs and electroshock; they acclaim current research that demonstrates the harmful effects of psychiatric interventions. In witnessing these attempts, Hope, Bach, and Fabris noted how antipsychiatry arguments remain marginal within scientific discourse and are dismissed for the most part by those in power, regardless of how rigorous the arguments are.

The critiques of scientific discourse that emerged in the present study pointed to how value-laden science really is. Participants like Xander and Hope were critical of the “truths that come from the science of madness.” Hope noted in a conversation that “the science of madness begins” with the dominant culture’s view of “madness as bad, dangerous,” and in need of suppression and elimination. For reasons such as this, Hope, Xander, and some others were skeptical about engaging with a discourse that begins with assumptions that posit their experiences and ways of being in the world as abnormal, dangerous, ill, and deficient.
As mad people discussed scientific discourse on madness, they were suspicious of the questions being asked in the field and asked their own questions in return. Hope asked: “Why are scientists trying to isolate the bipolar gene?” “Why do the biological processes of schizophrenia matter?” “Why are psychiatrists asking if a particular constellation of symptoms represents a new mental illness?” She viewed these questions as being at odds with the essence of the mad project, which resists the assumption that “humanity would benefit by rejecting, changing, or eliminating” diverse emotional and perceptual experiences. She instead embraces the belief that society would be better served by striving to value and celebrate the diversity of human beings.

Two main strands of critical thought about the role of science and biology emerged in the present study. The first strand represents an outright rejection of science as having any useful role to play in the community. Charlie, who took this stance, explained in a conversation that science is irredeemable, as it remains under the control of forces that are vested in the hegemonic order of things. He believes that scientific discourse about madness will continue to label various “problematic” behaviours and experiences as illness; “put resources into developing biological theories to explain the illness”; try to isolate genetic aspects of the illness; and develop interventions to cure, control, or eliminate the illness. Charlie and some others held a deep distrust of where such “scientific endeavours will lead, given that they begin with the assumption that there is a problem with our experiences” or behaviours under study.

Those who rejected science as a liberation tool for mad people look to history to see how science has been used against mad people. Charlie pointed to the eugenics
movement, which often pursued pseudoscientific notions of supremacy of dominant
groups and advocated for strategies to eliminate “undesirable” traits in humanity. Like
biological psychiatry today, eugenics was widely accepted in its time and was
promoted by governments around the world. The interventions that were practiced, as
a result of this movement, included segregation and institutionalization of individuals
who were deemed as genetically inferior, forced sterilization, and in the case of Nazi
Germany, mass extermination. Charlie pointed to the similarities between the eugenics
movement and biological psychiatry, which also deems certain alleged genetic
characteristics to be inferior and in need of correction or elimination. He stated:

The reason why they are researching the genetic basis of bipolar at CAMH is to
see how they can get rid of the gene. So that there will be no more people like me.
It is viewed as undesirable, to be exterminated.

Xander believed that a shift in epistemology is in order, replacing science with a
phenomenological approach. She explained in the focus group,

We cannot rely on science, because we all know as people...what drugs do to
us...We’re caught in a conundrum, because we want psychiatry to recognize the
harm that they’ve done to us. It’s almost like asking the devil.

Xander and others recognized that the community already knows why reducing
people’s experience to illness is harmful and how drugs, electroshock, and other
physical interventions cause significant damage in people’s lives. They have this
knowledge because they have been subjected to these treatments, and they did not see
the need for scientific studies to tell them what they already know.

As Ricky and Bach explained to me in different conversations, they did not
completely reject science as a tool for mad liberation, but rather wanted to change the
values underlying scientific discourse on madness. They agreed that the current questions being asked are driven by a hatred and fear of madness. However, they felt that if the research were to begin with valuing human diversity, including biological and genetic diversity, then mad people would not need to fear any biological differences that scientists come to associate with different emotional and perceptual experiences.

In fact, Ricky told me in a conversation that he suspects that physiological differences do exist in brains and contribute to various experiences deemed as mad; however, when not seen as deficient or sick, but simply as different, these physiological differences can lead to a sense of commonality among people. In a conversation, Bach connected this approach to the philosophical approach developed within the neurodiversity movement, which emerged from a community of people diagnosed with autism, and which asserts that “atypical neurological wiring is a normal part of human difference that is to be tolerated and respected as any other human difference” (Explanation Guide cited in Neurodiversity.com, 2010). Participants who viewed madness as influenced or caused by neurological differences believed that the mad constituency should focus on changing dominant (negative) attitudes towards madness and that given a different social climate, scientific methods in neurology could be used for mad people to understand themselves better. This critique was highly controversial within the larger community as, for some participants, it came too close to saying that there are biological underpinnings to theories of mental illness. Jackie and Innes felt that this approach was more aligned with arguments that support biological psychiatry than with those that support antipsychiatry. Innes stated in an interview, “I don’t understand. I think it is
contradictory, that people are embracing their so-called madness. Whose terms are they embracing? And if it's that they’re embracing, a diagnosis laid on by psychiatry, then I have misgivings.” Innes and Weitz felt that this physiological approach baits the trap of reducing human experience to biology, when both scientific knowledge and lived experience demonstrate that diverse living conditions play a significant role in shaping experiences of madness and of human experiences in general.

Participants who saw a potential liberation role for science agreed that there were risks associated with this approach. However, Ricky and Bach considered the real threats not to be based in the acknowledgement of neurodiversity per se, but rather in the meaning attributed to differences, the ways in which differences are categorized, and in the ways differences are used to maintain power relations. While the use of science in this regard was recognized as dangerous given present day conditions, in a different political climate, Ricky believes that it is possible to envision scientific methods being used to explore various biological dimensions of different human experiences, without reducing human experience to biology.

**Mad Academics**

The mad constituency has some significant ties to the academic realm in Toronto. There are particular initiatives within academia that have had a notable impact on community work and on the evolution of mad thought, including: the establishment of the Mad Students Society (2005 - present), a group for mad students to support each other and advocate for systemic change; research conducted by community members that challenges sanism and psychiatric hegemony; and offerings of courses that cover topics taught from the perspective of mad activists. As I noted in
my research journal, such developments have provided venues for mad scholars to
come together, discuss ideas about madness and mad oppression, and figure out how
to connect the university to the community in meaningful ways.

While several participants pointed to a variety of mad studies courses offered
at Toronto universities, they were particularly enthusiastic about the development of
mad people’s history courses. Reaume who now teaches at York University was the
first to design this course, which has since been picked up by Reville at Ryerson
University. More recently, Voronka, Ward, and Fabris have also begun to teach a
course about the history of madness at Ryerson. These courses examine the history of
mad people dating from before the emergence of psychiatry all the way up to
contemporary times. Both Reaume and Reville recognize that mad people’s first-
person narratives are often not included in the academic realm and try to help remedy
this in their courses primarily by including work by mad people. In an interview,
Reaume stressed the importance of remembering and honouring those people who are
“often totally forgotten and neglected... [who were locked] in asylums, who were very
poor, and who fought for their rights.” This exposure to the history gives mad people
in the contemporary context “more of a sense of where we’ve been in the past and...to
know we’ve done a great deal.” Nat felt that these courses helped people to develop
both analysis and a sense of history, a “cultural etiology” of sorts, and a positive
ground for self-understanding and meaning. She felt that the impact was particularly
strong because these professors are so strongly committed to bringing this knowledge
and education into the community.
Reaume and Reville spoke about bearing witness to people re-thinking ideas about madness and mad people when teaching courses. Reville explained:

I get about 220 students a year, and they get to hear about the social construction of madness that they wouldn’t get to hear otherwise. That’s really exciting. And bringing mad knowledge into the academy is an exciting adventure. It’s amazing the way that students respond to this.

Similarly, Reaume explained:

I’m very excited about doing that [teaching]. It’s my passion, needless to say... And it’s especially important to create a space for people who feel that they can talk about this history and identify with it as individuals who have lived it themselves. That’s important. The very first time when I taught it at U of T... I was getting quite the responses from people. So that was very important... One student, in fact, said that—she actually wrote it in her essay—that mad people opened her eyes to a way—and that’s ableist language—but that’s how she felt... opened her views or thinking of things in a way she never had thought of before. And that’s how we are getting people who are allies as well.

The fact that mad people have forged a place in the academy for scholarship that is respectful of mad experience was viewed as a major victory by Reaume, Reville, Nat, and Xander who boasted about the emerging mad scholarship in Toronto. As Reaume pointed out in an interview, the gains mad people have made within the academy to date would have been unthinkable years ago. He stated in an interview:

There is no way a person could have got the job I have 100 years ago or 50 years ago even with being public... probably even 30 years ago, but certainly 50 and
100 years ago, forget it... I feel a great obligation to all those who can never have any chance of such opportunities and privilege. So I wanted to talk about it. I want to make sure they’re always remembered... Many of us may have been locked up, if we had been down there years ago.

According to participants, the primary goals associated with bringing mad studies into the academy were to legitimize mad people’s knowledge and to use academic resources to provide for projects that would benefit the community. For example, in the focus group, Xander explained what she hoped to achieve:

My goal is around knowledge and knowledge production, and keeping the knowledge that psychiatric survivors and mad people have and recognizing that that is a form of knowledge. My lofty sort of goal is to have spaces within the academy that recognize different ways of thinking as different forms of knowledge. So instead of problematizing different ways of thinking, I want to problematize this idea of “normal” and “normalcy” as thinking.

Similarly, Fabris hoped that his current research would help challenge existing rhetoric about madness to create greater acceptance of mad thought and to shed light on its value in broader society. He explained in an interview:

There needs to be some kind of fashioning of the rhetoric and the terms and the discourses around [madness], so that we can talk about it in a way that’s not so programmatic. It seems to me that a lot of the language we use around crisis, it speaks to a program. It speaks to a kind of already written narrative. And so there should be ways of theoretically and creatively even disentangling some of
those knots and trying to open up conversations that are not simply one sided
and in which one person is not trustworthy, where they’re social worked into a
more normal relationship with the world, or whatever it may be. The question is
can we listen more? Can we engage that other with more receptivity rather than
with an interest in intruding in their line of thought, which is not credited with
any significant value, and interjecting again the social line of thought, which will
come back to recover and all of that?

The development of mad scholarship was also seen as an opportunity to make
connections to other progressive disciplines such as women or gender studies, equity
studies, and disability studies. The courses taught by mad scholars with whom I spoke
were couched within programs in these disciplines which proved to be a useful place
to spark inter-disciplinary and cross-movement dialogue. A few participants felt that
this has led to significant progress in some academic spaces, and in particular within
disability studies spaces, where people interested in mad and disability studies have
begun to work through some of the barriers between psychiatric survivor and
disability communities. As Nat stated in an email:

Being associated with disability studies has provided a place where some people
could think through some of these issues... the reasons why psychiatric survivors
haven’t wanted to associate themselves with physical disability and why disabled
people don’t want to associate themselves with madness... It has forced people to
face these questions and overcome prejudice on both sides.

The inter-disciplinary connections admittedly were not problem free. For example,
Xander pointed out in an interview that even in the realm of disability studies, sanism
continues to pose problems, and mad people do not necessarily have support to work through these problems in meaningful ways. She explained:

There are ways of accommodating physical disability that can be really sort of material and comfy, whereas madness isn’t always apparent. It’s always shifting, and it’s less tangible around accommodating in work places... It’s a shifty issue in sort of integrating mad people into an academic sort of community that insists that you be sane in order to be productive, right? ...Like having to stay well, or having to stay sane in order to do mad studies... I think madness can be a less visible status option than physical impairment, and I think that when madness erupts, oftentimes there’s a shame and the idea that you are supposed to sort of hide it in a way that physical disability doesn’t call for... In my experience, when I’ve been mad, it’s sort of expected that you retreat from the visible until you’re sort of functioning again.

Despite ongoing problems with sanism in the academy, numerous people addressed the value of legitimizing mad knowledge and forging connections with other disciplines that have overlapping interests.

Even given the excitement generated around mad studies, a few participants raised concerns about the direction some mad scholarship has taken and critiqued some mad academics for producing work that they viewed as disconnected from the needs of those who are most oppressed as mad. Rachel told me in conversation that she sees some scholarship as too obscure and inaccessible to people who are working on the ground or to people who are trapped within the system and has concerns about producing work about madness within the ivory tower of the academy that does not
have meaningful impact on the ground, where people need it most. Similarly, in an interview, Costa, who works at the Empowerment Council within Toronto’s psychiatric hospital, the Centre for Addiction and Mental Health, expressed similar reservations about some mad research and writing, stating that “mad academics can act as a blanket, silencing those voices who are not ‘professional crazies’.” She asserted that it is more important for the community to “pay extra attention and give forum to those quiet acts of resistance by people who don’t have access to money, power, and privilege.” When I asked Reaume about whether or not he had concerns about the connections between mad scholarship and the needs of mad people in the community, he agreed that there were complex issues of power to address. He stated:

Most mad people or psychiatric survivors are not professors, and...being a professor is upper class. There’s no question. Most people are poor. So yes, there’s class dynamics around who gets to tell the story, including me. Because I have a Ph.D. and got this position. Part of it is, I would argue, now that I got the position, I’ll use it to our full advantage in promoting it, since lots of professors historically have used their positions to our disadvantage, including to this day, psychiatrists and historians, among many others. But yes, in the community, I think the tension of “town and gown” is common.

Like Reaume, all mad scholars with whom I spoke throughout the course of the research cared about their work having a positive impact in the lives of mad people. Some felt that they could use their positions to benefit the community. It was also noted, by some participants, that mad people with academic credentials can open up opportunities for community initiatives within hierarchies in society that would
otherwise remain closed due to prejudice against mad people. In an interview, Reville pointed to the success of a particular initiative which he felt could not have happened without the involvement of a professor:

Part of the reason why it’s happening is because Geoff Reaume is a professor. He’s got letters. You’ve got to pay attention to a person with letters. So I’m thinking isn’t this cool. Here we’ve got a crazy guy with letters. He’s an associate professor and everything. And now, they have to say he’s credible, because they buy into all that stuff. They’re totally credentialist. Okay, show me a guy with credentials, and my god, he’s on the jury... It’s a fabulous thing.

Most of the mad scholars in the present study acknowledged that there are competing pressures within both the academy and the community that could lead them astray, such as influences coming from academic supervisors or pressures to spend time publishing papers rather than remaining active in community work. Nevertheless, all who were academics viewed it as their responsibility to use their positions within the academy to bring resources into the community, for example, through developing university-community partnerships, distributing research funds within the community, offering space bookings to community groups, and bringing educational initiatives into community spaces.

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Participants raised many issues that highlight an emphasis on inclusivity within the mad constituency, an emphasis driven by community members recognizing existing divisions among psychiatrized people and being inspired to re-invent mad ways of acting that might unite people across differences that now divide them. The following section will explore in more detail some of the complexities accompanying
mad developments in the community, looking at both some successes of the mad constituency as well as some conflicts, tensions, and barriers that appear to be arising.

**Section III: Working Across Difference in the Mad Constituency**

Given the mad focus on diversity, it was very interesting to explore the progress the constituency is making *vis-à-vis* engaging differently situated people in mad organizing and action. It was clear that the mad constituency has had more success in mobilizing some people whom the psychiatric survivor constituency could not, for example, some of those who identify as *mentally ill* or *consumer*. Yet the shift in focus towards diversity in the mad constituency has led to other problems. It has inadvertently caused its own forms of exclusionary practices, as certain manifestations of mad identity and new conceptualizations of “shared experience” still do not fit for many people who are oppressed as mad and liberal approaches end up reinforcing hegemonic social relations. Participants spoke about these problems in relation to two major trends. The first was related to attempts at creating mad inclusivity and breaking down divisions that have historically caused rifts in the psychiatric survivor constituency, and the second was related to experiences of compound oppressions that disrupt notions of radical acceptance of madness and emerging mad nationalisms.

**Striving for Mad Inclusivity and Breaking Down Divisions**

Mad inclusivity was a major focus within the constituency, and numerous mad people were very focused on opening up mad spaces to those who do not easily fit within the parameters set in psychiatric survivor identity politics. As seen in part II, mad people have different ideas about what it means to open up mad identity. For Jackson, Bach, and Fabris, it means including consumers who have been alienated from
psychiatric survivor spaces; for Rudy, it means moving away from defining mad in relation to the psychiatric system to include all people who feel oppressed by normalcy and sanism. Several participants felt the mad constituency had the potential to absorb people who have very limited experience with psychiatry, because, as Fabris put it in an interview, it is no longer

a bunch of survivors saying fuck you—you just ruined our lives....The message can be put out there, and it can be spread faster, because it’s a good news message...there is something for the normal outsider to get excited about.

Bringing mad pride and mad culture into the mainstream was something that many people who identified with the mad constituency valued. For them, broadening the definition of mad to include people who view their liberation as wrapped up in resisting normalizing discourses was viewed in a positive light. Fabris felt that welcoming a broader audience into the mad constituency had the potential to change conversations about madness even in realms outside of the community. In an interview, he explained,

No longer will people just simply assume that [mad] people...need to eventually be corrected somehow or they will simply go unmanaged and unruly. They won’t be able to assume that anymore, because there’s going to be a rhetoric that says...they don’t need to be fixed at all.... This is going to be coming from consumers. This is going to be coming from ordinary folk who don’t have anything against government or business.

In different interviews and conversations, Ruth, Fabris, and Charlie stressed that
opening up the mad constituency could ultimately help mad people gain greater credibility in society, as more people from various social locations and political affiliations come to view madness as acceptable and understand it as simply part of being human.

The value of mad inclusivity fits in many respects with the way the constituency currently functions—as a collection of different practices and political positions that has the potential to challenge normative bodies of knowledge and identities. As I noted in my research journal, Mad Pride is a strong example of this. In Toronto and around the world, in at least seven different countries, mad pride participants take part in artistic and theatrical actions that challenge dominant culture in many different forms. Within these group events, there are many traditions that stress the importance of self-expression and individual acts of resistance, such as dressing up and presenting in mad ways that are deemed as unacceptable in dominant culture. I observed and noted in my research journal that the strategy appears to be one of interrupting grand narratives that proscribe how people should act and what experiences and behaviours should be valued. Numerous mad participants valued the various ways that people resist dominant views and treatment of madness on both a collective and individual level. Rudy understood resistance in a Foucauldian sense, believing that “points of resistance come from many different places... [and that] a plurality of resistances is important in mad liberation.” Individuals who took part in subversive acts were seen to be using the power they wield within a network of social/power relations, refusing to submit to the positions carved out for them within dominant culture. As expressed to me in different conversations, Ruth and Rudy
viewed the spirit of Mad Pride as about recognizing and valuing different forms of resistance and reminding oppressed people that they are not simply victims, that they wield power, and that it is important to use that power to resist normalizing discourses and narratives by being who they want to be everywhere and anywhere. Mad Pride organizer, Ruth, spoke of her attempts to create sites where it is safer to celebrate each and every way mad people resist, whether that be within the walls of institutions or out on the street. She hoped that individuals could find ways to express themselves in ways that would help them. She explained her broad vision in an interview:

I’m doing that [organizing Mad Pride] in hope that it does to the community the same thing it does for me. It gives me a purpose, makes me proud of myself, puts the hell I’ve been through to good use, and it feels like good news on a dark day, and if that does it for me, I hope it does it for you. That’s it for that.

However, the value of mad inclusivity was met with reservations among a few participants. For example, in a conversation, Ricky expressed concern that opening up mad identity to include people who did not experience sanism to the same degree was “a hijacking of the mad experience.” He did not agree with defining “mad” as anything at odds with “normal”; he feared this would lead to an “identity without essence.” The perception was that this approach would render mad identity meaningless. When defining mad in this way, Ricky wondered how those who are at high risk of psychiatrization can connect and organize with one another, away from those who are more privileged as “normal” in the world. He felt the need for mad identity to have
more specific meaning at a time when having “safer spaces” protected by a common understanding and experience were still deemed necessary.

Several others worried about stressing inclusion to the detriment of having a strong critique of the psy-complex and other sanist institutions. They felt that the mad constituency could at times be very liberal and dilute critical problems faced by mad people. What some people viewed as a radical embracing of diverse localized resistance efforts, others viewed as relativism, where a multitude of perspectives are exalted as equal, regardless of what dominant values were left unquestioned. Fabris pointed out in an interview the reality that some people who are proud of their madness will still replicate dominant psy-discourses. He stated:

[the mad movement] has its own dangers. Don’t get me wrong, right?… if a consumer came out and started talking about their madness, you’re probably going to end up with a book like by Andy Behrman, the guy who wrote that shock thing, a book about himself getting shock treatments. *Electroboy*. He wrote about his manic-depression and getting shock. He’s a consumer who is proud of his madness in a sense. “Oh, you should have seen it! It was the wildest!” There’s going to be those stories. There’s going to be that replication. That’s a necessary part of this thing.

Rudy feared that including such narratives in the mad project could weaken messages about how mad people are oppressed. When I asked him about this in a conversation, he drew a comparison between gay pride and mad pride. He spoke about how gay pride began as a political event against homophobia and for the rights of queers, but as the community mainstreamed, changed from being radical to becoming a corporate
event that leaves many important issues facing queers out of the spotlight. He
questioned if the mad pride project will take a similar route and asked:

Is mad pride in danger of falling into the same traps as gay pride? Gay pride is
now sponsored by beer companies. Will mad pride be sponsored by
pharmaceutical companies in the future?

Jackie was concerned that if the mad constituency takes a relativist approach to
radical inclusion, it runs the risk of reproducing other forms of oppression such as
sexism, racism, homophobia, transphobia, ableism, ageism, and classism. For example,
she explained that to include all perspectives, as long as they are mad, opens up the
constituency to discourses that do not take into account how madness is defined and
shaped by a complex system of power relations. She stated in an interview:

If we just celebrate madness, whatever that is, we are forgetting about the ways
many women have been persecuted for being crazy because of their reactions to
violence. That won’t do for those of us who are being diagnosed and drugged
because of trauma... It is important to put our experiences back into context
instead ... recognizing and naming the specific dimensions of oppression... If
people don’t get it, we shouldn’t just stop at saying “okay, your perspective is just
as valid as mine.” We should be saying, “okay, let’s talk about different ways mad
people are oppressed, and you learn what it means to take a feminist mad anti-
oppression approach.”

While Jackie, Rudy, and Fabris were asking these critical questions, it was clear
that many who identified with the mad constituency generally valued its politic of
acceptance and inclusion. In recent history, Reville and Starkman purported that it has
had the most success in bringing together people with different ideologies in the
community who might not normally be sitting at the same political table in order to figure out what they can accomplish together. This was a very exciting development for many people in the community, and in various conversations I had with mad people, enthusiasm and hope were evident. Reville glowed in an interview about how “extraordinary” it was to have people “from all the tables in the same room” to discuss what the community should do to protect mad people’s history. In an interview, Fabris was excited about an experience he had at a recovery conference where he had met a consumer-identified man who openly spoke about how he had enjoyed his psychotic episode. To both Reville and Fabris, these events demonstrate how the mad constituency has broken through the divides of consumer/survivor to reach a new level of connection. While some people worry about this approach being too liberal, others view this kind of dynamic as ripe for possibilities of consciousness-raising within the community, where people connect on an experiential level, talk about their experiences in the world, and develop a political analysis together.

“Mad” and Compound Oppressions

Like psychiatric survivors, many who identified with the mad constituency were grappling with ways of breaking down old divisions within the community and finding ways to be more inclusive of differently situated people who are oppressed as mad. In discussions about this issue, the majority raised many of the same issues as psychiatric survivors did, such as the underrepresentation of particular groups in certain mad spaces, the inclusion of racialized people and youth, and problematic power dynamics within mad groups. Most also suggested many of the same solutions as psychiatric survivors, such as the importance of active engagement with other
political communities; holding events in accessible spaces; finding resources to pay for multi-lingual translation and interpretation, including sign language interpretation; and advertising more broadly in spaces that might attract people who are not already engaged in mad organizing. The history of the mad constituency is relatively brief, which explains why people identified so many of the same problems and solutions in trying to find ways of working across difference. However, there were some additional insights, tensions, and challenges around addressing compound oppressions that emerged specifically in relation to developing mad thought and practice.

**Radical acceptance?** While a significant goal in the mad constituency is to break down divisions among people who are oppressed by sanism, a few people felt that in some ways trends within the mad constituency are blocking this from happening. For example, Hope felt that the way difference is handled among members of mad peer support and CR groups can lead to tension, conflict, feelings of alienation, vulnerability, and danger. She explained that these groups represent an important community resource, but that some people belonging to marginalized groups feel they cannot connect with discourses of madness that seem to predominate in certain spaces. As Hope stated in a conversation,

> It is really hard bringing people together based on the fact that society thinks they are crazy... [and] expect them to understand each other’s experiences. I mean, what do I have in common with a white middle-class guy who is crazy but who has always had a supportive family and their money as a safety net? I don’t expect all crazy people to understand my experience, and I probably don’t want to turn to all crazy people for support.
Hope recognized that while many key players in the mad movement were aware of different manifestations of oppression, this awareness did not always go deep enough for group members to question how their own actions reproduce dominant power relationships within the group. Regardless of how people interpreted the cause of problematic power dynamics within mad spaces, it was once again clear that the notion of “shared experience” among mad people did not fit all people whom the constituency hopes to include.

In the Freirian codification group\textsuperscript{14} held at Psychiatric Survivor Pride, a discussion examining a scene depicting a community event clearly exemplified how group dynamics can play out differently for people of different genders. The codification showed a gender neutral person speaking at a podium in a room filled with chairs, with many empty chairs and two chairs lying on their sides, with a few women and gender neutral people sitting at the front, two women having a private conversation at the back, one person sleeping, and a person saying something while pointing at the podium and storming out of the room (see Appendix C). In the picture, some people were clearly meant to represent women, but those who were meant to represent men appeared more gender neutral, leaving the gender of half of the people open to interpretation. Here is how the conversation about the scene unfolded:

\begin{quote}
Truly: I think it’s pretty symbolic that there are only women in the audience, and we’re the population that is the most psychiatrized. And then the person who is
\end{quote}

\textsuperscript{14} As explained in chapter 3, the constitution of the Freirian codification group does not match up with the three constituencies that I am theorizing in this dissertation. Participants included people who identify as mad, psychiatric survivor, consumer, or a combination of these three identities. I decided to include this excerpt here because it demonstrates a tension within the community that emerged in conversations with mad participants who emphasized the notion of “radical acceptance”.

at the door is a man...he’s not only oppressing women by their gender; he’s also oppressing people who are involved in the psychiatric [survivor] movement, whether they are psychiatric survivors or allies...

Facilitator: Do you identify with parts of that in the image? You were speaking about the man at the door.

Truly: He’s the only man. I don’t see another man in the audience.

Madman: There might be one sitting on the other side of the row. Is that a man with the bald head?

Facilitator: I think a lot of them are gender ambiguous. It’s up to your interpretation. I think it’s interesting that you see all women...

Truly: And so there’s this man who represents patriarchal power coming in and oppressing those who are already oppressed on some level by the way that our society defines them.

Facilitator: Are people relating to that within the community, in terms of that gender piece, that’s coming from the broader culture and society that we live in? Do you identify with that in the picture?

Rachel: ...Well, I don’t know who flipped over the chairs, but I’m assuming it’s the guy at the door. And I think it’s kind of funny, because a lot of women end up in the psychiatric system because they’ve been exposed to violence and this kind of behaviour from men. And then he comes into this meeting and flips over the chairs. It’s kind of funny.

Facilitator: What’s funny?

Rachel: It’s like you’re the reason... It’s like he’s almost just trying to keep everything the way it is... He’s trying to keep everything the way the patriarchal
society wants it to be. And he’s just like a soldier of it. He acts like a soldier, whether he knows it or he doesn’t. He’s just doing exactly what his role is.

Facilitator: So he’s recreating the problem, within this room where people are trying to change the problem.

Rachel: Ya, well, these women sitting here. They might have been psychiatricized in the first place because they were exposed to violence, and then they have to go to a meeting that’s supposed to be peaceful, and they have to deal with it. That’s probably traumatizing them all over again.

Shiva: I guess this person is not really happy with the other guy’s lecture. He’s trying to convince the other people, and he’s not happy with them. He’s upset at him.

Mad Hatter: ... it doesn’t seem to me that the man is particularly angry. He seems to be pointing at something, and two of them seem to be looking at what he’s pointing at. The two people in the back row seem to be oblivious to what is going on. And the people in the front row seem to be oblivious to what’s going on in the room. Sitting in the front row listening intently.

Madman: ... I do think the guy, you said that you didn’t think he was angry, but I think he was wagging his finger, I think he was pointing his finger and that left hand has an interesting look to it. He’s wagging and pointing his finger and calling him down. Spatially, I think he’s a larger than life figure. I think that people who do that kind of things at meetings can have a kind of amplified effect on the order and progress of the group that they’re with, by not trying to work with them as a group.
Rachel: ...If you've ever seen people throwing chairs around, that's a very scary situation. I would see this guy as very angry, and he's very aggressive. It's not his finger pointing. He was obviously throwing around chairs. I'm surprised there's no police or something to arrest him. And no one is getting off their chairs to stop him.

Facilitator: So you're seeing the complacency.

Rachel: It's just socialization.

Rhisiast: I see it the other way around. He could have just walked through the door and be looking for somebody or looking for something. I think the image can be read in both ways. Yes, it could be read as he's the one who has knocked over the chairs, and he's on his way out. Or he could be just arriving and looking for someone or somewhere to sit.

The women in the group clearly identified the man walking out of the room as angry, violent, and threatening. They could identify with the women in the scene and worried about the impact the man was having on them. They also brought in an understanding of trauma, seeing the women as traumatized first by violence perpetrated by men, then by psychiatric violence, and then again re-traumatized by patriarchal relations within the community. For them, the priority was not on valuing this man's anger and/or madness, but rather on ensuring the safety of all people within the group and challenging patriarchal power relations. The men, on the other hand, viewed the man's behaviour as an understandable expression of anger, an attempt to get his own perspective across, or simply as an entry into the group and an effort to get himself settled. They did not describe the man as threatening or his expression of anger as a
problem and did not express concern about the safety of others or about how aggressive behaviour might have an impact on survivors of violence.

This example demonstrates tensions within the constituency between the desire to be accepting of and accommodating to expressions of madness and the commitment to maintain an anti-oppressive politic and respect for other people's needs and sense of safety. I wrote in my research journal about what I interpreted as some ambivalence within the mad constituency about how to respond when faced with expressions of madness that reproduce problematic power dynamics. This is perhaps due to a romantic notion of madness expressed by some participants—one that celebrates madness as part of the beauty of human diversity. This is different from the psychiatric survivor or antipsychiatry constituencies, which often frame at least certain experiences of madness as resulting from trauma. Many participants who were women, genderqueer, and/or racialized felt that the latter framing was a better fit for describing how their madness is shaped by experiences of sexism, racism, classism, and other forms of oppression. This is not to say that it is impossible to bring an understanding of trauma and compound oppression into mad ideology and practice, but it does not appear to be happening in certain spaces to the satisfaction of all people who are oppressed as mad.

**Challenging “mad nationalisms”**. An additional concern that was unique to the mad constituency was about emerging “mad nationalisms” that tend to place mad identity at the centre surpassing all other individual or group identities in a way that has the potential to decontextualize and homogenize complex personal experience. This stemmed in part from the entanglement of mad identity with cultural and biological etiologies of madness. This could be seen in narratives that stressed
connection through common experiences, such as hearing voices or having prominent mood changes. For example, Ricky viewed this connection as based in part on biological factors, while Rudy believed that shared culture emerges from similar experiences that are considered “outside of the norm.” A few participants felt that these types of understandings were at odds with the goal of building alliances with mad people who understand their experiences of madness, at least in part, to be rooted in compound oppressions. For example, following a conference presentation I gave in May 2010, entitled *Madness is For All of Us! Towards an Intersectional Understanding of Mad Identity and Mad Theory*, mad activist and scholar, Tam, shared her concerns about developing “mad culture,” which she viewed as potentially reinforcing essentialist notions of madness and mad identity. Furthermore, she was concerned about how sometimes mad oppression and liberation are treated as separate from other forms of oppression and liberation struggles, as if mad was a construct that could stand on its own. She noted how mad identity is often constructed as white in insidious ways, for example, when community members speak of how the mad movement is *like* the black movement, instead of understanding them as inseparable from each other. She advocated that we move away from mad nationalist tendencies and instead look at larger sets of power relations to understand sanism and psychiatric violence, for example, examining how racialization is involved in dominant constructions of madness and processes of psychiatrization. Her emphasis was on understanding mad people’s experience in context and veering away from mad identities that are constructed in rigid and essentialist ways.

Two other conference attendees who were engaged in building mad culture and history shared some of Tam’s concerns around constructing mad identity and
experience in homogenizing ways. Some important questions were raised by them about mad history and culture, such as: “Whose histories are included and excluded?” “How do issues of gender, race, class, and ability affect this?” Reaume took these questions very seriously and felt that it was critical to elucidate connections among various marginalized communities in his work as a historian in order to avoid homogenizing portrayals of madness and mad people. He recognized that records of mad history that are most readily available are often written by mad people who had access to more resources and privilege and tend to represent a middle-class white male perspective. In his work, he tries to seek out accounts written by those who do not normally make the history books, and he acknowledges this as a challenge within his course. According to Reaume, part of what needs to happen is to move beyond what is named as mad or psychiatric survivor to look at histories emerging from other marginalized and political communities. He explained:

It is also essential to build bridges elsewhere. I mean, for example, obviously I’m a man, but I learned so much from feminist historians, the women’s histories, which I obviously incorporated into my work. Gay and lesbian historians amongst people who are straight. Historians of African Canadian or African American experience amongst people who do not have that history. So it’s important first of all in those communities to reclaim their own history and tell it, but also to make sure people from elsewhere learn from it. And that we acknowledge the history which is so often being ignored elsewhere. Because, of course, history previously had been just a great myth largely speaking, and
before the late 50’s, early 60’s, when socialist historians started, [they] were generally great white men... from European backgrounds and North American.

Similar to Reaume’s and Tam’s convictions, Xander and Hope expressed commitment to drawing on theoretical insights and narratives that reflect critical understandings of race, class, gender, disability, and other markers of social location. The efforts of mad people to resist what Tam referred to as “mad nationalisms” and essentializing notions of mad identity, and to learn from differently situated mad people whose experiences expose the limitations of emerging etiologies of mad culture, demonstrate an important step towards developing ways of working in the mad constituency that address experiences of compound oppression.

Closing Remarks

As seen in this chapter, the mad constituency has in part evolved specifically to address divisions that have historically posed a problem within the psychiatric survivor constituency. The insights shared by participants who identify with the mad constituency, along with the work they are doing to address the multiplicity of mad experiences, demonstrate a commitment to a larger integrated anti-oppression project that brings to the centre the voices and perspectives of people who are generally pushed to the margins. It appears that the ways in which mad identity, culture, and history are currently constructed, however, do not always adequately reflect the multiple experiences of people constructed as mad within dominant culture and can at times have liberal tendencies that move mad initiatives away from critical anti-oppression understandings and ways of working. There are mad actors who are committed to moving beyond liberal notions of mad inclusion to a radical anti-
oppression approach and who are trying to address multiple experiences and
oppressive group dynamics that exist within and amongst mad people themselves.

This all points to promise in some of the constituency’s approaches, which are still
very young having only developed within the last ten years.

Having now met with the psychiatric survivor constituency and the mad
constituency, we now move to the last of the three, the antipsychiatry constituency.
Chapter 6: The Antipsychiatry Constituency

Part I: Introduction

The contemporary antipsychiatry constituency has emerged from a rich history of resistance efforts led by ex-patients, ex-inmates, psychiatric survivors, academics, and professionals. The primary goal of the constituency is to abolish institutional psychiatry or at least undermine the power and authority it is granted in large part by the state. In pursuance of this goal, the constituency often draws on the theoretical and empirical work of professionals and academics who are critical of psychiatry, as well as personal narratives of psychiatrized people who have had negative encounters with the system, in order to substantiate claims that undermine the fundamental tenets of biological psychiatry. Unlike the other groupings identified in this study, its key organizing principle is centred on political ideology rather than on notions of shared identity or experience. While the perspectives of psychiatric survivors are often considered front and centre, the constituency is open to all those who are interested in undermining psychiatric dominance and is comprised of a broad range of individuals including psychiatric survivors, mad people, radical professionals, academics, artists, and individuals who possess a combination of the above designations, including those who have not experienced the psychiatric system firsthand. This is a contentious organizing strategy which triggers many issues related to power relations between survivors and non-survivors, as well as psy-professionals and psychiatrized people, raising important questions about working across difference. Given that antipsychiatry is organized primarily around the goal of psychiatry abolition, those who identify as
antipsychiatry tend to be more uniform in their stance against biological psychiatry than those who take part in the psychiatric survivor and/or mad constituencies.

However, their ideas about how to best work towards this goal are variable and represent a wide spectrum of priorities, as diverse as those found in the larger community.

In this chapter, I set out to explore the priorities and concerns of those who associate with the antipsychiatry constituency, looking at how they conceptualize their work, what ideological and practical concerns define the approaches they take in community organizing, and what tensions arise from differences within the constituency. Part II of this chapter begins with a brief examination of the key themes that emerged in my ethnographic encounters. Part III then goes on to look at findings related to how ideological and social differences among those engaged in antipsychiatry work challenge current approaches in the constituency.

**Part II: Major Themes**

The majority of participants who identified as antipsychiatry also identified to varying degrees with the psychiatric survivor and/or mad constituencies. For this reason, it is not surprising that many of the themes that emerged in relation to the other two constituencies were also of concern to those who identify with antipsychiatry, reflecting the interconnected and close-knit nature of how the community functions. For example, antipsychiatry participants shared concerns about ending stigma and discrimination against psychiatrized people; resisting coercion and abuse; creating access to non-psychiatric healing alternatives; and developing decent housing and employment options. However, participants were clear that
antipsychiatry represents something unique in the community—an approach defined by a radical position against institutional and biological psychiatry, rather than organizing trends based on identity politics. As such, four themes emerged specifically in relation to antipsychiatry thought and practice: developing sustainable and long-term strategies for curtailing psychiatry; using science to debunk the merit of psychiatric theory and practice; utilizing academic resources to further the antipsychiatry cause; and building a more just world, free of psychiatry.

Curtailing Psychiatry

The primary characteristic that defined the antipsychiatry constituency was its unwavering position against psychiatry. All those who identified with this constituency understood antipsychiatry to be first and foremost about opposing psychiatric theory and practice, challenging psychiatric dominance, and ultimately, abolishing the institution. They unanimously rejected the fundamental tenets of biological psychiatry—that what is labelled as “mental illness” represents organic illness in the body that is best managed through physical interventions to “fix” that which is said to be out of balance. They viewed the institution as “irredeemable” and “unfixable” and were focused on radical transformative change. The following statements taken from interviews illustrate the sentiments shared by many antipsychiatry participants:

...The antipsychiatry movement should be moving towards getting rid of this existing system, which is institutional and abusive and aligned with the pharmaceutical industry... We’ve gotta stop creating these bizarre disorders...

What I would really like to see is the abolition of psychiatric institutions. (Innes)
Psychiatry is trying to get rid of diversity and difference... getting rid of anything that doesn’t fit under the hierarchical and capitalist system... we can’t just reform the system, we have to get rid of it. Getting rid of psychiatry and all of its abusive and coercive treatments is an important part of building a better, more just world. (Jackie)

The three f’s of psychiatry: Fear, fraud, and force. All participants who identified strongly with the antipsychiatry constituency opposed any type of involuntary intervention, whether that was in the form of incarceration, drugging, restraints, ECT, or community treatment orders. Many viewed coercion within the system to be “a violation of basic human rights.” Weitz and Innes went further to state that under the current psy-regime, consensual psychiatry does not exist, as even when people technically consent to psychiatric “treatments,” they do so without adequate information needed to make informed decisions. They felt that the power of biological psychiatry came from dishonest information propagated by corporate and state entities that hide and/or justify force used by psychiatry authorities. In an interview, Weitz succinctly captured the sentiments expressed by many antipsychiatry participants. He stated:

the system is built on three F’s : fear, force, and fraud... Psychiatry is inherently coercive. It works by force, which is ingrained, spelt out in every mental health act. That’s what involuntary committal means. Making you lose your freedom under the pretence of illness.

A few participants held a slightly different perspective. Xander, Bach, and Jackie strove to dispel myths propagated by psychiatry and its supporters, but recognized that some people might freely choose to use particular aspects of the current system to
cope, such as, for example, psychiatric drugs. Jackie explained in an interview that she wants to build a world where psychiatry does not dominate in the realm of “support services and helping professions,” but where people could still access particular tools if they wished, on their own terms, with full information about the associated risks, and where they would also have access non-psychiatric alternatives. She is working towards the end of the “psychiatric monopoly over healing,” by advocating for government de-funding of psychiatric services or, alternatively, the funding of non-psychiatric alternatives, as well as public education campaigns aimed at broadening discourses about “acceptable choices” for people who are in crisis or in need of support. She too rejects the fundamental tenets of biological psychiatry, does not accept the notion of mental illness, is deeply concerned about coercion, is aware of the many potential “harmful effects of various psychiatric treatments,” but could also “imagine a world where an individual might make an informed choice to take substances to cope,” while being aware of other options, without being coerced into doing so.

In the contemporary context, however, all antipsychiatry participants agreed that achieving informed consent is difficult, if not impossible, given the dominance of psychiatric discourse and psychiatry’s access to vulnerable people. As Gray explained in the focus group, the “stranglehold of information psychiatry has over the broader community” and “the medicalization of every aspect of our humanity” get in the way of realizing truly informed choice. Likewise, the lack of state support to access non-psychiatric alternatives was viewed as a major barrier for the vast majority of psychiatrized people who do not have resources to pay for services themselves. All viewed psychiatric coercion as a problem stemming from both actual force used to
administer psychiatric “treatment” against one’s will, as well as widespread psychiatric discourses which maintain that those labelled as “mentally ill” should consent to psychiatric intervention, because “it is their only good option.” As Truly explained in the Freirian codification group:

They [the professionals] are supposed to be there caring for these people, but they’re obviously just there to give drugs. There’s nothing there that is helping. If they’re defining them as ill, well, what’s missing is anything to help them get well. I mean, beyond drugs, which then goes back to this whole capitalist notion of power.

Weakening the psychiatric monopoly in the realm of “support and healing,” taking financial power away from the psy-regime and distributing it elsewhere, combating “myths about the need for psychiatric intervention in ‘extreme cases’,” and educating the public about the routine violence that occurs at the hands of psychiatry were universal goals within the antipsychiatry constituency.

**Psychiatry abolition: A long-term and complex endeavour.** All participants who identified as antipsychiatry believed that the world would be a better place if institutional psychiatry was abolished or rendered powerless. They also unanimously viewed the process of working towards this goal as complex and long-term. The institution was understood to penetrate so many different facets of society that shape dominant ways of thinking, and its support from pharmaceutical companies, other corporate entities, and state institutions so strong, that countering it was a daunting endeavour. Antipsychiatry activists voiced their “frustration,” “anger,” and their occasional feelings of “hopelessness” experienced in face of this seemingly “insurmountable mountain.” As Innes described,
It’s such a tough battle. It’s such a tough battle that you almost get discouraged because you think, “How can we win?... How do we make a mark on this as a movement when you’re up against such a big machine?”

Nevertheless, many were able to put their long-term visions into perspective to think strategically about how to accomplish their goal. As Jackie put it,

getting rid of psychiatry is not going to happen overnight... [we] need to strategize about how we go about making small incremental steps towards this goal... [and] do anything that involves weakening the power of psychiatry.

The majority were in touch with the long-term nature of their work and were ready to hold onto the small victories to help raise spirits in the long fight ahead. As Madman explained in the focus group,

In talking about acts of resistance and how this moves us closer to our goals, I think that every time this marginalized movement gets noticed, it’s a victory. It’s a kind of victory. An every time it gets documented, it’s a historical feat. We got to take those and keep working on them... We’re fighting against global forces, a western way of thinking that’s contrary to human logic and the basis of who we are as people... Every time we fight and get it out there, it moves us closer to our goals. At least in that, it keeps the hope alive.

**The attrition model.** One approach espoused by some antipsychiatry participants was the attrition model, originating from the prison abolition movement and first articulated by Burstow (2010) in the realm of antipsychiatry. It was also the
approach officially adopted in 2010 by the Coalition Against Psychiatric Assault\(^ {15} \). According to this model, antipsychiatry activists should focus their energies on initiatives that in some way weaken or undermine some aspect of psychiatry, to “gradually wear away at the system.” This could mean challenging particular types of psychiatric interventions, such as drugs or ECT; forms of psychiatric monitoring in the community, such as CTOs; faulty conclusions drawn from research claiming to “prove mental illness;” the psychiatric profiling of marginalized groups; or institutionalization itself. Some antipsychiatry activists believed that these goals could be accomplished by using a variety of tactics, such as developing and publicizing critiques; organizing public hearings or demonstrations; lobbying government; or producing public education campaigns. This model also discourages antipsychiatry activists from pursuing actions aimed at institutional reform that might in some way validate psychiatry by making it appear more humane or a friendly place for the community. Initiatives to avoid, according to this model, might include the development of “culturally-sensitive” services within psychiatric institutions aimed at particular marginalized groups or using space in psychiatric hospitals to hold mad pride events or peer support groups for psychiatricized people (Burstow, 2010).

A place for reform? Innes and Weitz were concerned about aspects of psychiatric survivor and mad organizing that deviated in a direction with which they did not agree, and in particular, were deeply critical of initiatives that “cooperated

\(^ {15} \) The Coalition Against Psychiatric Assault (from here on referred to as CAPA) is an antipsychiatry organization in Toronto that has played a major role in the constituency since 2003. At the time of my data collection, it was the only organization in Toronto that outwardly identified itself as antipsychiatry, and as such, it came to represent much of what was happening within the constituency at the time. The vast majority of participants in the present study who identified as antipsychiatry were connected to CAPA, although there were some who were not.
with the system in ways that make it seem better.” For example, in an interview, Innes stated:

We don’t need to identify any of them, but there are a lot of people who are well-intended and do their very best to improve the situation of psychiatric survivors. But getting back to that versus antipsychiatry or the abolition of psychiatric institutions... they’re including themselves in the psychiatric system, [and that] doesn’t make the system better. It just makes their lot better, right? I see a lot of that, but I don’t think it’s doing any good... I think whenever... lives are improved, it’s a good thing, but we can’t keep applying band-aids to things. We can’t do that all the time. Eventually, stuff just crumbles. We know this.

This antipsychiatry approach sometimes put activists at odds with others in the community who work with psychiatric agencies or use psychiatric language in order to meet their social change goals. Xander, Starkman, and Rachel took a somewhat different stance than uncompromising abolition. While they agreed that the world would be a better place without psychiatry, they did not prioritize the long-term goal of psychiatry abolition over the immediate needs of psychiatristized people. To them, it was sometimes worth it to work with psychiatric agencies and government initiatives and compromise on the language and ideological frameworks they use in order to secure services for psychiatristized people, such as housing or employment programs. They were more responsive to what they saw was needed in the present, willing to engage in reform work, even though in their hearts, they too wanted to get rid of the institution in its entirety. They considered reform work to be necessary in the short-
run in order to alleviate abuse and violence towards those currently caught in the system even though they too strived for the long-term goal of psychiatry abolition.

**The range of antipsychiatry goals.** Antipsychiatry participants were involved in a diverse range of initiatives – almost as diverse as the wider community – but did not necessarily consider all of these activities to fall under the jurisdiction of antipsychiatry. Most agreed that for an initiative to be considered antipsychiatry, it must in some way challenge, undermine, or discredit psychiatric dominance. Activists named many pressing goals that met this widely defined criteria, such as challenging psychiatric labelling, systemic discrimination, involuntary commitment, restraints, community treatment orders, forced drugging, and ECT; educating the public about psychiatric abuse and violence in its many forms; and bringing in community advocates to help those who are currently trapped within the system to get out or to end involuntary intervention.

**Curtailing electroconvulsive therapy.** Antipsychiatry participants named many goals that were important to them, but during the time of my data collection, the majority was most fixated on eradicating the use of ECT. The reason for this was clear. Years ago, the membership of CAPA decided it needed to develop focussed goals and strategies that would lead to incremental change in the direction of psychiatry abolition. They wanted to pursue goals in line with their antipsychiatry objectives but also valued input from the larger community and psychiatric survivors. As such, they decided to hold a community consultation meeting at Toronto City Hall in 2004 where community members gathered to hear about four possible directions the CAPA membership was considering and to vote on which direction they would like to see the organization pursue. The four possible directions included: combating the use of ECT,
combating the use of restraints and seclusion, combating the use of psychiatric drugs, and regardless of CAPA’s focus, using legislative theatre as a transformative education and organizing strategy. After the presentations and subsequent discussion, those in attendance voted to focus antipsychiatry resources on combating the use of psychiatric drugs and ECT. Since this time, CAPA has organized public hearings where psychiatric survivors gave testimony about their experiences with psychiatric drugs and electroshock, developed a campaign aimed at various levels of government in Canada against psychiatric drugs based on report recommendations developed from the public hearings, and most recently, since 2007, launched a global feminist campaign against ECT named Stop Shocking Our Mothers and Grandmothers!

For the most part, antipsychiatry participants were very enthusiastic about the current campaign against ECT. They saw this as an issue with longstanding importance in the community and considered the timing appropriate, with current statistics demonstrating that the procedure is on the rise. Weitz, Innes, and Jackie cited the disproportionate targeting of women and the elderly with the procedure and expressed the importance of raising awareness about how marginalized groups of people are targeted differently by psychiatry. In the focus group at Psychiatric Survivor Pride, long-time anti-ECT activist and insulin-shock survivor Weitz exclaimed:

Two to three times more women get shocked! It’s not an accident, and the statistics, whether they be in Ontario or in California, it’s the same thing... So we brought that issue, that women are particularly targeted, particularly elderly women. I consider it absolutely disgusting. I have to control my rage as I’m talking to you know. It's absolutely disgusting. It's a form of state-sanctioned
elder abuse. We’re going after some of the most vulnerable people in our society... zapping their brains.

The general feeling among Weitz, Innes, and Truly was that ECT represented such an obvious form of psychiatric violence that organizing against it presented many possibilities. As Truly said to me in a conversation, “it literally has shock value—people can’t believe this is still happening.” Truly hoped that with hard work they could engage sympathetic politicians and build coalitions with other marginalized groups, particularly those who are targeted by the procedure. As Innes explained in an interview,

It makes it worthwhile, because it has appeal on many levels, the fact that psychiatry is shocking elderly people, primarily women; that there is material that supports the fact that electroshock is not a beneficial medical practice; that it is harmful; that it’s akin to torture...It’s a method that governments use or regimes use to extract information from people, never to benefit them, only to harm them. So, in that way, the practice is so barbaric that it is more likely to offend people.

Innes and Weitz also viewed ECT as an issue that would help raise public awareness about the fraudulent nature of psychiatry more generally, and win over media with the devastating personal narratives of those who have experienced the procedure. As Weitz explained in the focus group:

The sub-goal would be educational, consciousness-raising for the media and the public to make them aware. A lot of people, as you know, still right now are surprised to hear about electroshock or drugging against one’s will, but especially electroshock--that it’s still going on.
In the same group, Truly described a conversation she had with some journalists that left her feeling deflated. She stated:

Not one of them [the journalists] believed electroshock still happens. They did not know that. And then they said that they would come if something bad happened, like perhaps if somebody had died. Something so drastic that if someone died from electroshock, then they might collectively do something about it. But it had to be something so severe.

Despite challenges with the media, Weitz, Innes, Truly, and Starkman saw ECT as an entry point that could potentially help people understand the many different dimensions of psychiatric violence, such as lack of informed consent, forced intervention, “fraudulent claims made by psychiatric authorities,” and lack of alternatives for people in need of support. While banning the use of ECT in Ontario and other jurisdictions was the primary goal of anti-ECT activism, participants also strived to bring power to dissenting voices and hoped that ultimately their cumulative actions would lead to the demise of the institution.

**The “Proof” Behind Antipsychiatry**

Antipsychiatry activists had mixed reactions about the role of science in their work. On the one hand, Weitz and Innes believed that science should play an integral role in their efforts and put a major emphasis on current research studies that demonstrate the harmful effects of various psychiatric interventions. On the other, they were disillusioned about how science has been used in support of psychiatric theory and practice over the past century. They were quick to point out “false assumptions” made and problematic theories developed to support theories of mental
illness and were eager to expose the “weak methodologies” of studies that claim successful outcomes of psychiatric drugs and electroshock. They argued that scientific method and language are abused by pro-psychiatry researchers and professionals in order to, in the words of Weitz, “deceive the public into believing their lies about mental illness... and the medical model.”

Similar to what was found in the mad constituency, Weitz and Innes were deeply concerned about how science has been and is currently used to justify “torturous practices concealed as ‘treatments.’” They were outraged about the “biased research controlled by pharmaceutical companies” and “other interests vested in maintaining the status quo,” the proliferation of “new disorders invented with every new issue of the DSM,” “faulty conclusions drawn from studies about psychiatric drugs and electroshock,” and “attempts at squelching human difference and diversity.” Like mad participants, Weitz pointed to similarities between psychiatry and the eugenics movement. Overall, antipsychiatry participants demonstrated a strong awareness about the historical and current dangers posed by psychiatric discourses about “mental illness” and physical interventions and were skeptical about the vast majority of research emerging from the psychiatric realm.

Nevertheless, despite these grave concerns, most antipsychiatry activists believed that the antipsychiatry constituency could not afford to leave science out of their initiatives. In an interview, Jackie stated that they had to “fight the bad pseudoscience of psychiatry with better up-to-date research to disprove their faulty claims.” Many relied heavily on the works of critical psychiatrists and other professionals, such as Dr. Peter Breggin and Dr. Thomas Szasz, to add weight to their critiques of psychiatric theory and practice. However, Weitz was concerned that this
was not enough and believed that the constituency needed a greater number of researchers on side to produce up-to-date research that would refute new pro-psychiatry conclusions. Bach was concerned about the frequent dismissal of Szasz’s work as being “out-of-date,” sensing that the constituency’s dependence on older research such as that of Szasz’s was to their detriment. He stated:

The science needs to be done. Science that is disputing mental illness by studying mental illness, that has to happen in a scientific way. So that would be one place to do it, research about that, and really having something that will destabilize the claim, that will really destabilize these concepts, and then those can then be used. So make science central.

This approach inspired some activists to enter the academy so that they could contribute to the type of research they felt was necessary. For example, Fabris described how earlier in his life, when he was more enmeshed in antipsychiatry and psychiatric survivor discourses, he thought about science and social change. He stated:

My whole worldview took a turn towards a more materialist understanding of the world. Still very empirical and increasingly as I got involved in the movement more and more... Being [involved]... essentially galvanized me as a person who is concerned about others, and it did so by giving me tools that are used in trying to change the minds of people in government and industry. And those tools are often empirical... what would make sense to the people who had any power whatsoever. Trying to change their minds would take something like a dramatic example or a study that you couldn’t refute. Let’s say that you could create a study in which we showed... how many more crazed “psychotic” people were violent while they were on drugs, including while they were withdrawing versus
when they had never been put on drugs. Some such thing where you could really seriously compare. Something where legislators would have to say, “yes, we don’t want to increase the amount of psychiatric drugs we use in the population, we want to decrease them.”

As Fabris described, others viewed empirical research as key in legitimizing antipsychiatry claims within the mainstream, and the idea of more community members engaging in such research strategies was exciting to them.

The role of science in the antipsychiatry constituency was not left completely unchallenged, however, particularly as participants engaged in dialogue about different perspectives in the community. For example, in the focus group held at Psychiatric Survivor Pride, an interesting dialogue took place between psychiatric survivor and long-time antipsychiatry activist, Weitz, and Xander who identified with all three constituencies. The conversation began with Weitz discussing the ongoing conundrum of psychiatric organizations ignoring evidence demonstrating the harm caused by ECT. The dialogue proceeded as follows:

Weitz: What is not a success is the ignoring of our efforts, of the serious effects of electroshock by the medical profession, including the Canadian Psychiatric Association and the American. They continue to minimize. They say that “no, there’s not much brain damage. Oh, your memory will come back in two to three months.” Those are lies, and no, we have scientific reports coming out. I consider that a success, finally believing us in printed journals. Yes, the damage is real, and it’s permanent. And yes, women are more damaged than men. So we’ve broken in, because of our grassroots protest, we’ve broken through the silence and
denial of organized medicine, because the reports in journals are finally supporting our position.

Xander: Don, can I ask a question around your thinking around scientific proof?

Weitz: Yes.

Xander: Just because it seems that as a group of people, we’re caught in a kind of conundrum, because in order to seek scientific validity and proof of the trauma that a lot of these drugs and electroshock do to us, we’re relying on science in order to back us up.

Weitz: ... As far as I’m concerned, ECT is suicide.

Xander: Maybe, not you, particularly. But we might not want to rely on science, because we all know as people, as beings, that the drugs, we know what they do to us. But I think there’s a real obstacle, for the community to be looking for those journals to be publishing proof and that kind of thing... I think it’s hard to look outside of medicine to validate our experiences. It’s so hard right? Because we, as a world, recognize science as truth, as valid.

Roslyn: Is it? Is science the truth?

Xander: No.

Weitz: I just mention it, because they’re finally recognizing, through their scientific methodology, the brain damage and permanent memory loss. It’s not a delusion. It’s a fact. That’s all I’m saying.

Xander asked important questions about the antipsychiatry focus and reliance on scientific discourse. She worried about how this might constrain the development of new ways of thinking and approaching community problems, because of the energy and resources it takes to work within the limits set by scientific discourse. However,
perspectives like Xander’s were the minority. Weitz, Bach, Laurence, and Innes were more concerned about “proving our points to government and the general public” and using science as a tool to do so. Rather than questioning if they should be relying on scientific method, most were grappling with how to use science effectively in support of their goals. While they were deeply critical of how science is used in support of psychiatry, leaving all types of faulty assumptions unquestioned, they strongly believed that this was discourse they had to engage with in order to convince those in power of what needed to be done. To them, this was one of the key ways of combating psychiatric theory and practice. They wanted to be well-equipped when they came head-to-head with proponents of ECT and other psychiatric interventions, drawing on research that would be viewed as cutting-edge, so that they could stand equal ground when defending their claims in the public arena.

**Antipsychiatry in the Academy**

Antipsychiatry has always had significant ties to the academy. As seen in chapter 2, it is a concept that was first articulated by professionals and academics, and the term itself was reinvented by psychiatrist David Cooper in 1967 to refer to the work of psychiatrists who at the time were challenging mainstream institutional psychiatry and developing non-psychiatric alternatives. Today, among scholars, antipsychiatry is still commonly associated with key theorists and professionals, such as Thomas Szasz (1960; 1974; 1987; 1989; 2002), who demonstrated how the foundational concepts of psychiatry are inherently flawed; R.D. Laing (1960; 1971) who located experiences of madness in social and economic systems; Michel Foucault (1961; 1980), who described in historical terms how psychiatry functions as yet
another institution that shapes individuals to fit the dominant social order; and Erving Goffman (1961; 1963), who exposed psychiatry as a form of social control. Despite the fact that these scholars either did not adopt the term or outright rejected the term as a descriptor of their work, they are often recognized as the key founders of antipsychiatry, at least in the academic realm.

Interestingly, not all participants in the present study who identified as antipsychiatry referred back to or knew about the work of these scholars. For example, Rachel told me in a conversation that she was drawn to the constituency because of her negative experiences with psychiatry, without having read the literature commonly associated with the movement. This is not to say that these theorists were without influence, as I noted in my research journal, some people I met joined the constituency precisely because they were inspired after reading their works. What I found was that the importance of these radical professionals and academics varied greatly among constituency members.

Despite the different perspectives participants held in relation to these particular scholars and professionals, it was abundantly clear that antipsychiatry in Toronto is still tied to the academy in many significant ways. For example, as I noted in my research journal, many antipsychiatry meetings and events take place on university grounds, and while there are people from many different educational backgrounds involved in antipsychiatry organizing, there is a fairly high number of people involved who are in some way connected to a university. As I observed the dynamics in this constituency, I realized that part of the reason for this is that Burstow who is a key organizer in antipsychiatry teaches a course about creative empowerment work with disenfranchised populations, in which students have the
option to volunteer with CAPA as part of the one of their assignments. This attracts many students who might not ordinarily be involved with the constituency, but who contribute energy and resources to initiatives. This has allowed major events to happen, which might not have come to fruition without the work put in by students. For example, the academic contingent in CAPA was the force behind the 2010 PsychOUT conference, a global event about organizing resistance against psychiatry. The organizers used university resources to build an event for academics and community members alike to discuss strategic and tactical issues in resistance work across different geographical locations.

Secondly, antipsychiatry activists, particularly CAPA organizers, often draw heavily on theory and research produced in the academic realm. For example, in its recent campaign against ECT, CAPA members compiled an educational resource booklet that included a recent article printed in a scientific journal about the lasting effects of ECT, an article by Dr. Peter Breggin looking critically at this piece of research, and an article printed in an academic journal by Dr. Bonnie Burstow articulating why ECT should be considered a form of state-sanctioned violence against women. In formulating their arguments, many antipsychiatry participants tended to rely on an “evidence-based approach” drawing on multiple sources including personal narratives of those who are subjected to psychiatric interventions, as well as research and theory from the academic realm.

Adam, Weitz, Jackie, Innes, and Xander were very pleased that antipsychiatry organizing was happening within the university context. They felt it raised the profile of radical dissenting perspectives, giving some credibility to grassroots work, sometimes even helping to garner the attention of the media. They also saw the
connection to academia as helpful in terms of securing support, both in terms of “people power” and material resources. For example, Jackie commented about the PsychOUT Conference,

The organizing committee’s attachment to the university brought resources from university organizations and departments. That support never would have been there for a grassroots antipsychiatry project, and the grassroots usually doesn’t have access to those kinds of resources... It also brought more attention... and maybe in some people’s eyes more legitimacy... A conference against psychiatry was held at the University of Toronto... that is fucking amazing!

While many looked positively upon the academic bent of antipsychiatry, Laurence, Erlich, and Blaser felt that the constituency’s connection to the academy limits who is comfortable participating. These concerns will be further explored in part III of this chapter in a more in-depth examination of tensions and power among differently situated antipsychiatry activists.

**Imagining a World Without Psychiatry**

The vision of antipsychiatry as explained by Florence, Weitz, and Innes expanded far beyond psychiatry abolition to transforming the current social order and economic regimes that cause “problems in living.” They recognized that getting rid of the psychiatric system would not address “many of the ills of society that cause human suffering,” and that they had to dig deeper to understand other changes needed to build a more just and caring world.

Jackie said to me in conversation that she understands psychiatry “as a symptom of a sick culture” that uses tools and institutions to protect the dominant social order.
Similarly, Hope told me in conversation that psychiatry steps in to keep those who challenge the status quo in their place either with direct punishment disguised as treatment or with the looming threat of psychiatric intervention. Jackie described psychotized people as “political prisoners” who are locked up for their responses to various forms of violence and oppression, acting as examples for others who dare to react to the oppressive conditions in their lives in ways that disrupt power relations. She viewed psychiatry as “an institution of social control” designed to keep people in their place and punish those who deviate from their ideological roles as defined by the hegemonic order. She explained in an interview:

Psychiatry plays an important part in keeping everything just the way it is. If you behave in a way that challenges the status quo, you are targeted. They can keep you quiet, and even if you aren’t quiet, they can make it so that everybody around you dismisses you because of unsound mind... That’s why oppressed people like women are key targets of the system. They have a reason to rebel, and psychiatry is one way of dealing with that rebellion.

In various different research activities, Florence, Jackie, and Weitz argued that getting rid of psychiatry would not be sufficient in a world where so many hierarchies and power imbalances exist. As Jackie stated, “even if we got rid of psychiatry...the world would still be a mess without it.” In line with this understanding, the majority agreed that it was important to make connections with various groups of marginalized people and other political communities that are trying to build a more egalitarian world. Many pointed out that such groups and communities share mutual interests and that the issues they are addressing are in fact inseparable from one another. For
example, in the focus group, Weitz described how antipsychiatry and anti-poverty struggles are completely intertwined. He explained:

Poverty, it is part of the capitalist system, unfortunately... But we have to get rid of the psychiatric system that systematically oppresses people and deprives people of working. As long as we have psychiatry, they support the status quo...

You know, there are studies, and people know this. Once you’ve been in the system, you become poor. You either lose your job or you can’t get a job. So psychiatry is a support [that] actually encourages people to become poor. You can’t talk about one without the other.

In the Freirian codification group, in a discussion about the codification that includes the woman who has been given a community treatment order (see Appendix B), Truly described how the psychiatric system targets women. She stated:

I think it’s such a patriarchal and paternalistic reflection of what happens... The woman is the one that is becomingpsychiatrized, and her husband has bought into the system, saying you are disempowered. I am the one who has control.

Jackie further explained in an interview why feminist anti-violence initiatives and antipsychiatry initiatives have to be considered together. She stated:

Psychiatry is where women end up after they’ve experienced other forms of violence... abuse in the family, child abuse, spousal abuse, rape, other assaults... and when they react... when they are not functioning in a way that makes others around them uncomfortable, they are sent to the doctor... they are drugged, shocked into submission, until they learn to act in a way more comfortable to others... the feminist movement and antipsychiatry movement need to make
stronger connections with each other, because they are fighting the same fight, just with a different focus.

Jackie, Weitz, and Gray spoke about their active involvement in other political communities and how they tried to bring awareness from one community to the other, making critical connections among them.

The majority of antipsychiatry activists were very radical in their transformative vision, imagining building a world where caring, nurturing, and support are prioritized and embedded in the very thread of community life. As Innes described in an interview,

I would like to see people just accept one another and live in harmony and peace, mutual support, tolerance, understanding, all of those things. And psychiatry doesn’t promote that at all.

This radical vision was also captured in CAPA’s antipsychiatry mandate, which states, CAPA is a coalition of people committed to dismantling the psychiatric system and building a better world... We see problems in living which are currently pathologized as largely created by sexism, capitalism, racism, ableism, heterosexism and other systemic oppressions... We see a connection between globalization, intolerance, and the mass marketing of the mental health industry. The world which we strive to co-create is one where people are not pathologized, where care is neither commodified nor professionalized, where choice and integrity are respected, and where we are all joined in caring and creative community to each other and to the planet earth. (cited from http://coalitionagainstpsychiatricassault.wordpress.com/)
All antipsychiatry participants viewed antipsychiatry as one branch of a much larger transformative project that necessarily involves many different efforts stemming from various political communities and recognized that work needs to be done to help establish stronger understandings and connections among these various efforts.

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Antipsychiatry activists addressed many themes that demonstrate their commitment to creating stronger alliances with marginalized groups of people and with other political communities that consider how various systems of oppression are infused with one another. The following section will explore in more detail some of the tensions and complexities emerging, as antipsychiatry activists attempt to build these alliances, and will also point to successes and ongoing challenges faced in forging solidarity.

**Part III: Working Across Difference**

It was interesting to explore with participants how antipsychiatry’s ideology-based approach shifted understandings *vis-à-vis* their efforts to work across difference and build stronger solidarity networks. In the context of a larger community, where identity politics play a central role, this shift in approach changed how people conceptualized problems stemming from power dynamics. Specifically, several community members were particularly concerned about antipsychiatry’s accountability to psychiatrized people. An exploration of this concern helped them develop critical insights into false dichotomies widely accepted within the community, the reproduction of hegemonic assumptions left unchallenged in antipsychiatry discourse, and the various legitimate priorities and goals emerging from the
experiences of differently situated people. Antipsychiatry activists grappled with these insights and their implications for healing wounds among the various constituencies within the community and building stronger alliances with other political communities.

The Shift to an Ideology-Based Approach

One of the key features that differentiated antipsychiatry from the other two constituencies was its move away from identity politics towards ideology-based organizing. The majority of antipsychiatry activists believed that the constituency should be a place open to virtually any person interested in organizing against psychiatry as long as they did not disregard other equality-seeking values. On a practical level, Florence, Weitz, and Truly felt that it was important to actively build coalitions and open up the constituency to as many people as possible to strengthen resistance against pro-psychiatry organizations and state-sanctioned psychiatric programs. As Jackie explained,

We can’t afford to tell people they have no business in antipsychiatry. We should be more focussed on outreach. Instead of telling people they can’t be antipsychiatry, we should be talking to them about why they should be invested in our causes.

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16 Some participants clarified that they did not wish to work with the Church of Scientology or the Citizens’ Commission on Human Rights (CCHR), despite the religious organization’s abolitionist stance on psychiatry. They were worried about the church’s agenda and past actions of some of its members and expressed concern about their alleged use of interrogation tactics, blackmail, mistreatment of psychiatrized people, and claims of having alternatives that will save people from suffering in order to draw vulnerable people into the religion.
Truly expressed in the focus group that it would be beneficial to reach out to more friends and family. She stated:

I think it’s important to get friends and family involved... They seem to discriminate or have prejudice simply as a result of lack of education. So I think what’s missing is those people closest to us. And if we start there, then we can really move into greater community organizing.

As I noted in my research journal, in recent years, non-survivors have played key organizing roles in the majority of antipsychiatry initiatives in Toronto. The public consultation meeting determining CAPA’s focus, the public hearings about psychiatric drugs and electroshock, the campaign against psychiatric drugs, and the current feminist campaign against ECT were all organized and executed by groups which included psychiatric survivors, mad people, non-survivor activists, professionals, academics, artists, and others. While some of these events, such as the public hearings about psychiatric drugs and electroshock, privileged the standpoint of psychiatrized people, all those involved in organizing, regardless of their personal experiences with psychiatry, were given a say in the direction of these initiatives.

One major ideological reason behind allowing organizing power to people regardless of their firsthand experience of the psychiatric system is the belief that every person is affected by “living in a society that embraces psychiatry” and therefore has a stake in organizing against psychiatry (Tsao, citing one of her research informants). Florence pointed out that while people are affected in different ways by psychiatric discourses and institutions, every person can trace a map of “how they too have been personally affected,” thereby justifying their active participation in community work. Interestingly, this was the same rationale that led a few psychiatric
survivors and mad people to embrace as community members particular individuals who have not been psychiatricized and do not identify as mad. For example, in an email exchange I had with a psychiatric survivor/mad person, Charlie, about my position within the community, he rationalized my right to participate in the following way:

I consider you to be a survivor of psychiatry, because of the experiences your family members had and your connection to them. Even though you haven’t been put through the system yourself, you understand and come from the same perspective because of those experiences you have too.

The majority of antipsychiatry participants did not use an identity politics framework to understand or justify individual participation in community initiatives. Rather, they approached issues of inclusion using an analysis that ultimately legitimized every individual’s participation. Florence, and Truly pointed to the proliferation of pro-psychiatry messages in government, media, education, social services, and nearly every other domain and purported that “every person is at risk of swallowing psychiatric lies, being turned in by somebody else, or even turning themselves in thinking it is what they need when they are in emotional distress.” “Everyone is at risk” was a key message in the antipsychiatry constituency and was the belief that justified the potential inclusion of everyone.

**Accountability to psychiatricized people.** This broadly defined ideology-based organizing approach in antipsychiatry was met with reservation among some people who had firsthand experience with the psychiatric system. I recorded in my research journal observations of several instances when I believed psychiatric survivors or mad people felt threatened by the inclusion of non-survivors, particularly those who were academics and professionals. For example, in a conversation, Ricky spoke about the
hard work involved in building “safer spaces with others who share the survivor
experience” and how he worried that dominant power dynamics would be reproduced
with the inclusion of those who do not share the same experiences of oppression. A
few survivor and mad participants felt that some antipsychiatry initiatives do not have
“survivor-friendly” process because of the involvement of academics and professionals
who they perceived to dominate. Bach and Starkman questioned if antipsychiatry
initiatives always reflect the needs and desires of psychiatristized people. Starkman
stated in an interview, “I think CAPA is making a mistake... We should be much more
reactive to individual circumstances and not be tied up in, ok, shock and drugs, shock
and drugs, shock and drugs.” Starkman and Bach maintained that all community
initiatives, including those that are antipsychiatry, should privilege a psychiatric
survivor perspective and take direction from those most personally affected by the
institution. They felt that the direction of antipsychiatry should be determined
primarily by psychiatric survivors and mad people and did not want to see the
constituency taken over by non-survivors, academics, and professionals. The
perception was that without at least taking guidance from psychiatristized people that
the antipsychiatry constituency would become progressively less relevant to those
who are currently caught in the system.

Rudy and Bach questioned if the constituency is currently already too far
removed and perhaps was always too far removed from the lived experiences of
psychiatrized people, given the constituency’s roots embedded in the academic and
professional realm. In a conversation, Rudy expressed that he feels the antipsychiatry
stance ignores positive experiences of support in favour of a total rejection of the
system. He argued that antipsychiatry activists are striving for an unrealistic goal,
which if achieved would leave many people in desperate need of help without state-sponsored supports they are currently able to secure. Both Bach and Rudy were concerned about losing support from social assistance programs for people with disabilities, employment programs available for those who are labelled as mentally ill, and disability accommodations in education and employment settings. All of these programs require psychiatrized people to have psychiatric diagnoses as proof that they are disabled and in need of assistance, and Rudy felt that antipsychiatry activists who are not dependent on these programs do not take seriously the implications of getting rid of the psychiatric system when it is so deeply intertwined with other state institutions.

In their respective interviews, Florence and Weitz noted that they were aware of these critiques and were concerned about the perception of their position within the community. Weitz attempted to dispel misrepresentations about what antipsychiatry stands for by participating in educationals or producing written material. It was clear that Florence, Weitz, and other activists care a great deal about the well-being of psychiatrized people and want to be accountable to the psychiatric survivor constituency. They acknowledged the immense power of psychiatry, the dependence of state programs on the psychiatric paradigm, and the lack of viable alternatives for people without financial resources, but conceptualized this as part of the larger problem of psychiatric hegemony that needs to be remedied.

**The importance of an abolitionist movement.** While people raised concerns about antipsychiatry’s accountability to psychiatrized people, or responsiveness to other oppressed communities, it was clear that all those who identified strongly with the constituency believed that antipsychiatry should maintain its abolitionist focus. I
recorded in my research journal that survivors at a PsychOUT meeting felt it was important to have spaces specifically for psychiatric survivors and mad people to come together, away from those who have not been psychiatricized, given that this was something viewed as useful and necessary by many community members. However, they did not agree that every community space had to offer these same characteristics or meet everybody’s needs and felt that it was necessary to have some community spaces defined by shared political ideology and a radical transformative vision. In my research journal, I also took notes based on a conversation with Burstow who values spaces carved out specifically for strategizing and organizing actions challenging psychiatry; she is not interested in participating in more process-oriented spaces. While a few people perceived the move away from an identity-based approach as a threat to psychiatricized people, in a conversation, Jackie described the ideology-based approach as ripe for possibilities of bringing more people into the community from diverse social locations with the ultimate result of building a stronger political movement against psychiatric dominance. She wondered if a different approach could lead to a broader and more inclusive analysis that goes beyond the experiences and identities of individual members.

**Challenging false dichotomies.** In my research journal, I kept notes about encounters with community members who were specifically uncomfortable with the constituency’s inclusion of professionals and academics. For example, several psychiatric survivors and mad people at the PsychOUT Conference expressed that they did not want community work to be hijacked by individuals who did not have the same vested interest in challenging psychiatric dominance; they worried about professionals exploiting the experiences of survivors and mad people in order to
advance their own political and professional agendas; and they wanted to level the
ground as much as possible within community organizing spaces. Above all else, they
did not want hierarchical relationships between professionals and psychiatrized
people (like those to which they had been forcibly subjected) to be reproduced in the
community.

Taking into consideration the material and historical oppression faced by
psychiatrized and mad people, these are all understandable and legitimate concerns.
However, what I observed and recorded in my research journal during my time in the
community was that factors underlying power dynamics and divisions were not
always as straightforward as presented by some psychiatric survivors and mad people,
and often were about more than the survivor/non-survivor or
professional/psychiatrized divides. In fact, these issues appeared to be more
complicated on a number of fronts. For one, the survivor/mad vs.
professional/academic dichotomy conceptualized by some did not accurately reflect
the actual lived experiences of many community members, because a large number of
professionals and academics involved in community work had been psychiatrized
themselves. For example, two people who choose to remain anonymous told me that
they have not gone public about their experiences, because the stakes are too high in
the professional world. They fear being delegitimized or dismissed by their colleagues.
As one of them explained to me in a conversation, “once you come out in your
professional life, there is no going back. That label will follow you around forever.”
Both explained that they were driven to become professionals in order to do work that
would help the community. While academics such as Reaume, Reville, and Xander
made a conscious decision to go public about their experiences in order to shatter
stereotypes about psychiatrized people, and these two anonymous professionals made a conscious decision to keep their experiences private within the system in order to maintain respect from their colleagues so that they could use their positions to affect change from the inside, both choices were made to advance the work of the community. There were many complicated dynamics involved in the strategic and personal decisions taken by psychiatrized and mad people who were also professionals or academics, and they often were forced to make compromises that they were not fully at peace with. However, as I observed in my research journal, this was not radically different from some of the dynamics described within the psychiatric survivor and mad constituencies regarding the professionalization of peer support and the establishment of consumer/survivor positions within psychiatric programs. As described in chapter 4, there are many conflicts of interest now arising for psychiatric survivors and mad people working in peer support roles; they too benefit from perks that accompany their work and face constraints in what they can do publicly because of their jobs. There are now numerous psychiatrized people in positions of power over other psychiatrized people in their professional roles. This no doubt complicates power dynamics within the community, but the dichotomy which constructs the psychiatrized and the professionals as two discrete oppositional groups no longer rings completely true in the contemporary community.

Although this dichotomy needs to be problematized, there are significant privileges that come with being a professional or academic that the majority of psychiatrized people do not enjoy. Laurence noted how these differences can lead to tensions within groups, particularly when these power dynamics go unacknowledged. In an interview, Laurence explained:
When you have academics and survivors working together, the academics get something different out of it than the survivors, those who are not academics... They have different knowledge of the system, although non-academics survivors can have this as well, a sophisticated analysis or at least the language to communicate within a certain sphere. They will have money. To a certain degree, they have that privilege. And the actions themselves give them access to grants, beefs up their CV, can lead them to different positions... It sets up an unequal terrain.

The concerns voiced by Laurence point to the importance of paying attention to differences in resources among constituency members when planning and executing actions, for example, by acknowledging that academics might be able to put more time into organizing (and include this as part of their job) than other community members.

**Responding to Difference and Building Solidarity Networks**

There were varying degrees of awareness among participants about experiences of marginality within antipsychiatry organizing. However, this constituency is rooted in a radical transformative vision extending beyond psychiatry abolition and wishes to win over as many people as possible in order to build coalitions. Regardless of some differences in awareness, when experiences of marginality were brought to their attention, all activists expressed interest in figuring out ways to strengthen strained relations among the various constituencies and political communities.
**Responding to difference within the community.** There were some ideological or political differences among constituency members that I observed that did not pose serious problems, as solutions were found fairly easily that worked for all of those involved. For example, at a meeting for organizing an anti-ECT demonstration, there was a male activist who wanted to use the character Nurse Ratchet from One Flew Over the Cuckoo’s Nest in a statement against ECT. Many feminists in the group felt that the portrayal of Nurse Ratchet drew on too many sexist stereotypes of women, and so the symbol was not used. At another time, one of the anti-ECT protest organizers wanted to fry eggs on site, displaying the slogan, “fry eggs, not brains.” I objected to this because I did not feel comfortable accepting the oppression of animals at a demonstration about protecting people against ECT. The group conceded and put on a completely vegan event. Both of these instances represent moments in antipsychiatry organizing when differences in analyses came forth, were discussed, and activists were able to work together to invent alternative symbols and slogans that did not contradict any of the members’ political convictions.

However, there were other differences within the constituency and among other constituencies that were not so easily resolved. For example, activists such as Innes, Truly, and Florence did not want to rely solely on an identity politics approach in their work, despite critiques coming from psychiatric survivors and mad people. Florence and Truly recognized that opening up the constituency to all people who espoused an antipsychiatry perspective introduced complex power dynamics, but these were complexities they wanted to work through. They were interested in finding ways to build bridges among the antipsychiatry, psychiatric survivor, and mad
constituencies, but they were not willing to change their political and ideological approach.

Antipsychiatry activists engaged in a variety of activities aimed at addressing the concerns raised by psychiatristized people, dispelling common myths about antipsychiatry, explaining what their long-term vision is about, doing outreach with psychiatristized people, and trying to recognize common ground to see where they can come together with survivors and mad people in their organizing work. For example, Weitz and Rachel went to community events, including Mad Pride, where they distributed information about CAPA and its recent campaigns; CAPA organized and hosted events such as Psychiatric Survivor Pride and film nights where members distributed information and engaged in dialogue about what is happening in the larger community; Bach established a peer support and consciousness-raising group connected to CAPA specifically for psychiatristized people, where there were opportunities for communication and feedback between groups; Weitz, Burstow, and I wrote a fact sheet clarifying what antipsychiatry activists strive for in their work; and the PsychOUT organizing committee created venues at the conference for various constituencies to explore what issues and organizing strategies can help constituencies work together in solidarity.

It mattered a great deal to most activists that they be accepted as a part of the community, and they cared about being relevant and accountable to those who are most vulnerable to the psychiatric system. In separate interviews, Weitz, Innes, Starkman, Jackie, and Florence felt that it was important to find ways to open up lines of communication and address critiques voiced by psychiatristized people directly. Weitz and Innes emphasized the importance of working in various different ways to
challenge psychiatry, including using an attrition approach, and did not view this wearing away of different parts of the system as disrespectful to the experiences of psychiatristized people. They agreed with psychiatric survivors and mad people who emphasized the importance of developing non-psychiatric alternatives and advocated for large-scale social and economic transformation, so that people would have adequate supports in their lives without psychiatry. They also wanted psychiatristized people to understand that their systemic change work does not target individuals. In an interview, Weitz adamantly stated:

Antipsychiatry is a position against the system. There’s a difference between talking about a system and about individuals. I’m not assassinating a person or going after a person.

Weitz, Innes, and Florence felt that their radical analysis puts them at odds with other community members who fundamentally disagree with their approach. In their respective interviews, Weitz and Reville recognized that historical tensions within the community between survivors and non-survivors, professionals and non-professionals, radicals and reformists have “left scars that will require ongoing efforts on all sides.” In an interview, Weitz expressed feeling hopeful about what they have seen so far resulting from their outreach efforts. Similarly, in the focus group with members of my research team, Burstow noted the positive outcomes she saw come out of the PsychOUT Conference. She stated:
I was watching the conference with the issue of people coming together in mind, because it was one of the main purposes of the conference... My sense is that a lot of people came with that wish in the first place... intent on coming together. But beyond that, I did see people taking it up and quite dramatically... At our panel, we had an interesting situation... I remember we had two people who were antipsychiatry and two people who were not, which was not uncommon for panellists... And so what would happen if somebody in the audience took on antipsychiatry? And someone did. Someone in the audience said, “you’re giving the stuff a bad name. Why don’t you just, you know?” And both of the people who were not antipsychiatry immediately weighed in saying why don’t you let these people answer and immediately weighed in as if this was a conceivable position, which was very, very interesting... I thought, something has shifted. Some ground has shifted for this to be possible.

Weitz recognized reparative work as an ongoing process and voiced a strong commitment to continuing his efforts. He felt it was a necessary part of the antipsychiatry project which in the past has at times been neglected, but which activists were no longer willing to neglect. Even though Weitz and Florence recognized important differences among the various constituencies, they viewed psychiatric survivors and mad people as the most obvious groups with whom to work. In a conversation, Jackie expressed her belief that there are ways to co-exist peacefully with each other, respecting key differences among them, while coming together in the ways that feel right on all sides.
Building stronger networks among political communities. Antipsychiatry activists felt that marginalized groups should be actively involved in antipsychiatry struggle, given that the oppressed were viewed as particularly vulnerable to psychiatrization. In line with this, the PsychOUT conference prioritized cross-community alliance building in their call for papers, which read:

The purpose of this global conference is to provide a forum… to come together and share experiences of organizing against psychiatry. Dialogue about these experiences is intended to foster networking and coalition building across disciplines, social justice movements, and geographical locations; to clarify some key goals in the struggle against psychiatric oppression; to develop some longer-term strategies to help us achieve these goals; and to help us critically examine how we use specific tools for social change, such as the law, science, theory, media, art, and theatre.

This call for papers also specifically invited submissions that had a feminist, anti-racist, prison abolitionist, queer and trans, disability, or youth focus. This call for papers was developed by activists who felt that it was very important to focus on coalition building with other political communities.

During the time of my data collection, I noted in my research journal that the constituency was particularly determined to build stronger ties to feminist organizations in Toronto, because of their focus on the feminist anti-ECT campaign launched in 2007. They organized educational and workshops for feminist organizations examining ECT as an issue of violence against women and went to speak at community organizations such as Sistering and the Women's Counselling, Education, and Referral Centre. They also spoke about their efforts to recruit sponsors
and endorsers for this event from other political communities to garner the resources necessary to support the demonstration and to raise awareness about ECT. However, the majority of antipsychiatry participants were not satisfied with the amount of involvement of other political communities in their events and initiatives.

Starkman had insights as to why they might be having difficulty garnering more active support. For example, he described “the need for communities to respond to on-ground crisis,” and that in order to be able to do so, they need funding. Jackie and Xander recognized that being connected to the term antipsychiatry was not helpful to marginalized people who are trying to fund projects aimed at providing front-line services to their communities, because of resistance to radical ideas within mainstream funding bodies. In an interview, Jackie explained how local Aboriginal people are challenging the system in their own communities away from the antipsychiatry constituency. She stated:

A lot of Aboriginal people don’t buy into the psychiatric model... But their focus is on finding ways to get supports for their community members. They need money from the system to fund non-psychiatric alternatives... They want to do things outside of the system, and maybe don’t want to compromise their ability to do that...

The material need for resources was viewed by some as a major barrier preventing antipsychiatry activists from building stronger alliances with marginalized groups, particularly because associating with antipsychiatry did not represent the best strategy to meet the immediate goals of some marginalized groups.

Xander and Jackie suggested that what is missing from building meaningful connections with other political communities is the lack of two-way dialogue and co-
development of initiatives that prioritize the experiences and political concerns of
differently situated people. They pointed out that currently, when activists do
outreach to various community organizations, they are inviting them to support an
initiative that has already been defined according to the terms of a small group of
antipsychiatry activists. They felt that this was very different from contacting
organizations to determine together what the issues are of mutual concern and then
defining and designing actions and campaigns collectively. In an interview, Jackie
explained:

The result is that the experiences and priorities of the groups you are inviting are
not represented in the action, except for maybe in tokenistic ways, and people
aren’t going to be that enthusiastic about joining in.

Reaume, Bach, Reville, and Fabris raised concerns about dominant power relations
reproduced at antipsychiatry events. For example, in an email correspondence,
Reaume pointed to a specific example of terminology, which he perceived as ableist,
used by some activists in reference to effects caused by psychiatry’s interventions, for
example, referring to psychiatric drugs or ECT as “brain-disabling treatments” or
saying that they “cause disability.” These critiques were in contrast with the priorities
of some antipsychiatry activists who were primarily concerned with capturing the
severity of effects caused by psychiatric interventions that can alter people’s ability to
remember, learn, and feel, sometimes on a permanent basis. Their intention was not to
oppress disabled people by using language that is often associated with the disability
community, but rather to describe the life-altering physical changes that many people
endure that are caused by psychiatric intervention. There was no solution posed that
people representing various positions agreed upon.
During interviews, Laurence, Blaser, and Erlich also spoke about the problems associated with antipsychiatry being linked to academia. According to Erlich and Blaser, this association creates barriers for some marginalized youth who might otherwise be interested in antipsychiatry organizing. In a group interview, they shared the following insights:

Blaser: I also think that a lot of this exists within an academic framework, and they aren’t exactly accessible to those who aren’t involved with the academic system already. That can make it a lot more challenging to involve youth in such activities.

Erlich: In terms of an academic environment, it’s hard to organize antipsychiatry within an academic environment, especially with youth who are the most likely to drop out of school. These environments are even more inaccessible to the typical youth population. Like, I dropped out of high school. Jenny dropped out of high school. And obviously we’re both incredibly intelligent people (laughing).... Both of us dropped out of school. We did go back, but a lot of youth don’t have that same drive because of those experiences and are so tired of butting heads with the system that they never go back.

Similarly, Laurence voiced concerns about holding meetings within a university setting. She stated:

It’s happening in a university setting... it’s an institution, and institutions have hurt so many people, and schools have hurt so many people. I think from that virtue, it excludes.

As I recorded in my research journal, the 2010 PsychOUT Conference represented a major attempt on the part of antipsychiatry activists to build bridges with other
political communities, promote dialogue about various approaches to organizing resistance against psychiatry, and find common ground. The conference initiators invited various organizations from different political communities to send representatives to join the organizing committee and encouraged presenters to cover a broad range of topics relating to differently situated people, including youth, the elderly, women, poor people, disabled people, queer people, trans people, racialized people, and prisoners. They succeeded in sparking critical dialogue among various political communities, as the conference covered topics related to queer and trans people, disability rights, the prison abolition movement, and racism in the psy-complex. However, even with all of these markers of success, several participants, including antipsychiatry activists, also issued critiques about the conference. For example, despite their efforts, in the end, the organizing committee was not representative of the communities they wished to engage; the conference description and call for papers used language that some participants considered to be inaccessible; the process for submitting papers was very typical of other academic conferences and was intimidating to some who were not academics; holding the conference in a university setting was alienating to those who had, as Laurence put it in an interview, “terrible experiences in institutional settings and schools”; and the conference was not advertised widely in spaces outside of the political community. These problems can be taken into account in future organizing, particularly those related to inaccessible language and the implementation of academic processes; however, as pointed out by Burstow, it is also important to recognize that a number of these issues stem from the limited resources available to organizers. In the case of this conference, and other similar situations, community members are faced with the difficult task of figuring out
what trade-offs are worthwhile considering what they are trying to accomplish with
the insufficient resources available to them. Jackie and Innes also recognized that they
are up against pro-psychiatry forces creating significant barriers in their work and
believed that they had trouble garnering support from other political communities, in
part because, as Jackie put it, “even political people lack an analysis because of the
pervasive pro-psychiatry propaganda that is everywhere.”

**Closing Remarks**

The antipsychiatry constituency has a long and hard road ahead in its journey
towards psychiatry abolition. This is a challenging venture in consciousness-raising, as
people will not easily understand antipsychiatry, given that the psy-complex is an
empire backed by enormous money making industries that the public-at-large has not
yet come to question very deeply. This empire has the public relations advantage of
serving the vested interests of many who inhabit positions of privilege and who have
massive resources to finance subtle and pervasive propaganda in its support. In light
of these external barriers, antipsychiatry activists must work harder, not only at
building more understanding of what they stand for among other constituencies, but
also at understanding the complexities of what people coming from other
constituencies stand for. Many antipsychiatry participants felt that they would benefit
from building even stronger processes to engage psychiatric survivors, mad people,
and others engaged in political communities and by planning initiatives that prioritize
the lived realities of those who are most vulnerable to psychiatrization. This process
will necessarily involve greater attention to power dynamics, including differences in
resources among groups and individuals within the community, which if left
unchecked could impede progress or weaken this political constituency. Tensions will always exist between those who would reform current institutions to ease immediate pain and suffering and those who would transform society to meet human needs in alternative ways that intrinsically respect the dignity and welfare of all. The most important question is: How do we react to these differences? There are no easy answers to the complicated process of bringing people together, but antipsychiatry activists, like psychiatric survivors and mad people, must grapple with these difficult questions. Everybody is needed if we are going to make changes in the direction of eliminating sanism and psychiatric oppression.
Chapter 7: Working Across Difference: Solidarity, Transformation, and Liberation

At the beginning of this dissertation, I stated that one key purpose of the present study is to offer up ideas and strategies to approach problems grounded in specific events and experiences in the Toronto community that reveal patterns of ongoing tension and conflict among differently situated people. It is my hope that, by openly facing these frictions and fissures, the community can build solidarity across difference and go on to forge alliances to better work towards ending the tyranny imposed by sanist institutions. This chapter offers up my own analysis based on insights gained from this research and advances reflections generously shared by members of the community as well as ideas stimulated by feminist scholarship on working across difference and building solidarity to achieve political goals. I have tried to capture a snapshot of the many diverse and creative ways that community members theorize problems stemming from psychiatry and other sanist institutions, how they go about creating change in the world, and how they respond to the ideological and strategic differences in their midst. This analysis of findings is based on a specific moment in history and will not accurately portray what is happening in this fast evolving context for long. Nevertheless, it is useful to examine the dynamics of difference, defined by theory and practice at this time, in order to glean insights about barriers that block people from building stronger solidarity networks, and identify some steps that might lead to stronger coalitions. While new ideas and new actions have already come into existence since I have completed this dissertation, and others
have become part of history, tensions that arise from social and political differences remain constant.

Difference in the community can be understood along many different lines. People who identify with the Toronto community come from many different social locations defined by gender, class, race, sexuality, disability, and other dimensions; many different experiences with the psychiatric system, ranging from working as a psy-professional to being incarcerated within a psychiatric institution; and many different worldviews, shaped by the aforementioned determinants and other contextual factors that shape individual subjectivity. All of these differences matter and should not be glossed over in community organizing work. As seen throughout this dissertation, the feeling of belonging to a cohesive community is important to many people, as it helps people build relationships with one another, often through generating notions of shared identity or experience, and provides people with hope and inspiration. However, in situations where notions of shared identity, experience, or politics overpower and further marginalize the experiences of oppressed people, they are destructive and work against the ideal of building community for all people who have a stake in resisting sanism and psychiatric oppression. This is not to undermine the importance of political (re)articulations of identity, experience, and interests, but rather to assert that these articulations must be part of a larger understanding of community, one that recognizes differences and encompasses them into the process of developing transformative visions and agendas for change.

This chapter will revisit some of the central struggles emerging from various constituencies to foreground questions of analysis that permeate community discourses and indicate the importance of developing a paradigm that encompasses
the multiple truths drawn from community members’ experiences. I am not engaging
in this analysis to identify “right” or “wrong” perspectives as expressed by differently
situated people, but rather I am engaging in this examination to demonstrate the
partial and incomplete nature of any given entry point, hoping to work towards a
richer, more nuanced understanding. Instead of privileging a certain limited version of
identity politics, or instead of disposing of the importance of experience altogether, I
draw on concepts that value experience as a starting point for recognizing the
inseparable nature of anti-sanist, anti-racist, feminist, anti-imperialist, queer, youth,
disability, and other liberation struggles.

**Different Entry Points, Understandings, and Solutions**

Setting an agenda claiming the best interests of all psychiatrized people poses a
challenging task, yet it is a goal that many community members hold as they pursue
healing, empowerment, and social change initiatives. In the present study, the vastly
different histories and social locations of active community members and those whom
they wished to include in their imagined community proved time and time again the
lack of natural, homogenous, or self-evident interests that can serve as a basis for a
community agenda. Each of the three constituencies examined throughout this
dissertation posed unique challenges in pursuance of this goal, and despite genuine
efforts to grapple with tensions stemming from difference within the community, none
escaped the complex power dynamics that come with building diverse political
networks. Each new innovative approach attempted by community members brought
its own set of complicated dynamics that created tensions among some members of
the community. The first part of this chapter will offer a brief summary of key ideas
and areas of tension that emerged from the psychiatric survivor, mad, and antipsychiatry constituencies.

An examination of identity politics in the psychiatric survivor constituency demonstrates that it is impossible for any particular individual or any specific group of individuals to accurately claim that they represent all psychiatrized people, when it is clear that not all psychiatrized people agree on any given issue. In contrast to the views of many psychiatric survivors in the political community featured in this dissertation, numerous psychiatrized people accept psychiatric definitions of self and believe that complying with their psychiatrists’ orders is what is best for them. In fact, even psychiatrized people already politically engaged in the community hold different and sometimes contradictory perspectives about what needs to be done to improve oppressive conditions in their lives. Some strive to work completely outside of the psychiatric system, towards its complete abolition, while others are willing to work within to create better conditions for psychiatrized people. Still others believe that there is no real “inside” or “outside” of the system, that we are all implicated in the system in some way, and that all of the different initiatives and approaches emerging from the community have an important role to play. In contrast, some radicals believe that the “insider” work some psychiatrized people participate in is part of what is blocking the liberation of psychiatrized people.

Despite these divisions, many who identify as psychiatric survivors are extremely invested in psychiatric survivor identity politics. They maintain that shared experiences of psychiatric oppression are key in bringing psychiatrized people together across difference. Peer-support and consciousness-raising groups are viewed as the foundational pillars of the community, and many psychiatric survivors testify as
to how these groups have changed their lives for the better or even saved them.
Meeting with other psychiatrized people provides spaces where people can question
the disempowering rhetoric they have been coerced into accepting and helps them
recognize external circumstances that have led them into the system. Some people
speak of other psychiatrized people as their family and of the community as a sort of
home that offers a safer space away from an outside, hostile world. Some psychiatric
survivors who uphold identity politics as a key organizing strategy are striving to
achieve a standpoint that elucidates the oppressive conditions that need to change and
solutions that will improve the situation of psychiatrized people.

Yet, the experiences of differently situated individuals demonstrate how
difficult it is to achieve a standpoint that fits the experiences of all psychiatrized
people. The experiences of some women, disabled, Deaf, young, and racialized people
contribute different truths about psychiatry, madness, and power dynamics within
political communities. For example, some do not feel safe in support or consciousness-
raising groups with white men and do not feel a stronger bond with them because they
share the characteristic of being psychiatrized. They view their experiences as
different from those of their white male counterparts and do not assume that they
share much in common with them, personally or politically. They feel more
comfortable seeking support and organizing empowerment and social change
initiatives with others whose critiques of psychiatry are embedded in a larger analysis
of racism, ableism, and patriarchy.

Many who identify primarily with the term mad hope to address some of these
problems arising from the parameters set in psychiatric survivor identity politics,
eager to move past consumer/survivor or radical/reformist divisions to celebrate a
“plurality of resistances” and subversive acts against sanism. Understandings of mad range from an umbrella concept used to capture the many different identities and perspectives of those who are oppressed as crazy to a discursive approach emerging within the community from its intersection with academic poststructuralist trends. The latter approach has introduced some interesting dynamics in attempts to build a more inclusive community. Proponents of this perspective consider how the meanings and practices, which construct notions of mad and normal, are created and maintained through a variety of institutional discourses. They do not view madness as an actual state of being, but rather as a construct that becomes intelligible through these discourses. Imaginary standards of mad and normal, based within specific cultural and historical contexts, regulate how people are expected to feel and behave. These standards are seen to affect all people, as we all learn to regulate ourselves internally for fear of being labeled and treated as mad, and resistance is seen as taking place in many different ways at individual and collective levels.

According to some, the potential for people to understand the construct of “normal” as an oppressive ideal can open up even mainstream realms to mad activism. However, what some people view as a radical embracing of diverse localized resistance efforts, others view as relativism, where a multitude of perspectives are considered equal, regardless of what dominant values are left unchallenged. For example, one fear that was raised is that this dynamic sets the community up to privilege those perspectives, identities, and actions least disruptive to the hegemonic order, thereby further marginalizing critiques of psychiatry and other sanist institutions. Another fear is that if the community takes a relativist approach to radical
inclusion, it risks reproducing other forms of oppression, such as sexism, racism, homophobia, transphobia, ableism, and classism within community spaces.

Community members who critique mad identity politics frequently point to examples of essentializing notions of madness and experience as an issue of concern within the mad constituency. Indeed, there are some mad people who favour notions of mad identity based on cultural or biological etiologies of madness. They feel that particular dimensions of mad experience, such as hearing voices or living highly variable emotional states, which may or may not have genetic and/or biological causes, can serve as a foundation for mad culture. This appears to be a comfortable and even empowering narrative for some mad-identified people, who focus on how mad people are oppressed under structures that do not accommodate them. However, others fear that this type of approach essentializes difference in ways that compromise more complex ways of understanding people’s experiences based on historical, social, and material contexts. They assert that this orientation of mad identity places mad at the centre, surpassing all other individual or group identities in decontextualizing and homogenous ways. It is clear from my interactions with community members that some psychiatrized people, who understand their madness as an essential part of who they are, still have a critical analysis of systems of oppression that block mad people from equal participation in society. They come to be proud of who they are, rejecting disparaging images and stereotypes about the “mentally ill,” and display their attributes and share their unique understandings derived from their social location as mad people. The problem, as seen in the present study, is that essentializing discourses could potentially play into and add strength to dominant psychiatric discourses which conceptualize madness as illness inherent to certain individuals,
based on flawed genetics and malfunctioning biology. Furthermore, essentializing mad discourse and psychiatric discourse both have the potential to obscure how processes of racialization, gender, class, disability, sexuality, and other oppressions shape and define madness. This is particularly problematic for people who are labeled as mad or are psychiatrized because of their responses to traumatic and oppressive conditions in their lives. The experiences and narratives of many marginalized mad people bare testimony to how madness is molded by a complex system of power relations, and narratives that fail to address this reality tend to alienate individuals whose identities are shaped by this very understanding. While many community members are enthusiastic about finding ways to bridge alliances with differently situated people, some fear the liberal direction that some mad approaches to inclusion can take within the community. Ultimately, they do not want to sacrifice anti-oppression priorities, complex understandings of compound oppression, and an analysis of psychiatric hegemony for the sake of mainstreaming the mad constituency.

The ideology-based approach of antipsychiatry activists poses its own challenges, as community members who do not have firsthand experience of psychiatrization attempt to work with others who do have this experience to pursue their ultimate goal of psychiatry abolition. Their approach offers a counter-hegemonic perspective on how psychiatric dominance works in the world without relying on an identity politics approach. It rejects popular psychiatric conceptualizations that cast particular manifestations of emotional, behavioural, and perceptual experiences, and problems that arise from living in oppressive conditions, as pathological problems residing within the individual. One central idea is that psychiatric power works in the interests of the dominant class, (white, male, able-bodied, heterosexual, rational,
middle-class), by labeling as “mentally ill” those who challenge dominant cultural
ideals or norms, and subsequently “treating” the “deviant classes” into submission.
Psychiatry is viewed as an “institution of social control” designed to handle those who
do not fit within dominant social relations, so that the hegemonic social order can
continue to function in the interests of elite groups, with as little inconvenience or
interruption as possible.

The inclusion of people who do not have firsthand experience of
psychiatrization is viewed as both a strength and a weakness in the antipsychiatry
constituency, depending on one's vantage point. The inclusion of those who have not
been psychiatrized is viewed as a benefit by those who want the community to branch
out and to garner more support to build stronger political networks among radical
political communities. Furthermore, some antipsychiatry activists believe that an
emphasis on psychiatric hegemony can lead people to consider the effects of
psychiatric dominance on all people, whether or not they have been psychiatrized.
This analytical approach has guided people to ask themselves how they benefit and/or
suffer under the current organization of society, without simply slotting people in the
categories of the oppressor or the oppressed. This effectively broadens the scope of
how people conceptualize possible alliances with others who have not been
psychiatrized. Some antipsychiatry activists emphasize the widespread implications of
psychiatric dominance, for example, how psychiatric discourse shapes popular
consciousness, causing people to police themselves and others around them, as they
screen for “mental illness” in day-to-day encounters at work and with family and
friends.
On the other hand, some psychiatric survivors and mad people assert that those who have not been psychiatricized often lack the insight needed to respond with appropriate respect and sensitivity when addressing the experiences, needs, and desires of those who have been psychiatricized. Those who do not agree with the long-term goal of psychiatry abolition or with specific approaches taken by activists in pursuance of this long-term goal question the legitimacy of some initiatives undertaken by the antipsychiatry constituency. The principal concern among these critics is that the work emerging from groups that include those who have not been psychiatricized will marginalize the perspectives of psychiatricized people and ultimately fail to respond appropriately to their everyday lived experiences. This is a valid concern that speaks to the value of identity-based groups restricted to psychiatricized people; when there are spaces where psychiatricized people can come together to explore their experiences, understandings can emerge that help inform what actions are needed, allowing psychiatricized people to contribute more fully to the larger community. The present study also suggests that understandings emerging from the antipsychiatry constituency at times do not encompass an awareness of how psychiatric oppression shapes the experiences of differently situated people, based on factors such as gender, race, class, sexual orientation, age, and disability. Participants who share an understanding of psychiatry as a hegemonic institution often center psychiatric dominance as the most pressing form of oppression to be addressed by the community and often treat other systems of oppression as secondary in their work. This is in contrast to some participants’ emphasis on intersectionality or compound oppressions that calls for the centering of marginalized psychiatricized voices in order
to develop analysis and strategy aimed at challenging all systems of oppression
together, equally, without ranking the importance of the many forms of oppression.

Despite all the challenges stemming from different theoretical and strategic
approaches in the community, many members are determined to figure out ways to
address tensions and build stronger solidarity networks. Community members
understand the enormity of what they are up against and recognize the need for a
broad-based coalition of people who have a stake in working towards social change
while fully admitting different experiences, understandings, roles, and access to
privilege among differently situated community members. I propose that there are
ways of fostering empathy and understanding across difference that will prove useful
in developing analysis and strategy that fully takes into account the many different
(partial) truths emerging from a multiplicity of locations/experiences (Hill Collins,
2000; Mohanty, 2003). The differences among community members are neither static
nor essential, but rather stem from structural systems of power that keep people
apart. The next part of this chapter will look at some structural forces that are working
against attempts to build stronger solidarity networks. It is my hope that expanding
awareness of these structural dynamics will represent a critical step towards resisting
systemic barriers that keep oppressed people divided.

**Blocks to Recognizing Various Forms of Marginalization**

The diverse narratives of community members make it abundantly clear that
not all people experience psychiatry in the same way. In part, it is this diversity of
experiences that people have within the psy-complex that accounts for the different
solutions people view as appropriate in their healing, empowerment, and social
change work. For example, the racialized woman living in poverty who has been pathologized for how she copes with the insidious trauma of living in a sexist, racist, and classist society views resistance against racism and classism to be central to her resistance efforts. The woman who is psychiatricized because of how she has responded in the context of an abusive relationship finds the most useful support from feminist anti-violence initiatives. The white man who is psychiatricized for hearing voices finds home in a group focused on depathologizing his experiences and offering alternative supports. The professional who has become radicalized after witnessing abusive practices within the psy-complex and rejects the psychiatric paradigm finds a place to organize within the antipsychiatry constituency. Community narratives and initiatives that resonate most with an individual’s firsthand experience will have the strongest draw, and there is nothing wrong with there being a range of healing, empowerment, and social change initiatives addressing the specific needs of particular groups of people. At the same time, as Black feminist Davis (cited in James, 1998, p. 299) points out, it is important to “be more reflective, more critical, and more explicit about our concepts of community” to recognize that “there is often as much heterogeneity” within specific identity groups as within larger political networks. In line with this understanding, there are some trends within the community that need to be questioned: What is preventing people from recognizing the diversity of needs and desires within the community? What factors make it so difficult for community members to recognize how differently situated others experience sanism and psychiatric oppression differently from themselves? And why are multiple lived realities not being incorporated into dominant community narratives about sanism and psychiatric oppression?
The phenomenon of dominant power relations being reproduced in the context of progressive political communities has been studied extensively by Black feminists. Audre Lorde (1984), for example, was among the first theorists to describe how these dynamics are reproduced when marginalized people strive to attain the status of the *mythical norm*, which in the context of the political community under study is defined as white, able-bodied, hearing, rational, young (but not too young), male, heterosexual, cis-gendered, Christian, middle-class, and thin. She explains that marginalized people often identify one way in which they are different from the mythical norm and assume this to be the primary cause of oppression, ignoring other misrepresentations of differences, some of which they end up perpetuating themselves. The collective consciousness of political communities is shaped by this mythical norm, and while all people know on some level that they can never attain this norm, they believe that the closer they get to attaining it, the more respectability and power they will gain.

This desire to ascend to the pinnacle to attain the mythical norm creates a hierarchical structure within society that permeates all structures including social movements and communities like the one under study. This poses major barriers to people coming together, to work in solidarity to challenge systemic oppression at its roots. But why do political communities that are founded on liberation ideologies fall into this trap? Fellows and Razack (1998) assert that it is an act of survival. They argue that people fear their own erasure if they do not continuously prioritize what they see as their primary issue and therefore focus on their own subordination as a self-protective response. In addition, when individuals do not relate to a specific manifestation of oppression, or are even privileged in relation to others as a result of
it, they are likely to discount others’ claims about injustice, just as dominant groups do when they hear the narratives of marginalized groups (Fellows & Razack, 1998). As Fellows and Razack (1998) point out, each individual is privileged by certain dominant representations of the “other”, which they use to convince themselves that the “other’s narrative” is not as legitimate as their own. To think or feel otherwise, to focus on their own complicity in the oppression of others, is experienced as a threat to their own claims for justice (Fellows & Razack, 1998). Within the matrix of domination, where some groups of people are set up to always be constructed as “lesser than” and their oppression is naturalized through the power of the mythical norm, marginalized individuals are pitted against one another in a race for respectability.

I do not mean to suggest that the process by which certain groups are constructed as inferior is accepted at a conscious level by psychiatric survivors, mad people, and antipsychiatry activists, as it is clear in the present study that when these issues are brought to their attention, most people are eager to examine why many community initiatives do not attract a wider diversity of people. Rather, as described by Fellows and Razack (1998), this process is often invisible to those who belong to dominant groups, those who are seen as “simply human,” and who remain unmarked by identity labels. They (1998, p. 341) explain,

The marking of subordinate groups and the unmarking of dominant groups leaves the actual processes of domination obscured, thus intact. Subordinate groups simply are the way they are; their condition is naturalized. To be unmarked or unnamed is also simply to embody the norm and not to have actively produced or sustained it. To be the norm, yet to have the norm unnamed, is to be innocent of the domination of others.
In other words, dominant culture conditions individuals to see human differences in simplistic oppositional relationships that are constructed through binaries such as normal/pathological or superior/inferior (Lorde, 1984; Diamond, 2006; Wilchins, 2004). The “normal” subject is always positioned at the centre, while all other subjects who deviate from the mythical norm are relegated to a “lesser than” status. The “normal” is left unquestioned and unscrutinized, while all other subject positions are under constant surveillance and re-evaluation (Wilchins, 2004). The processes by which this happens are so ingrained in the organization of the world, built into language and the foundation of societal institutions, creating a situation where individuals within political communities have to work hard to bring them into consciousness and make them visible.

The competition that marginalized groups engage in as a means of survival is evident in concrete ways in the present study. Immense pressure for community members to put forth a subdued and less radical vision to represent all psychiatrized people, glossing over the differences among them, is coming from funding sources that are not particularly inclined to engage the multiplicity of concerns and interests arising from the lives of psychiatrized people (Hawkesworth, 2006). For example, as seen in chapters 2 and 4, governmental agencies and influential psy-organizations have made space for what they often call “the voice of consumers” and have job positions and funding for a small number of psychiatrized people who they hire to represent “the consumer voice.” The pressure is immense to put forth a subdued, less radical version of what many people in the community would like to see happen. This pressure can be seen in both subtle and blatant ways. One recent more obvious example of pressure put on community members to develop “one unified common
"voice" is in a document released by the Mental Health Commission of Canada (MHCC) aimed at the “consumer” community, which declares:

Our goal is one we share with you: to make a difference in the lives of people living with a mental illness or mental health issues. Unless we are one unified common voice working toward this common cause, the public will not take us seriously” (MHCC, 2009, p. 1).

Given the context in which this statement was released, it is not surprising that the voice most often represented is that which engages with dominant psychiatric frameworks, adopting their language and ideology to make incremental steps towards building a more humane system, curtailing the most horrific abuses, and providing psychiatricized people with some material supports. Those in power might look to include consumers in various planning efforts, but they are not looking to alter their overarching frameworks or underlying assumptions, at least not to the degree many psychiatric survivors, mad people, and antipsychiatry activists would like. This creates a situation where it is almost impossible to continuously bring forth the range of critiques emerging from the community without risking loss of funding or employment. This is not to say that the people who choose to work with mainstream psy-organizations are not trying to engage a multiplicity of voices. A number of participants in the present study are attempting to do just that, but working within a system that looks for a monolithic “consumer voice” makes it difficult to seriously grapple with the diverse perspectives of psychiatricized people. It is a trade-off that many community members feel is justified in order to begin meeting some the material needs of psychiatricized people.
The structure of state processes for implementing change and the pressure on activists working “on the inside” to put forth a consumer perspective also affects how grassroots activists handle issues of representation. Many activists resent how a small group of psychiatrized people is appointed to represent all psychiatrized people. The need to be heard has created a competitive energy as people struggle over who has a right to speak for and represent the needs of psychiatrized people in the public arena. The desire to advance particular agendas to those in power has fostered strained relationships within and among the various constituencies in Toronto, for instead of just listening and hearing what other people invested in this struggle have to say about their experiences, activists are glossing over, denying, or silencing particular experiences in fear that they will add strength to conclusions that contradict what they feel needs to happen.

Some community members believe that the most sensible option is to oppose the efforts of mainstream psy-organizations and attempt to diffuse their power. They are angry about being painted as consumers who should be satisfied with what they often perceive as a superficial engagement in policy- and decision- making. They want to make it clear that they are against the psychiatric framework adopted by most mainstream organizations, which they believe limits the direction of institutional change, and refuse to accept terms like mental illness or consumer in order to have their voices heard. Unfortunately, this struggle for representation often results in an over-simplification of psychiatrized people’s needs and desires in grassroots initiatives as well, as activists are prone to falling into the trap of claiming they know what is best for psychiatrized people, often rationalizing their claims using identity politics discourse about shared experiences and drawing on the testimonies of
psychiatric survivors who have been deeply hurt by the psychiatric system. They too neglect, on an ongoing and consistent basis, to incorporate an analysis that encompasses the range of experiences shaped by compound oppressions. Grassroots activists feel pressure to set an agenda that can be claimed for all psychiatrized people, because this can feel like their only hope in securing policy ground that would otherwise remain unaddressed or inadequately addressed (Hawkesworth, 2006).

It is clear that choosing either path puts pressure on individuals and groups to overlook contrasting views in order to develop a collective viewpoint as they come up against psy-organizations and governmental institutions that wield a lot of power and money. Unfortunately, when community members make claims for and about psychiatrized people, they risk projecting an inauthentic voice onto those most silenced. This combined with hegemonic power dynamics within the community, that further marginalize the experiences of some psychiatrized people, creates a dynamic that often creates barriers to the participation of many who have a stake in resisting sanism and psychiatric oppression. Within the context of American feminism, Audre Lorde (1984) argues that the silencing of black women is not just an omission; it is part of the oppression they experience. Likewise, Mohanty (1991, p. 52-55) characterizes these forms of “ethnocentric universalism” as structural domination that suppresses the heterogeneity of community members. Paying attention to the words of these wise women, community members recognize the importance of looking at where the voices of racialised, women, disabled, trans, young, elderly, poor, Deaf, institutionalized, queer, and otherwise marginalized people are situated within their work. This is a critical step towards building stronger solidarity networks within and among political communities.
The race for respectability extends beyond the political community at the heart of this dissertation into other political communities that have a stake in resisting sanism and psychiatric oppression. As seen in chapters 4 and 5, it is often the case that individuals associated with other political communities do not want to be viewed as “crazy” or “mentally ill” and so distance themselves from people who identify as psychiatric survivors, mad people, and antipsychiatry activists. They may at times forge strategic alliances with psychatrized people and those who associate with them, but ultimately, they do not want to risk the further pathologization of their own oppression. This causes major barriers for all three constituencies in their attempt to build coalitions and solidarity networks with other political communities.

A key example of this problem dates back as far as the early 1970s when the diagnosis of homosexuality was still in the DSM. At this time, gay rights activists were fighting for the removal of the diagnosis, arguing that being gay does not mean that a person is “mentally ill”. While there was some overlap between the gay rights movement and the ex-patient movement at that time, given the large number of queer people who were labeled and treated as mentally ill, the arguments used to depathologize queerness were based on and reinforced the normal/abnormal dichotomy. In other words, the mainstream gay rights movement wanted gay people to be seen as normal, respectable members of society, unlike those who were legitimately viewed as sick and inferior.

Finally, in 1973, the diagnosis of homosexuality was removed from the DSM due to mounting pressures from the gay and lesbian community and changing societal norms. It was replaced with the diagnosis egodystonic homosexuality, a term used to describe a mental disorder related to the distress experienced by many queer people,
a diagnosis failing to take into account that one can expect to feel distress when
associated with an identity that is despised in dominant culture. This again left the
most marginalized queers behind in the fight for respectability, as many lesbians, gay
men, and other queer people, who did not fit the mold of the “respectable” gay man or
lesbian, were still constructed as sick and abnormal by psychiatric discourse and by
larger society. While egodystonic homosexuality was eventually taken out of the DSM as
well, the discourse used to depathologize gay men and lesbians remains strong and
does little to aid the situation of the most marginalized in the queer community. To
this day, for example, queer youth who are kicked out of their family homes, those
trying to support themselves as sex workers, and those who cope with oppressive
conditions by using strategies viewed as deviant, such as drug use, remain
marginalized and vulnerable to psychiatrization because of discrimination and their
reactions to poverty, racism, homophobia, ageism, ableism, audism, adultism,
heterosexism, and sexism.

This historical example demonstrates how the gains made by marginalized
groups, that strive to achieve the status of the mythical norm for some of their
members, takes place on the backs of those most oppressed in their communities.
There are many other examples where this type of strategy has been used: feminists
fighting to depathologize women's reactions to trauma by challenging diagnoses such
as borderline personality disorder without considering how differently situated women
are oppressed with other diagnoses such as schizophrenia; disability and Deaf activists
refusing to associate with psychiatric survivors in their liberation efforts for fear of
being associated with the stigma of mental illness; the trans community differentiating
themselves from others who are labeled as mentally ill, while recognizing the utility of
having the diagnosis to access sex-reassignment surgery, without making connections  
to parallel struggles such as the need for diagnosis to access supports such as the  
Ontario Disability Support Program (ODSP). All of these oppressed groups are fighting  
for the privileges associated with gaining status as “normal,” but are doing so without  
questioning the marginalization of others who are labeled as mentally ill, including  
those who belong to the identity group which they are trying to depathologize. It is  
understandable that marginalized groups want to avoid being further pathologized,  
but in the long-run and in the bigger picture, these are not effective strategies. As  
Fellows and Razack (1998, p. 352) explain,  

respectability is a claim for membership of another group; attaining it, even one  
aspect of it, requires the subordination of Others. Moreover, because  
subordinate groups that gain a measure of respectability do not by definition  
possess all the attributes of respectability, they are in an inherently unstable  
position.  

In other words, while oppressed people may feel they are advancing their own claim  
for justice by differentiating themselves from other oppressed people, by failing to see  
one’s own domination, they are leaving all the systems that privilege them and  
oppress them intact, assuring the perpetuation of injustice (Fellows & Razack, 1998).  

While community members recognized the marginalization of many oppressed  
groups of psychiatristized people, there is one group that is highly vulnerable to  
psychiatrization that was largely ignored: the elderly. The only time concerns about  
the psychiatrization of elderly people were brought up was in the context of  
electroshock, despite the fact that many elderly people are institutionalized and are  
being forcibly subjected to a wide variety of psychiatric interventions against their
will. This omission is particularly interesting given that several elderly people participated in the present study. However, the elderly people who participated were people who have been involved in the community for decades. Rarely, if ever, do elderly people who are newly psychiatricized join psychiatric survivor, mad, or antipsychiatry initiatives. I suspect that they are simply too marginalized and oppressed and often do not have the freedom or capacity to make it out to community meetings or events. This, however, is not a good justification for leaving the elderly outside of the community’s awareness. In fact, given that many elderly people are not in the position to advocate for their rights, it is all the more important for this political community to take on the oppression of elderly people as an issue of major concern.

While it is often the recognizable differences among people that are seen to create divisions, feminists like Audre Lorde (2007, p. 115) have argued that it is actually “the refusal to recognize those differences, and to examine the distortions which result from our misnaming them and their effects upon human behaviours and expectation” that separates us. All people exist within contexts where these distortions shape our living, and it is the systems that create these distortions that are common to all people. In the present study, many differences came forth as barriers to building solidarity networks. Yet in examining the histories of these various different groups, an interdependence is revealed. It is difficult, for example, for feminists to retain moral credibility while pointing out the psychiatric targeting of women abuse survivors without simultaneously recognizing how racialized survivors of violence are often pathologized as *schizophrenic* (Metzl, 2009; Sharpley & Peters, 1999). Similarly, it is problematic for white psychiatric survivors to recognize the impact of institutional violence within the psychiatric system without recognizing how racism, sexism,
ageism, adultism, heterosexism, transphobia, audism, and ableism put specific groups of marginalized people at greater risk within the system they are critiquing. Additionally, it is very impractical for all of us to ignore the psychiatrization of elderly people, given that most of us will belong to this group one day and suffer the same risks that elderly people do today. As Hill Collins (2000, p. 247) points out, the same inseparable forces of domination shape the various experiences of marginalized groups, and this recognition “can serve as a foundation for building empathy” among various groups.

Developing a Framework for Solidarity Work

Numerous paradigms of oppression emerged from the lived experiences and transformative aspirations of differently situated community members. I am sympathetic to all of these approaches and have tried to do justice to them in describing their appeal, their relevance to the community, while also addressing their limitations and the tensions and conflicts among them. For the most part, I view the contradictions among these paradigms as rooted in practical dilemmas based in the specific priorities and experiences of their proponents (De Lissovoy, 2008). This understanding, alongside my political commitment to solidarity work, has pushed me towards a perspective that moves away from singular principles or epistemological assumptions towards a more complex and inclusive paradigm (De Lissovoy, 2008).

What does this paradigm look like? To begin, it encompasses a clear understanding that being psychiatrized, or being perceived as mentally ill, has consequences in the world we inhabit that are often unjust and vary depending on one’s economic and social marginality and privilege. It requires an acknowledgement
that sexism, racism, ableism, classism, ageism, adultism, misogyny, transphobia, and heterosexism are entrenched in social and political institutions that rule, including psychiatry, which will inevitably shape the everyday experiences of differently situated people, putting some people at greater risk of violence and marginality. It also recognizes that processes of sanism, psychiatric oppression, ageism, adultism, audism, sexism, racism, heterosexism, transphobia, classism, and ableism are each infused with one another, are inseparable, and are completely integrated into the social and material world. It understands that hegemonic ideologies shape and define all of our lives, albeit in different ways depending on how we are situated vis-à-vis dominant culture. And in addition to bringing all of this into consciousness and developing a clear analysis and critique of institutions, behaviours, attitudes, and relational patterns, this paradigm emphasizes the need for transformative visions, as well as strategies for realizing these visions (Mohanty, 2003).

This approach shares many key principles found within the other paradigms espoused by participants in the present study, but responds to the limitations and challenges found in each. For example, it draws on elements of identity politics, recognizing that an analysis of how the everyday lived experiences of marginalized people leads to knowledge about systems of domination that shape all of our lives, but rejects the premise that we can rely on the perspective of any single marginalized group to develop a more holistic understanding of how systems of domination are at work. It also recognizes that we need to go beyond merely bringing together many different perspectives, but rather to subject each experience or perspective to a process of critical interpretation and theorization, taking into consideration its historical and material basis, before it can become part of the foundation for solidarity
and struggle (Mohanty, 2003). Harstock (2004, p. 239) refers to this as a “standpoint” approach that involves working towards “an engaged vision... that exposes the real relations among human beings as inhuman.” She recognizes that lived experiences produce different perspectives, and thus, she conceptualizes a “standpoint” as something achieved through consciousness-raising processes, rather than a pre-given viewpoint (Harstock, 1983). Similarly, Mohanty (2003) has named this approach a “politics of location,” which recognizes that location enables particular ways of reading and knowing the dominant, while acknowledging that any one particular location is limited in its understanding of the whole. These are useful concepts that allow us to incorporate multiple complex realities into our analysis that will serve as a basis for solidarity work, helping us to avoid the pitfalls that come with overly simplistic approaches to identity politics or relativist (liberal) notions of inclusion (Mohanty, 2003; Harstock, 1983, 2004).

This perspective also draws on intersectionality theory, highlighting the complex and compound nature of oppression (Hill Collins, 2000). It recognizes that systems of oppression rely on each other in inseparable ways, aiding community members to understand how, for example, psychiatric exploitation works with other hierarchies, based on class, disability, gender, and other factors (Hill Collins, 2000). It addresses the erasure and marginalization of particular voices by emphasizing the importance of bringing the voices of those who are currently most marginalized by psychiatry to the centre of our analysis, as it is the most marginalized locations that will elucidate the compound nature of oppression and demonstrate why challenging one part of the system without simultaneously challenging the others is “ultimately futile” (Fellows & Razack, 1998, p. 336). It also recognizes the changing nature of
sanist institutions and takes into account the importance of a historical purview of psychiatric oppression, which clarifies the changing nature of which groups are most vulnerable to sanism and psychiatric oppression in different locations and at different moments in time.

Instead of theorizing this as “intersectionality,” I prefer to use the term compound\textsuperscript{17} oppression, a metaphor that escapes the image of overlapping spaces where, for example, race, gender, and class connect, but can still be considered as separate entities. The compound metaphor I am using is derived from chemistry, a concept referring to “a whole formed by a union of two or more elements or parts” (thefreedictionary.com). I am theorizing systems of oppression that make up what Hill Collins (2000) refers to as the “matrix of domination” as elements that do not exist in the same way without the other elements, which come together in the lives of individuals to form experiences that are unique. Such experiences can only be theorized by looking at them as a whole, as the individual elements cannot account for what they become in any particular constellation in the individual’s life. While I am using a different metaphor, this approach draws on many points that intersectionality theorists have put forth—that any one dimension of identity or experience is infused with all processes that define racialization, gender, disability, class, sexuality, and

\textsuperscript{17} Other theorists have used the term compound to describe concepts that highlight the fusion of various systems of oppression. For example, in a recent article about conceptualizing oppression in educational theory, De Lissovoy (2008, p. 84) describes a compound standpoint as “a perspective that resists the prioritization of singular principles of the social in favor of a focus on their simultaneity and mutual imbrication within historical processes of domination.” Similarly, Makkonen (2002, p. 10) writes about compound discrimination occurring in situations “in which several grounds of discrimination add to each other at one particular instance.” What these theorists have in common is their emphasis on how various systems of domination work in inseparable and simultaneous ways, an emphasis that I have incorporated into the paradigm I present in this chapter.
psychiatrization; that one dimension of power cannot be considered without all of the others; and that all individuals are subjected to these processes that shape their everyday lived experiences in ways that are not always straightforward or obvious.

The paradigm I am suggesting views institutional psychiatry as a tool within the larger “matrix of domination” that helps monitor and regulate those who disrupt hegemonic social relations and institutional processes, while always considering how it responds to people differently based on various dimensions of power. In other words, the threat of being labeled as mentally ill and treated against one’s will foregrounds the analysis and strategy developed within the community; but the importance of paying attention to how the presence of this threat differs in people’s lives, depending on their social locations and individual histories, is emphasized. As such, it also foregrounds how the psychiatric system is shaped by and interacts with other ruling institutions that are likewise complicit in processes such as colonization, capitalism, heterosexism, ableism, audism, sexism, ageism, adultism, and patriarchy. It insists that resistance efforts are based in the recognition that all people are implicated in and affected by psychiatric dominance, drawing on an analysis of how various systems interact with one another to shape the lives and experiences of individuals in diverse ways. It is highly critical of dominant constructions of madness, normality, or sanity, recognizing the flawed nature of simplistic dichotomous and oppositional constructions of difference as “dominant/subordinate, good/bad, up/down, superior/inferior” (Lorde, 2007, p. 114). While every attempt is made to understand and contextualize why some people find essential notions of mad identity to be empowering, this approach rejects any universal claims made about mad people or madness, recognizing that madness is constructed differently in various historical
and cultural contexts, and that there is no real basis of inherent or natural
characteristics that define an eternal mad subject\textsuperscript{18}. It recognizes and values the many
different forms of resistance against psychiatric dominance, but avoids liberal
tendencies that exalt all perspectives and actions as equal, as it analyzes their
particular social, historical, and material foundations, recognizing where various
beliefs and actions come from, while trying to understand where they fit within the
larger comprehensive whole.

This paradigm also recognizes the political and (sometimes) academic nature of
theorizing difference and incorporates a humanistic view that stresses the potential
uniting strength of common experiences which people share across the very
differences that are made central to this approach. While the power relations that
divide people and the heterogeneity of social locations and positions that exist among
us are important to reflect on as we strive to create more inclusive communities, it is
also critical to remember the existential conditions that unite us as people. We all
experience love, connection, grief, anger, hope, and sadness. Many of us are parents,
grandparents, aunts, or uncles. These types of experiences can differ according to
culture and social location, but also have some defining importance that can lead to
connection, perhaps because of their power to break down barriers so that we can see
the humanity of the other more clearly.

\textsuperscript{18} This perspective does not altogether dismiss the critical mad approaches to science
that are interested in developing better understandings of biological processes
associated with different states of consciousness and diverse emotional and
perceptual experience, but rather rejects the overly simplistic biologizing of human
experience and the erasure of social, material, and historical context that is endemic in
psychiatric theory and practice.
All of these principles lay important groundwork for creating conditions that can foster solidarity within and among political communities. It is a paradigm that is open to all people who are interested in fighting back against psychiatric oppression and sanism in their many insidious forms. Yet, it also foregrounds an analysis of power dynamics among community members, based on social, material and historical contexts. Rather than relying on notions of shared experience or identity, the practice of solidarity depends on people choosing to work and struggle together. It places at the centre the values of diversity and difference—"to be acknowledged and respected, not erased in the building of alliances" (Mohanty, 2003, p. 7). Achieving solidarity involves an ongoing process of active struggle "to construct the universal on the basis of particulars/differences" (Mohanty, 2003). Building solidarity requires critical self-reflection about how as individuals, we embody systems of power, as well as a material and historically-based understanding of how others are situated in relation to ourselves, the issues we are examining, and the actions we plan. Very importantly, it recognizes that we all have a stake in resisting sanism and psychiatric oppression and that working across difference can be achieved if we are willing to challenge the very systems that shape our material and subjective realities that keep us apart.

**Practical Considerations for Working Together in Solidarity**

Providing well-developed strategies for operationalizing this paradigm goes well beyond the scope of this dissertation and, in fact, would violate the very principles upon which the paradigm is built. Within the paradigm, strategies could only be developed while having participants from multiple social locations represented in the process from the beginning and throughout. However, throughout
this research, practical suggestions emerged from both community members and theorists that might help facilitate the implementation of the paradigm. These elements of strategies that fit the paradigm are shared here as preliminary sign posts so that they are not lost to the community.

As psychiatric survivors, mad people, and antipsychiatry activists work towards the ideal of creating greater understanding across difference, greater accessibility in their initiatives, and putting forth multiple visions of radical transformation, there are practical steps they can take in building coalitions and in learning about what it means to work in solidarity with other political communities and marginalized groups. For example, community members need to be able to identify areas where people can come together with others who do not share the same ideologies, without assuming that they need to convert others to accept their own analysis. As explained by Reville in an interview,

building coalitions isn’t mysterious. What you have to do is find some common ground and some way to put aside the deal breakers. To say, ya, I know, we don’t agree on that, but we do agree on this.

This means that people do not have to agree on ideology to form specific types of coalitions. For example, antipsychiatry activist and scholar Burstow (2010) has noted that antipsychiatry activists who espouse the ultimate goal of psychiatry abolition should still see the merit in creating non-psychiatric alternatives or resisting the spread of psychiatry in the community through, for example, community treatment orders. Indeed, it would be absurd to argue that the entire psychiatric system needs to be overturned before alternatives can be considered. It is possible and worthwhile to build political coalitions with people engaged in reform work, even those who
currently might be completely uninterested in transformative change, by agreeing on
principles underpinning a mass campaign to resist particular manifestations of
psychiatric violence or sanism. There can be ideological differences within coalitions,
while still working towards eradicating practices that reduce participation of potential
members.

As community members attempt to build coalitions among differently situated
people, they need to remain open to challenging their own assumptions and personal
understandings of the world around them and their ideas of social transformation.
Working across difference requires a certain degree of humility and the understanding
that no one individual knows the complete truth about or the only possible solution to
any given problem. As seen in the present study, sometimes radical activists assume
that people will come to coalition work with a developed political analysis of the issues
being addressed. This will often not be the case, especially in a coalition that
successfully expands its boundaries to include many differently situated people. This
does not mean that there is nothing to learn from differently situated people, even if
they do not have an analysis of what is problematic about psychiatric language or if
they are completely unfamiliar with the community’s many (re)articulations of
identity. They still come to coalition work with reasons based in their own lived
experience, and if their lived experience is different from that of those already engaged
in community work, there is something to be learned on all sides. As differently
situated people come into contact with one another and remain open to others’
different perspectives and understandings about people and society, political
communities will shift and change, just as people themselves will shift and change
when they come into contact with political community (Phelan, 1994). This the beauty
of diversity, to see how our differences bring us to deeper understandings so that we can articulate our universal concerns more fully, and ultimately, more effectively.

Given that psychiatric exploitation works with and reinforces other hierarchies, based on race, class, disability, gender, age, sexuality, and other factors, it is important to bring the most marginalized locations to the centre of any analysis and action planning that is being done within the community. However, psychiatry changes which groups it targets at different moments in history, in different geographic locations, and as such, community members must continuously re-evaluate which groups in society are at greatest risk. Despite our best intentions, our reactions are shaped by survival mechanisms that help us select out the Other and privilege our own experiences. To overcome this phenomenon, the goal of valuing all experiences must be clearly stated and visibly embedded in all actions within the community. In developing analysis or any activity within the community, those who take on leadership must become the guardians of the practice of including marginalized voices in the discussion and equally must ensure that diverse participation is reflected in any outcomes of the analysis or activity. All materials that emanate from community analysis and action should clearly state and demonstrate the objective of hearing all realities and centering those that are closest to the margins. When oppression is lifted at the margins, all oppressed people will benefit.

Accessibility surfaced in this study, in many different ways, as another significant barrier to widening the community and working in coalition across difference. For example, the majority of literature, manifestos, and events associated with the community are steeped in language that is so specific to those already engaged in the community or to those in the academic realm, that they remain
inaccessible to the vast majority of people. The community has only begun to produce
a body of visionary theory written in accessible language to be shared through oral
and written communication. Having a body of simple, straightforward, clear-talking
education materials is basic to getting the word out. Most people in our society are
completely unfamiliar with the ideas emerging from the psychiatric survivor, mad, and
antipsychiatry constituencies, and broader methods of communication must be
created to build a community for everyone. This will be an uphill struggle, as schools,
television networks, and the media more generally are not sympathetic to the
community’s dissenting perspectives. Connecting with people coming from diverse
social locations also requires community members to create materials that speak to
people who are not already engaged in politics. For example, it makes sense to reach
out to people as concerned parents, grandparents, neighbours, teachers, or friends to
appeal to those who are uninterested by or unfamiliar with politicized identities.
Creating accessible ways of expressing our ideas in a multiplicity of ways, all in clear
and easily understandable language, is a very important goal.

Accessibility goes beyond expressing political analysis in ways most people can
comprehend and relate to. It also means finding ways to dismantle other barriers to
participation, including making event fees optional or sliding scale, providing free
childcare and transportation, using wheelchair accessible spaces, providing ASL
interpretation, creating spaces for specific marginalized groups to strategize at larger
events, and, if possible, given the resources available, creating multilingual
environments. These are all small but important pieces in the larger project of creating
accessibility within the community. As identified in the present study, there are major
financial barriers to meeting some accessibility requirements, but it is nonetheless
critical to overcome these barriers, wherever possible, and prove that these are priorities within various parts of the community. There is a lot at stake in the community’s failure to do so. As feminist disability activist and youth advocate Erlich (2011) describes in a recent article,

By not recognizing the responsibility to provide accommodations for a number of disabilities, communities speak strongly about who is truly a member of their community. By planning events without a budget line for accommodations (which I recognize can potentially be the majority of the costs associated with the event, depending on the budget for the event) it indicates that disabled people are not expected to care about these issues, be impacted by these issues and that they have nothing of any value to add to the conversation. It continues to isolate disabled people, and push their agendas, insights and experiences to the margins. It negates the fact that like others, disabled people often hold complex intersecting identities...Where one identity exists, the other is erased. Clearly, community members do not want to strengthen the message that particular marginalized people do not have an important place in the community. Rather, many community members recognize that the disability community shares many obvious overlapping interests and agree accessibility should be prioritized in every way possible. This belief needs to be put into practice more often in order to demonstrate a meaningful commitment to disability liberation in psychiatric survivor, mad, and antipsychiatry practice.

Another problem identified in the present study is that when activists do not have adequate resources, they often bypass self-education in order to move quickly to action. This is understandable in face of the urgency to eliminate the pain and suffering
inflicted by institutions like psychiatry. However, within a paradigm where strength is
derived from understanding multiple social locations, compound oppressions, and the
infused nature of all institutions, including psychiatry, that work together to support
the dominant social order, time must be set aside to first educate ourselves about the
various histories and lived experiences of people who we wish to engage in our
struggles. We must come together and get to know each other and see how we are
mutually oppressed by various social institutions. We must take the time to
authentically integrate various perspectives into the goals and actions that are being
pursued. In this process, we will regularly encounter new ideas and must be ready and
open to listening to and accepting change that comes with expanding participation.
New voices bring diverse ideas, and diversity is strength, but only when all
perspectives are heard and fairly reflected in our message can we effectively carry a
coherent and authentic community message to other political communities in order to
join together in mutual struggle. Many community members speak to the value of
consciousness-raising as one valuable tool for getting to know each other and building
solidarity within constituencies. This expertise is well developed in the community,
can be improved by incorporating the insights shared by participants in the present
study, and can be applied to help build solidarity among various political communities,
locally and globally.

When thinking of doing self-education and outreach to other political
communities, the value of recorded history becomes obvious. In conducting this
research, I learned a lot about the lack of recorded history of the various
constituencies and the community as a whole. The Toronto community rests on a
considerable and significant history but much of this is carried “word of mouth” by the
members who were there and is not always written down for posterity. Eventually, the understanding of perspectives and events will disappear, and the lessons embedded in that early history will be lost to those who pick up the struggle. Each successive generation hopes to build on the successes that have gone before and to avoid pitfalls of the past. The Psychiatric Survivor Archives of Toronto (PSAT) is one very important initiative designed to preserve community history, but its volunteers can only do so much towards this goal when so much of what happens within the community remains unrecorded. PSAT and other initiatives aimed at preserving community history will be much more successful in their mandates if community members take the time to record what has happened and deposit their documents in places like PSAT where future generations can access the information.

Another key insight that emerged in the present study is that “process matters.” Just as it is tempting to overlook education in favour of moving straight to action, it is equally tempting to overlook or to short circuit “process”. Unfortunately, when the discipline imposed by an agreed-upon egalitarian process is lost, unequal power relations flow in to fill the vacuum. Good process requires the valuing of all perspectives, the sharing of all available resources, and a consistent re-evaluation of processes and progress. Equal space, in every respect, is critical to achieving a fair and respectful undertaking and outcome. To keep up morale, it is important to make time to celebrate every victory, no matter how small. The task of eradicating sanism and other systems of oppression is daunting. The goal is definitely long-term given the nature of the times in which it is now being pursued. People need to savour success to restore energy and gain power for the next political step. It is also important that gentleness prevails in interactions with each other within the community and among
coalition members. There are enough harsh critics on the outside to tear us down and deride community goals. Mistakes will be made, and it is important to recognize that in the building of community and coalitions, there is as much to be learned from mistakes as from victories. The important follow-up to any action, even a failed one, is to take the time to analyze it and record both its strengths and challenges. This type of constructive reflection strengthens our actions and builds solidarity – blaming individuals or groups for their mistakes only serves to weaken morale and divide us from one another.

**Putting Ideas into Action**

I hope that the paradigm I am proposing in this chapter, and the paradigms put forth by others grappling with transformative questions, will spark conversation and encourage critical thinking about working across differences within and among political communities. As these discussions unfold, transformative community practice will become clearer and progress.

However, even if community members are inspired to regroup based on emerging critical thought from many different sources, there is much hard work that remains to be done. As we have seen throughout this dissertation, there are blocks that impede transformation. For example, some community members experience a sense of safety from working for change within the existing social order. While people have legitimate strategic and practical reasons for making compromises to reduce the current suffering of psychiatristized people, in a general sense, forsaking the larger vision of social change makes the community more vulnerable to co-optation by the mainstream psychiatric system and capitalist patriarchal interests. The hierarchies
that shape our social world and the desire by some in marginalized groups to achieve respectability make powerful teammates to block transformation. People need to hold onto radical transformative visions in the midst of all these hegemonic dynamics. Even when people find it necessary to collaborate within the psychiatric system to meet the immediate needs psychiatrized people, a lot is lost if it means they give up on the larger vision of what the world could potentially become.

As bell hooks (2000, p. 110) writes, “To be truly visionary, we have to root our imagination in our concrete reality while simultaneously imagining possibilities beyond that reality.” In line with these words, I am proposing that we keep working towards a vision that is based on our commitment to anti-sanist, anti-racist, feminist, anti-imperialist, disability, trans, youth, Deaf, and queer liberation. In some ways, the radical visions developed in different political communities share a lot of common ground, even though the truths of the most marginalized within any given community are often obscured within these visions. Yet, the transformative vision articulated by bell hooks’ (2000, p. 110) feels very familiar to the activist who has crossed boundaries within various political communities. She writes:

the dream...[is] of replacing that culture of domination with a world of participatory economics grounded in communalism and social democracy, a world without discrimination based on race or gender, a world where recognition of mutuality and interdependency would be the dominant ethos, a global ecological vision of how the planet can survive and how everyone on it can have access to peace and well-being.

While this statement can be expanded in many ways, the spirit of hooks’ transformative vision is one that I hope more and more people will embrace as they
come to recognize how human suffering is endemic to the current organization of the contemporary world. The fulfillment of this vision rests upon the eradication of sanism, psychiatric tyranny, and all systems that make up the matrix of domination.

I am optimistic that the community can move towards its goal of engaging others to end the pain and suffering now inflicted on psychiatricized people. My optimism is based in my firsthand knowledge of the commitment of all three constituencies to end the oppression imposed by sanist society that wields psychiatry as a tool. But in addition to psychiatry, there are many tools in the master’s house (Lorde, 2007). The paradigm that I am offering urges us to bring together the whole arsenal of tools, to examine them to gain a better understanding of how they are wielded against us often in combination. We can blunt these tools and even dispose of them by reaching out and embracing all who are injured. By working together we can dispose of these tools forever and in their place create implements to nurture growth where we now have destruction. The knowledge we gain by truly listening to each other and linking arms to save each other can inspire in us the vision and perseverance needed to work together to end sanism and psychiatric oppression and in doing so help transform the racist, ableist, audist, patriarchal, heterosexist, transphobic, adultist, ageist, and classist society that now causes so much pain. I am confident that the community at the heart of this research can use its exemplary strength, experience, talents, and caring to help carry us towards the realization of transformative visions of peace and well-being for all.
Suggestions for Future Research

Moving forward from this research, there are many directions researchers can take in developing important and groundbreaking projects that have the potential to spark social transformation. One suggestion I would like to make here is the development of a participatory action research project beginning with the central priorities outlined within each constituency to come up with a paradigm and plan for future action rooted in the goals and aspirations of community members. Given the positive experiences resulting from my use of Freirian methodology, as well as those of Burstow who also used this methodology with an incarcerated population, I would highly recommend using Freirian codification groups in future research projects. It is a methodology that has the potential to draw on the creative talents of oppressed people and foster critical dialogue about structural oppression and possibilities for social change that can have concrete positive effects in the lives of marginalized people. Most importantly, I strongly suggest that within the development of any future projects, researchers make concerted efforts to bring the voices closest to the margins to the centre of their projects in order to help remedy current hegemonic power relations. While I do not believe that I always lived up to this tenet in the present study to the extent possible, my experiences as a scholar and activist in the past several years have led me to make this a high priority that will remain so in all of my future work, as it is clear to me that what is in the best interests of those most oppressed is in the best interests of all of humankind and the earth itself.
Chapter 8: Study Implications for Clinical and Counselling Psychologists

This final chapter addresses clinical and counselling psychologists, bringing forth key themes and questions for consideration, based on rich and complex understandings emerging from the Toronto-based community comprised of psychiatric survivors, mad people, and antipsychiatry activists. In my work as a researcher and community member, I have gained valuable insights that have shaped who I am as a psychologist and human being, and I believe that the ideas, initiatives, and visions that are emerging from this community can play a critical role in shaping how other professionals work as well. At the same time, I am aware that psychologists who read this dissertation will likely come to a diverse array of conclusions and solutions, many different from my own. I hope that this chapter can spark conversation within the professional realm, as regardless of what the readers’ beginning assumptions are or where their beliefs end up, I am certain that the ideological perspectives and initiatives described in this dissertation will inspire critical reflection on various issues surrounding the theorizing and treatment of mad people in the psy-complex. I recognize that while this dissertation has presented many moving experiences and compelling viewpoints, it has not given much attention to evidence-based arguments, outside of those presented by participants. In this sense, the present study is not meant to prove or disprove any particular viewpoint, but rather shed light on a complexity of factors that formulate various positions within the political community. Nevertheless, regardless of one’s personal beliefs about madness and its causes, the words of participants clearly and irrefutably demonstrate that some
people feel harmed by psychiatric interventions, and some find a more comfortable place in the world after coming into contact with non-psychiatric alternatives, alternative support networks, and political community. If these assertions are accepted as truth, then it is incumbent on us as psychologists to figure out how we can use the community as a resource for people, consider how we ourselves might get involved with the community in ways that resonate with our personal beliefs and values, and grapple with how we can incorporate key insights emerging from the community into our practice.

**Connecting with Community**

In the present study, people from many different social locations tapped into the political community, contributed in different ways, and derived benefits from their participation. Likewise, there are a number of different levels at which psychologists and the people with whom we work can engage with this community. How and the degree to which we get involved will largely depend on where we stand personally and politically *vis-à-vis* the various issues being addressed. I will begin this chapter by exploring some of the ways psychologists can draw on the community as a resource for people and include important considerations when making these community referrals, and then move into a discussion about how psychologists might wish to get involved more directly to support or create various types of community initiatives.

**Helping People Establish Connection With Community**

As seen throughout this dissertation, finding community can be a life-changing experience for psychiatrized and mad people as they forge meaningful connections with others who have experienced sanism and psychiatrization. When psychiatric
survivor and mad participants spoke about what helped them most when they were in distress, they often referred to experiences of meeting others who believed in them, who respected them, and who did not blame them for the oppressive conditions in their lives. Many found comfort in being with others who were less likely to judge them because they too had experiences with the psychiatric system and also faced the stigma of being psychiatrized and treated as mad. The community offered psychiatric survivors and mad people forums to celebrate, share stories, and create art. In many cases, people found alternative support systems that became integral to their sense of safety in the world. Others found housing or employment opportunities that were more accommodating to their needs and where they did not have to hide. The potential for establishing mutually beneficial relationships and finding activities, employment, housing, or alternate care are important reasons why psychologists might choose to share knowledge about the community with others. Many participants in the present study also derived significant benefits from getting involved in direct political action opposing ideologies, laws, and practices that they viewed as oppressive in their lives. Some of the people with whom psychologists work might similarly derive such benefits and have an interest in getting involved in political actions and events.

There are many ways psychologists can facilitate connecting people with the community in both direct and more indirect ways. For example, more indirect methods might include putting up posters or laying out literature advertising community initiatives, events, or employment opportunities, or keeping books in the waiting room that include community literature. Psychologists might also wish to post events or links to community resources on their websites or in their resource
pamphlets. These types of indirect actions can help raise awareness that this political community exists, indicate that the psychologist is open to what this community has to offer, and might inspire discussion in session about how people can benefit from community engagement. Some people with whom we work might not be interested in making direct contact with the community for a variety of reasons, but even in such situations, people can benefit from coming into contact with narratives and ideologies emerging from the community. For many participants in the present study, literature or online media was their first way of connecting to the community, sometimes before they were ready to engage in more tangible ways, and this too played a very powerful role. Reading the narratives of others helped to validate their own experiences and externalize some of the problems that they had previously believed were an internal and defective part of themselves. Even without the physical presence of others, community literature and media can help people to feel less alone in the world. In situations where the psychologist has a strong sense that specific initiatives or events might be of particular interest to a person, it might be appropriate to take a more direct approach, for example, by discussing directly resources you think might be beneficial or by exploring how the person might tap into community initiatives.

When making direct referrals to community groups and resources, it is helpful to consider the vastly different approaches associated with the psychiatric survivor, mad, and antipsychiatry constituencies. For example, if we believe a person might benefit from a peer support group organized around the experience of hearing voices, it is probably makes sense to connect them with mad organizations associated with groups like Intervoice. If a person has undergone traumatic experiences within the psychiatric system and feels alone in what they have gone through, it might make
more sense to refer them to a psychiatric survivor peer support group. If a person is
outraged by the ways they have seen people treated within the psy-complex, or they
have had negative experiences and are ready to take action aimed at systemic change,
they might benefit from joining an antipsychiatry activist group. If a person is in need
of survivor- and mad-friendly housing or employment options, they might find useful
resources at consumer/survivor agencies. If a person is primarily concerned with
experiences of trauma and oppression that led them into the psychiatric system,
rather than what they experienced in the psychiatric system per se, they might want to
explore what types of feminist anti-violence initiatives are happening.

There are many perspectives, initiatives, and resources in the political
community designed to serve a range of experiences and needs. To make helpful
referrals, it is important that psychologists have a sense of what is happening across
the various community constituencies so that we can match people’s needs to what is
available. Psychologists can stay up-to-date with what is happening in the community
by joining listservs, subscribing to magazines and newsletters, and checking the
websites of key community organizations. The community is in a constant state of
transformation, and so it is important to update our knowledge of community
resources on a regular basis.

**Professionals in Direct Action**

Not all psychologists will want to invest time and energy into direct
involvement in the community, and some will not agree enough with the goals of
specific initiatives to get involved, but for those who are interested, there are many
opportunities for psychologists to support the initiatives of psychiatric survivors, mad
people, and antipsychiatry activists or to create our own initiatives in which community members can get involved.

During the period of my data collection, I observed psychologists and other helping professionals support community priorities by participating in a variety of ways. For example, at the 2010 PsychOUT conference, psychologist Dr. Rosemary Barnes collaborated with psychiatric survivor Susan Schellenberg in putting on a workshop exploring how art can be used as resistance against psychiatry. At the event Inquiry into Psychiatry in 2005, psychologist Dr. Roy Moodley volunteered as a panel member for the hearings on electroconvulsive therapy and helped write the report, *Electroshock Is Not an Healing Option*, which contained dozens of recommendations for municipal, provincial, and federal governments. Psychologists have at times also joined professional organizations that support community social change priorities. For example, in 2011, psychologists Dr. Roy Moodley and Dr. Brenda LeFrancois joined an international speakers’ bureau of professionals opposing the use of ECT, Healthcare Professionals Against Electroshock, shortly after it was founded. The professionals involved in this anti-ECT group joined together, because they recognized the need to put forth in the media professional perspectives other than those of pro-ECT professionals.

Many psychiatric survivors and mad people welcome, sometimes with cautious reservation, support from progressive professionals, but as seen throughout this dissertation, there are power dynamics that enter into collaborative efforts that need careful consideration. Radical professional Burstow (2004) warns that the very status that professionals can use to support community initiatives comes from hegemonic
power dynamics that shape the oppression of psychiatrized and mad people’s experience. She points out that, “given societal oppression and therapeutic hegemony, 

1. Our opinions as clinicians are generally over respected.

2. The opinions of survivors are generally underrepresented and often downright dismissed.” (Burstow, 2004, p. 149)

The power differential between professionals and psychiatrized and mad people, to which Burstow (2004) refers, are grounded in dominant cultural values, as well as in differences in social and economic capital. Dominant culture is infused with the belief that the “mentally ill” are different from “us,” the “normals,” or the “professionals.” These are, of course, false divides in many ways. While few psychologists feel free to openly disclose their experiences, many have gone through periods of intense personal struggle, and some have been psychiatrized themselves (Bassman, 2001). Regardless of what we may or may not have in common with psychiatrized and mad people, the material benefits and social capital that most psychologists can access and that most psychiatrized and mad people cannot are real and need to be accounted for in collaborative actions. There are a number of steps we can take towards at least starting to equalize these dynamics. For example, we can play supportive roles in community initiatives, offering our titles as psychologists to facilitate psychiatric survivor or mad groups receiving grants, without imposing our own perspectives about what should be done and how. We can use our social and economic capital to secure resources that are beyond the reach of the community. We can use our credentials as psychologists by putting our names to demands aimed at changing unjust mental health laws and practices. We can support the anti-poverty work of
political communities advocating for better access to education, employment, and affordable housing.

As psychologists, we can also challenge policy- and program-making bodies to include community representatives in any initiative originating from our profession. However, it is important to pay attention to how this is done in order to avoid tokenizing marginalized individuals or projecting an inauthentic voice onto oppressed groups. As seen throughout this dissertation, many professional initiatives currently include consumers in their projects so that they appear accountable to psychiatristized people. However, in doing so, they fail to listen to the multiplicity of voices emerging from the community or they resist incorporating understandings that challenge their fundamental frameworks, which are most often psychiatric in nature. When creating policies and programs that are meant to be more accountable to differently situated people, it is necessary to include in the process psychiatristized representatives from many different social locations. Another approach entails psychologists seeking direction from psychiatric survivors and mad people and using this input to pursue new policy change or program development, thereby using our status as psychologists to advance the agendas of marginalized people through joint actions. In these types of initiatives, it is critical to prioritize the realities of those who are at highest risk of psychiatristization, while at the same time considering the complex multiple realities of all those invested in these struggles.

Critical psychologist Prilleltensky asks: “Can professionals partner with citizens in fostering strengths, prevention, empowerment, and changing community conditions?” He presents this as a challenge, and what I am suggesting is that we can find many meaningful ways to connect with, support, and draw on the community in
our work. Some psychologists will choose to engage in community action on an ongoing basis, particularly those who identify strongly with one or more of the constituencies, but we can also tap into specific initiatives that resonate with our personal and political beliefs for finite periods of time. It is important to realize that providing support to community initiatives does not necessitate acceptance of specific ideological or political commitments emerging from the community. For example, psychologists might support the anti-ECT campaigns of antipsychiatry activists without agreeing with the long-term goal of psychiatry abolition; they might provide space to peer support groups for people who hear voices without conceptualizing hearing voices as simply a part of human diversity to be accepted; or they might oppose community treatment orders, because they are against coercive intervention, while believing that psychiatric drugs are beneficial to most people who are given these legal sanctions. It is up to us to consider and evaluate various issues related to our profession and that have direct impact on the lives of psychiatrized and mad people and decide how we want to act.

**Emerging Questions for Clinical Consideration**

At this precise time in history, confronting and challenging prevalent medical discourse in our field is a particularly challenging feat. We are in a political climate where interventions that are plugged into the money-making pharmaceutical industry, promising the fastest results, are favoured over longer term individual, interpersonal, and community-based solutions (Whitaker, 2002; Marsa, 1997). Yet, many psychologists are asking questions about prevalent trends in the discipline, and psychiatric survivors, mad people, and antipsychiatry activists have many important
perspectives to bring to the current debates. For example, in the present study, community members shared sophisticated and nuanced insights about the effects of forced interventions and coercive treatments; the social and economic problems faced by marginalized individuals; the impacts of poverty, racism, sexism, ableism, audism, ageism, and other compound oppressions; and the suppression of diverse ways of coping with and processing events in the world. Grappling with the multiplicity of perspectives emerging from the community only has the potential to make us better at our work and bring us closer to identifying what needs to be done to meet the real human needs of the questioners.

**Thinking Critically about Madness and Problems in Living**

In the past few decades, mainstream psychology has come to embrace the medical model – a model that conceptualizes emotional, perceptual, and behavioural experiences, such as hearing voices or instances of human suffering, as symptoms that indicate some type of neurobiological malfunction (Honos-Webb & Leitner, 2001; Newnes, 2004). In contrast, psychiatric survivors and mad-identified participants in the present study were clear that medicalized definitions of their experiences do injustice to the complex dynamics that shape their lives. During the time I have spent in the community, I have observed people refer to the medicalization of human experience on two levels.

The first level is the medicalization of people’s reactions to oppression and trauma, which occurs when people have difficulty functioning in the ways they are expected to because of oppressive conditions in their lives. One example that illustrates this is the story of Blaser (2011), a young Deaf woman who was
psychiatrized after contacting the police to report a stalker. The police came to her home and found her hiding in her bedroom closet, an enclosed space that made her feel safer as she waited for the police to arrive. They asked her how she communicated with her stalker, and when she indicated that she communicated with him by using her voice, they misconstrued what she was saying and reported that she was hearing voices. They brought her to a psychiatric hospital, where a psychiatrist took the police report at face value, decided that she was having a psychotic episode, and neglected to consider the fact she may actually have a stalker. The way Blaser demonstrated fear, accompanied with the assumptions the police and psychiatrist made about the inability of a Deaf woman to communicate orally, led them to believe that she was delusional. She was committed, given a diagnosis of schizophrenia, and forcibly drugged. The intervention she was subjected to when she reached out for help taught her that it was not safe to turn to the police or to mental health professionals when she is in distress and in need of help, as they will only impose more harm in her life at times when she is in clear and imminent danger (Blaser, 2011).

The second level is the medicalization of how people experience and process the world around them in a wide range of ways without considering the naturally occurring diversity in human cycles and processing. For example, within the psychiatric paradigm, hearing voices is viewed as a psychotic symptom. In contrast, Intervoice, a global hearing voices organization, asserts that somewhere between 4% to 13% of people hear voices that others do not and that hearing voices is simply a part of human diversity, despite the fact that this experience is stigmatized in many parts of the world. Starkman (2010), an elderly Jewish man and participant in the present study, shared in video format his experience of hearing voices, which he now
views as part of a spiritual experience that plays both challenging and helpful roles in his life. He states:

The first time I heard voices was in 1993. The voices followed me everywhere. They were mostly in German. Mainly it was Hitler’s voice. I would hear Hitler’s voice loudly and audibly all the time. He would scream at me in guttural English, in German, and even in Yiddish, “Bang your head against the wall, Mel!... Filthy Jew!” It was a long arduous process to recover, which started with a nightmare when I was incarcerated in a psych ward. The nurses’ response to me when I woke up screaming was: “It’s just a dream. Get over it, or I’ll up your medications.” In over thirty years in the system, I was always patronized and oppressed. I realized the voices were the internalization of self-hatred. To cope, I tried many things. Some worked, and some didn’t... I focused on reading, social justice, being a survivor activist, and connecting with friends and peers. As an antipsychiatry activist, my passion was to help others. I would spare them the torture I had endured, and in the process, become a better person... I realized that in the frame of reference of the voices, there were good ones and evil ones, and I could choose which to turn on, which ones to listen to, and which ones to ignore. In truth, the counter changing force was when I interpreted it as a spiritual presence operating in my best interest. God. If I could help someone, I am helping myself and the whole world. Hope brings the dream in my life. My mantra now is cool, calm, collected, reasonable, and conscious. There is hope for all who hang in there. If I can do it, you can.
Starkman found positive meaning in his life through developing his own narrative about his voices, rather than by accepting the medicalized definition and physical interventions forced upon him within the psy-complex.

There are countless stories in the community at the heart of this dissertation similar to those of Blaser (2011) and Starkman (2010), in which human diversity and different responses to real events in the world were decontextualized and conceptualized as illness. Most participants criticized the medical conceptualization of their experiences, arguing that this approach ignores violence, oppression, and differences among human beings. Participants placed importance on understanding personal experiences within the context of structural hierarchies, compound oppressions, interpersonal relationships, family dynamics, support networks, community, personal and community history, and learning to (re)articulate narratives and identities constructed on one’s own terms - terms that make sense in the circumstances of the individual’s situation.

This study did not uncover any one true definition of madness, and in fact, no two participants conceptualized what they recognized as madness or problems in living in exactly the same way. They did, however, describe a diversity of meanings that had particular significance in their individual lives and in the larger community and that can be traced back to some common sources of oppression. The perspectives they put forth and the questions they asked led me to more questions for psychologists to consider: What would it mean to acknowledge diverse human experiences as part of the natural range of experiences that occur among us without labeling them as pathological? How would it change clinical and counselling work to explore the meaning of alternative experiences of reality or different processing experiences
rather than to try squelch them with drugs? What are the implications of recognizing how experiences of violence, abuse, and oppression affect marginalized people in our work? No one dissertation or one person can answer these questions. But these are real questions that are derived from concerns voiced by psychiatric survivors and mad people – the very people we hope to support. If we grapple honestly with these questions and enter into our work with an openness to people’s experiences and perspectives of self and the world, we will be in a better position to support them. It is important to always be attuned to the individual and remain cognizant of the many unique ways that systems of domination play out in individual lives, of the diverse ways people cope, and of the strength and resilience of marginalized people.

**Responsibilities as Resource Person**

Determining what will help an individual to feel better in the world often involves a long journey of self-reflection, exploration, and changes in external conditions. It is evident from the diversity of views represented in this dissertation that some people will not choose to work with psychologists at all in their journey, whether this is because of past negative experiences or because what they are seeking can only be offered through a more collective experience. However, there are also many oppressed people who view therapy as an important part of their journey, and it is important for these people to be able to find psychologists and other professionals who are receptive to their counter-hegemonic understandings of self and the world. When psychiatrized and mad people come to us for support, there are special considerations for us to think about associated with issues related to information, consent, and safety.
Many people turn to psychologists for answers about what they can do to feel better in their lives. Yet, psychiatric survivor and mad participants in the present study emphasized the power that came with the realization that they were the experts of their own lives, not professionals. Knowing that no one answer is true for all people, and that professionals cannot know with certainty in advance what will help, it is critical to aid people in coming to this realization and support them in their exploration of what decisions are best for them. At the same time, as professionals, we are expected to have expert knowledge about various approaches, and as such, it is important that we keep aware of alternatives, including community-based alternatives, and share information about various approaches. We also need to keep aware of the interventions commonly used within the psy-complex, such as psychiatric drugs and other types of procedures, so that we can understand how people’s experiences are affected. Regardless of what resources we offer, people have many ideas about what they should do to cope with their situations, and many are already on psychiatric drugs when they come to us, and so it is important that we are knowledgeable about the possible effects of various interventions so that we can share this important information as needed.

In the present study, community members shared many different viewpoints about various interventions, reflecting their vastly different responses to them. For example, one person might find relief in taking a (prescription or non-prescription) drug as a coping strategy for some time, while another person might experience unbearable and sometimes irreversible effects from the same drug (Breggin & Cohen, 1999; AGIDD-SMQ, 2003). Their reactions are not contingent on being given a particular diagnosis, nor the specific cause of their distress, but rather are shaped by a
wide variety of factors, internal and external to the body, that make it impossible to predict ahead of time what the consequences will be (Breggin, 2008). There are always risk factors involved in trying out different approaches, albeit different types and degrees of risks. For example, there is risk of experiencing discomfort or flooding when speaking about traumatic experiences with a professional, and there is risk involved in taking a drug that is known to cause suicidality in some people (Burstow, 1992; Herman, 1997; Breggin, 2008). The people we work with need to know about these risks and what we, as professionals, can do to help create safety as they explore various options.

In addition, people who access resources outside of their work with us, either with other professionals or within the community, can benefit from learning how to advocate for themselves in strategic ways. As stated by participants in the present study, many supports available in the community are connected to the psychiatric system, and therefore, when psychiatrized and mad people go to access these services, they are entering into realms where they are at risk of further psychiatrization. As professionals, we can use our knowledge of the psy-complex to impart to others information about how to navigate these systems and resources more safely, for example, by helping people understand how they can get into trouble with limits of confidentiality or the Mental Health Act. Burstow (2002) points out that it is important to help psychiatrized and mad people gain skills assessing how others are likely to respond to how they express themselves or cope. For instance, if people speak metaphorically about how they wish to kill themselves to express their desire to escape distressing experiences, it is important that they understand how others might interpret this as grounds for committal. Being empowered with this knowledge can
help them express themselves in strategic ways and to get the supports they need without putting themselves at higher risk of unwanted intervention.

Ultimately, I view it as our responsibility as psychologists to support the people who access our service to come to decisions that feel right to them, while maximizing their safety to the extent that we can. Regardless of any preconceived ideas we have about what people might benefit from, it is ideal to take direction from people themselves, particularly psychiatric survivors and mad people who routinely have power taken away from them, while acting as an information resource and teaching and encouraging critical research and reflection skills.

**Ethical Questions Relating to the Right to Choose**

One central value shared by all participants in this study was rooted in having choice in what happens when they seek out various approaches to feel better in the world. They were unanimously opposed to coercion or forced intervention in the psychiatric system and stood solidly opposed to laws and practices that further compromise control over what happens to one’s own mind and body. In the words of Nat, “there can be no forced healing or recovery.” Yet there are particular situations where, by law, professionals are mandated to report, such as when a person is deemed to be a danger to themselves or to others (Service Ontario, 2010). These legal imperatives touch on ethical questions that we must grapple with as psychologists – at what point, if any, should a person’s freedom to choose be taken away? Should people have the right to kill themselves? In considering these questions, it is critical for us to make a distinction between experiences that are pathological according the psychiatric paradigm and those which pose a real physical threat to others. No
participants in the present study suggested that anybody who poses a real threat to others should be free to assault, rape, or kill. What they did address was the stigma and fear attached to people labeled as mentally ill which can lead others (including psychologists) to assume threat where none really exists. Hope pointed to empirical research that demonstrates that those labeled with mental illness are no more likely to commit violent acts than those who are not labeled (Grohol, 2004), and yet, despite this evidence, psychiatric survivors and mad people described many instances where stereotypes of mad people led to their institutionalization or other forms of restraint.

What does all of this mean for our clinical practice? What questions must we ask ourselves when we are contemplating the commitment of an individual? What does this mean in our work with people who are on community treatment orders? Or for those who have been told they will end up back in the institution if they do not comply to the treatment prescribed to them by their doctors? Psychologists need to weigh out the issues and come to what they believe is ethical. On the one hand, incarcerating people can restrain them from harming themselves or others while the restraint is in place. On the other hand, many psychiatric survivors and mad people state that coercive interventions do not further one’s journey towards feeling better in the world, but rather further traumatize, harm, and shatter trust.

Psychiatric survivor and mad participants discussed at length resources outside of the psy-complex that have improved the conditions in their lives, and often, helped protect them from re-incarceration and forced psy-interventions. What can we do as psychologists to help people discover the resources in their lives? As a beginning point, it seems wise to discuss preventative measures that will help protect psychiatrized people from unwanted intervention in the future (Burstow, 1992; 2002).
They might list community resources that have been helpful to them when they have been in crisis. They might decide to choose whom they want as support people in their lives if they become overwhelmed, discuss with these people what they want them to do, whom they do not want to be involved, what supports they have found helpful, and what they do not want to be repeated. Janes, Poulin, & Richard (2005) suggest developing written contracts with others to help ensure that they have adequate supports in place before their right to choose is taken away. This type of exercise can help people identify sources of power and support in their lives, as well as oppressive conditions, including interventions prescribed by professionals that they want to avoid (Hagan & Smail, 1997; Newnes, 2004; Burstow, 2002; 2004). The safety plans people develop will be specific to their own lives, but the principle of preparing vulnerable people for possible foreseeable intrusion can help us avoid the ethical conundrums that often lead to far worse situations.

There are many issues addressed by community members in the present study that leave us with questions to grapple with as professionals. There are many poignant experiences and nuanced positions emerging from the community that challenge us to think critically about dominant trends in psychology. I know that during my time in this community, as an activist and researcher, I have had to face many hard questions, and I expect to face many more ethical conundrums as I continue in my work. The struggles we face test us as ethical people who care and who want to do what is best in the world. However difficult, facing these conundrums is necessary in our work if we wish to be resourceful professionals who can be trusted by those who have been harmed by the psychiatric system and other sanist institutions.
**Psychological Work in the Bigger Picture**

The work we do with individuals can have a significant and positive effect in people’s lives, but it is only a small part of a much bigger picture. As critical psychologists Prilleltensky and Prilleltensky (2003) write:

Helping people to enjoy life is a most worthy goal, one that we fully support. But as with any single value, wellness cannot stand on its own... Wellness cannot thrive in conditions of inequality and injustice. The impact of poverty, marginalization, exclusion, exploitation, and injustice is just as deleterious to the body as it is to the soul. To ignore this evidence is to pretend that psychological interventions can be potent enough to undo the damage of structural inequality as expressed in deficient health services and employment opportunities for the poor. We think practitioners can afford to be humbler and admit that psychological interventions are not that powerful.

Taking on this challenge, however, particularly in a way that targets the hegemonic medical model in psychology itself can be intimidating. I would like to acknowledge that as an insider to the discipline of psychology, I have both witnessed and experienced the immense pressures we face as professionals to accept, without much question, psychiatric conceptualizations and practices. This pressure stems from psy-industries that have become enmeshed in law, education, healthcare, social assistance, and other parts of government. This problem is structural and cannot be fixed at the individual level.
Let us take training programs for psychologists as an example. The education system that all future psychologists go through is shaped by standardized curriculums approved by accrediting organizations, such as the American and Canadian Psychological Associations, which have a vested interest in protecting the prestige of the discipline by closely associating with psychiatry, medicine, science, and related major funding sources. These organizations set standards that largely fall in line with dominant psychiatric conceptualizations of human emotion, processing, and behaviour, because they want to ensure the viability of the profession, by ensuring that psychologists are utilized by state organizations and granted the status of expert professionals and scientists in the public eye. As clinical and counselling psychology graduate students, we are required to take courses that train us to conduct assessments in line with the psychiatric paradigm and are expected to complete internship placements in the psychiatric wards of hospitals, even if this is not where we envision ourselves working in the long-term. We learn very little, either in the classroom or in internships, about the perspectives of psychiatric survivors, mad people, or antipsychiatry activists. By the time we complete our graduate degrees and prepare for registration as psychologists, we are intimately familiar with the medical model approach and key psychiatric texts, such as the *Diagnostic and Statistical Manual*. By then, we have witnessed at least some of the effects of physical psychiatric interventions. Yet it is so easy to witness experiences of psychiatric oppression and, using the medical lens of our training, to interpret the resistance of psychiatricized people as “symptomatic” of their “illnesses.” Such interpretations are common within our profession, perhaps because well-meaning professionals have so few alternatives to working in settings where psychiatric oppression and sanism are widespread and
rarely, if ever, talked about. Those who remain aware of the oppression of marginalized people in the psy-complex often have difficulty getting through to complete their degrees; some feel that their choice is either to leave the profession or face ongoing ethical trials for years before earning the right to call themselves psychologists.

While there are psychologists who are involved in resistance against this, the trend in psychology in North America and many other places around the globe over the past few decades has been going in the direction of biological psychiatry. The industry that dissenting psychologists are up against is enormous and powerful, and therefore, it is necessary to forge stronger links with others who share our concerns about how humanity is being conceptualized and intervened with in the contemporary psy-complex. It is my hope that the positions and experiences of participants in the present study stir up enough cognitive dissonance to stimulate more critical discussions in our profession, perhaps leading some psychologists to consider this direction. I know that the vast majority of us become psychologists to support people who are suffering and in no way wish to inflict any harm on others. Yet, I also believe that many professionals do inadvertently participate in harming people, even if only by remaining silent while other professionals limit people’s right to self-determination and choice. There is no way to turn this around without being bold enough to face the experiences described by psychiatrized and mad people that are commonplace within the institutions where psychologists work and join efforts to create change at the structural level. From my vantage point, it is not enough to simply do our best with the individual people with whom we work; to create lasting systemic change, we have to
be willing to stand up against prevalent tendencies within our profession. Such a challenge is scary business, but in my opinion, critical and urgent.

The details of the challenge that I am posing are, of course, beyond the scope of this dissertation. My hope is that future theorizing takes up this challenge on both individual and systemic levels. I end with the voice of one of my participants, Jackie, to light our path:

I dream of a world that is more caring, based on mutual support... [with] better options so that there is a place of dignity for all of us. I want the humanity in all of us recognized... I am against the medicalization of everything... we have to stop inventing disorders for every human experience that challenges the status quo... I dream of a world where people can peacefully co-exist... [where] differences are accepted... [and where] I and everybody else has a place.
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Appendix A: Codification I
Appendix B: Codification II
Appendix D: Demographics Form

CONFIDENTIAL
Demographic Information

Name: ________________________________

Contact Address: ________________________________

________________________________________

Telephone: ________________________________

E-mail: ________________________________

Age: ____________

How do you describe your identity in relation to psychiatry?
(e.g. psychiatric survivor, mad person, consumer)

________________________________________

How do you describe your affiliation with the psychiatric survivor, mad, and antipsychiatry community?

________________________________________

How do you describe your gender or sex?
(e.g. woman, man, transsexual, transgender, Two Spirited, queer...)

________________________________________

How do you describe your sexuality or sexual identity?
(e.g. straight, bisexual, queer, lesbian, gay, Two Spirited...)

________________________________________

How do you describe your racial or ethnic identity?

________________________________________

How do you describe your socio-economic or classed identity?

________________________________________

Do identify as being disabled or having a physical impairment? If so, please describe.

________________________________________

Do you identify as having any other disability/ies? If so, please describe.

________________________________________

Do you belong to any other group that you feel is discriminated against in society?
If so, please state which group.

________________________________________

Pseudonym: (Please suggest a name you would like me to use to maintain your anonymity)
Appendix E: Focus Group Poster

Looking at Psychiatric Survivor, Mad & Antipsychiatry Activism

Sunday, September 28th, 1-3 P.M.
252 Bloor St. W., 7th Floor Peace Lounge

Open to all Survivors, Mad People, Activists, Artists & Professionals

Involved in Community Activist Work

A focus group about psychiatric survivor, mad & antipsychiatry activism, the strategies we've used, the successes we've won, the challenges and obstacles we've faced.

This focus group is part of Shaind Diamond's research project about goals in the psychiatric survivor, mad, and antipsychiatry community and the obstacles that get in our way. This research study is being conducted under the auspices of the University of Toronto.

Free food and beverages will be served. Vegan friendly.

This event is wheelchair accessible.
Appendix F: Freirian Codification Group Poster

PSYCHIATRIC SURVIVOR PRIDE PRESENTS
RESISTANT ART:

UNDERSTANDING & EXPLORING
PSYCHIATRIC OPPRESSIONS
SUNDAY, SEPTEMBER 28TH, 10-12 P.M.
252 BLOOR ST. W., 7TH FLOOR PEACE LOUNGE

WORKSHOP OPEN TO PSYCHIATRIC SURVIVORS AND MAD PEOPLE
A workshop using art to explore what is blocking psychiatric survivors and mad people
from meeting hopes and aspirations, an opportunity to think collectively about what
needs to be done to change oppressive conditions in their lives.

This workshop is part of Shaniidi Diamond’s research project about psychiatric survivors,
mad and anti-psychiatry empowerment and resistance work. This research study is being
conducted under the auspices of the University of Toronto

FREE FOOD AND BEVERAGES
WILL BE SERVED. VEGAN FRIENDLY.
THIS EVENT IS WHEELCHAIR ACCESSIBLE.
Appendix G: Focus Group Information/Consent Letter

Dear Prospective Participant,

My name is Shaind Diamond. You might know me from my work with the Coalition Against Psychiatric Assault or my involvement in events within the community. I am inviting you to consider participating in a focus group called *What was, what is and what will be Looking at psychiatric survivor, antipsychiatry, and mad organizing and action*. If you are not interested in participating, please do not worry for my sake, as this will cause me no difficulty.

The purpose of the focus group is to identify goals within our community, activist and artistic strategies used to meet these goals, the successes resulting from activist work, as well as the obstacles and challenges encountered. I have included with this letter a list of questions that are similar to the types of questions that will be discussed in the group to give you an idea of what to expect at this event. This group will last for around two hours and will include approximately 10 participants who are survivors, mad people, activists, artists, and radical professionals involved in community activist work.

The focus group is only one part of a larger research project. The larger project, called *Surviving Psychiatry: From Individual Trauma to Collective Empowerment*, is examining goals coming out of our community, how these goals are connected to the everyday experiences of psychiatric survivors and mad people, and obstacles that are preventing people in our community from meeting goals of healing, empowerment or systemic change. I am hoping to come up with a comprehensive analysis of the institutional blocks and social relations, individual psychological factors, and gaps in knowledge or skills in strategic activism that block community goals.

For the purposes of this research, I am framing our community as a diverse group of people who come together from different experiences and social locations. What we have in common is a shared sense of belonging together, in opposition to institutional psychiatry and mentalist culture, and an understanding that the oppression faced by psychiatric survivors and mad people is at the forefront of community concern.

As an antipsychiatry activist, I am interested in this research, because I want to contribute ideas about how psychiatric survivors, mad people, and activists can move closer to meeting our goals. I am conducting this research as a student of the University of Toronto as a requirement for my doctoral degree in counselling psychology. This project is being supervised by Dr. Bonnie Burstow, a faculty member in my department at the university, who you might know from her involvement in the antipsychiatry movement over the past several decades.

This is an opportunity for you to participate in a group aimed at developing a better understanding of successes and challenges in our community. This might be of interest to you as an activist who is committed to meeting movement goals and gaining insight into how we can improve strategies and approaches in collective resistance.
While I do not expect that this will happen, there is a risk that some participants will find aspects of the group discussion to be upsetting. If you find yourself needing to talk about what has come up for you in the group, I will be available to talk afterwards. In addition, an experienced counselling professional, who is involved in the antipsychiatry movement, will be available to talk to you during or after the workshop. Please let me know if you need support after the group, and I will direct you to the support person and provide you with a list of referrals for free or low-cost counselling and peer support resources.

The information collected in this study will be posted online at _______ and may be included in future publications or presentations. Your name and other information that might identify you will not appear in the group transcripts, the final report, or any future publication or presentation. I will ask you to fill out the demographics form, requesting your contact information and information about your social location. The information in this form will be kept strictly confidential. You will be given the opportunity to choose a pseudonym to represent your contributions in the research. If you do not choose a pseudonym, I will choose a name to represent you.

In order to protect each person’s right to privacy, I am asking all participants, including you, to respect confidentiality of other group members. This means that personal information that is shared in the group should not be discussed outside of the focus group. At the same time, I cannot guarantee that all participants will respect this agreement.

The group session will be audiotaped and transcribed, and the information collected in this group will be used for the purposes of my thesis research. The only people who will have access to original data are me, my thesis supervisor, Bonnie Burstow, and a research assistant, who is also a member of our community. The audiotapes and original transcripts will be kept in a locked filing cabinet in my home and will be destroyed upon completion of the study.

You have the right to withdraw from this study at any point during the research process without any negative consequences. To do so, please contact me by email or telephone, at _______, or Bonnie Burstow, at _______. You may also contact the Ethics Review Office at ethics.review@utoronto.ca or 416-946-3273 if you have any questions about your rights as a participant.

If you wish to participate in this workshop, please sign where indicated at the bottom of the page, after you have read and understood the information in this letter and you have been given a copy of this letter for your reference.

If you have any further questions or concerns, please feel free to contact me or Bonnie Burstow using the contact information provided above.

Thank you very much for your consideration. Happy Psychiatric Survivor Pride!!!!

Yours truly,

Shaird! Diamond
Appendix H: Freirian Group Information/Consent Letter

Dear Prospective Participant,

My name is Shaind Diamond. You might know me from my work with the Coalition Against Psychiatric Assault or my involvement in events within the community. I am inviting you to consider participating in a workshop called Resistant Art: Understanding and Exploring Psychiatric Oppressions. If you are not interested in participating, please do not worry for my sake, as this will cause me no difficulty.

The workshop will involve examining pictures to explore what is blocking you from meeting healing and empowerment goals and working with others to develop a better understanding of what needs to be done in order to change oppressive conditions in the lives of psychiatric survivors and mad people. I have included with this letter a list of questions that are similar to the types of questions that will be discussed to give you an idea of what to expect in the group. The workshop will last for around two hours and will include approximately 10 participants who identify as psychiatric survivors or mad people.

The workshop is only one part of a larger research project. The larger project, called Surviving Psychiatry: From Individual Trauma to Collective Empowerment, is examining goals coming out of our community, how these goals are connected to the everyday experiences of psychiatric survivors and mad people, and obstacles that are preventing people in our community from meeting goals of healing, empowerment or systemic change. I am hoping to come up with a comprehensive analysis of the institutional blocks and social relations, individual psychological factors, and gaps in knowledge or skills in strategic activism that block community goals.

For the purposes of this research, I am framing our community as a diverse group of people who come together from different experiences and social locations. What we have in common is a shared sense of belonging together, in opposition to institutional psychiatry and mentalist culture, and an understanding that the oppression faced by psychiatric survivors and mad people is at the forefront of community concern.

As an antipsychiatry activist, I am interested in this research, because I want to contribute ideas about how community members can move closer to meeting our goals. I am conducting this research as a student of the University of Toronto as a requirement for my doctoral degree in counseling psychology. This project is being supervised by Dr. Bonnie Burstow, a faculty member in my department at the university, who you might know from her involvement in the antipsychiatry movement over the past several decades.

This is an opportunity for you to participate in a workshop that is designed to foster a critical understanding of your situation, your oppression, and yourself. Coming together in an environment where psychiatric survivors and mad people can speak their own experience is part of reclaiming your ‘right’ to speak the world. The workshop also offers an opportunity to work collectively with others to develop a better understanding of what actions are necessary to overcome or change what is blocking you from meeting healing and empowerment goals.
While I do not expect that this will happen, there is a risk that some participants will find aspects of the group discussion to be upsetting. If you find yourself needing to talk about what has come up for you in the group, I will be available to talk afterwards. In addition, an experienced counselling professional, who is involved in the community, will be available to talk to you during or after the workshop. Please let me know if you need support after the group, and I will direct you to the support person and provide you with a list of referrals for free or low-cost counselling and peer support resources.

The information collected in this study will be posted online at ________ and may be included in future publications or presentations. Your name and other information that might identify you will not appear in the group transcripts, the final report, or any future publication or presentation. I will ask you to fill out the demographics form, requesting your contact information and information about your social location and affiliation with the community. The information in this form will be kept strictly confidential. You will be given the opportunity to choose a pseudonym to represent your contributions in the research. If you do not choose a pseudonym, I will choose a name to represent you.

In order to protect each person’s right to privacy, I am asking all participants, including you, to respect confidentiality of other group members. This means that personal information that is shared in the group should not be discussed outside of the workshop. At the same time, I cannot guarantee that all participants will respect this agreement.

The group session will be audiotaped and transcribed, and the information collected in this group will be used for the purposes of my thesis research. The only people who will have access to original data are me, my thesis supervisor, Bonnie Burstow; and a research assistant, who is a member of our community. The audiotapes and original transcripts will be kept in a locked filing cabinet in my home and will be destroyed upon completion of the study.

You have the right to withdraw from this study at any point during the research process without any negative consequences. To do so, please contact me, by email or telephone, at ________, or Bonnie Burstow, at _________. You may also contact the Ethics Review Office at ethics.review@utoronto.ca or 416-946-3273 if you have any questions about your rights as a participant.

If you wish to participate in this workshop, please sign where indicated at the bottom of the page, after you have read and understood the information in this letter and you have been given a copy of this letter for your reference.

If you have any further questions or concerns, please feel free to contact me or Bonnie Burstow using the contact information provided above.

Thank you very much for your consideration. Happy Psychiatric Survivor Pride!!!!

Yours truly,

Shaindi Diamond
Appendix I: Interview Information/Consent Letter

Dear Prospective Participant,

My name is Shaind Diamond. You might know me from my work with the Coalition Against Psychiatric Assault or my involvement in events within the community. I am inviting you to consider participating in a one-on-one interview about your work in the psychiatric survivor, mad, and antipsychiatry community. If you are not interested in participating, please do not worry for my sake, as this will cause me no difficulty.

The purpose of the interview is to identify what your goals have been for our community, what are the activist and artistic strategies you have used to meet these goals, the successes resulting from activist work, as well as the obstacles and challenges encountered. I have included with this letter a list of questions that are similar to the types of questions I might ask in the interview. This interview will last for one to two hours. I will be interviewing approximately fifteen people who are survivors, mad people, activists, artists, or radical professionals involved in community activist work.

The interviews are only one part of a larger research project. The larger project, called Surviving Psychiatry: From Individual Trauma to Collective Empowerment, is examining goals coming out of our community, how these goals are connected to the everyday experiences of psychiatric survivors and mad people, and obstacles that are preventing people in our community from meeting goals of healing, empowerment or systemic change. I am hoping to come up with a comprehensive analysis of the institutional blocks and social relations, individual psychological factors, and gaps in knowledge or skills in strategic activism that block community goals.

For the purposes of this research, I am framing our community as a diverse group of people who come together from different experiences and social locations. What we have in common is a shared sense of belonging together, in opposition to institutional psychiatry and mentalist culture, and an understanding that the oppression faced by psychiatric survivors and mad people is at the forefront of community concern.

As an antipsychiatry activist, I am interested in this research, because I want to contribute ideas about how psychiatric survivors, mad people, and activists can move closer to meeting our goals. I am conducting this research as a student of the University of Toronto as a requirement for my doctoral degree in counselling psychology. This project is being supervised by Dr. Bonnie Burstow, a faculty member in my department at the university, who you might know from her involvement in the antipsychiatry movement over the past several decades.

This is an opportunity for you to participate a project aimed at developing a better understanding of successes and challenges in our community. This might be of interest to you as an activist who is committed to meeting movement goals and gaining insight into how we can improve strategies and approaches in collective resistance.
While I do not expect that this will happen, there is a risk that you might find aspects of our discussion to be upsetting. If you find yourself needing to talk about what has come up for you in the interview, I would be happy to speak with you and provide you with a list of referrals for free or low-cost counselling and peer support resources.

The information collected in this study will be posted online at _______ and may be included in future publications or presentations. I will ask you to fill out the demographics form, requesting your contact information and information about your social location and affiliation with the community. You will be given the opportunity to choose between using your real name or a pseudonym to represent your contributions in the research. If you do not choose a pseudonym, and you do not indicate that you want your real name used in the research, I will choose a name to represent you. If you choose to use a pseudonym, your name and other information that might identify you will not appear in the group transcripts, the final report, or any future publication or presentation, and the information in the demographics form will be kept strictly confidential.

The interview will be audioated and transcribed, and the information collected in this group will be used for the purposes of my thesis research. The only people who will have access to original data are me, my thesis supervisor, Bonnie Burstow, and a research assistant, who is also a member of our community. The audioatedes and original transcripts will be kept in a locked filing cabinet in my home and will be destroyed upon completion of the study.

You have the right to withdraw from this study at any point during the research process without any negative consequences. To do so, please contact me by email or telephone, at ______, or Bonnie Burstow, at ______. You may also contact the Ethics Review Office at ethics.review@utoronto.ca or 416-946-3273 if you have any questions about your rights as a participant.

If you have any further questions or concerns, please feel free to contact me or Bonnie Burstow using the contact information provided above.

Thank you very much for your consideration.

Yours truly,

Shairidi Diamond
Appendix J: Research Group Information/Consent Letter

Dear Prospective Participant,

I am inviting you to consider participating in a focus group to discuss your observations about coalition building at the PsychOUT Conference. If you are not interested in participating, please do not worry for my sake, as this will cause me no difficulty.

The purpose of the focus group is to identify how people in the antipsychiatry/psychiatric survivor/mad community are finding ways to work together and what kinds of obstacles arise that prevent people from effective coalition building. This focus group will be emphasizing these issues in terms of what we witnessed happening at the PsychOUT Conference, which was designed to facilitate coalition building. This group will last for around one hour and will include 4 people from our thesis support group.

The focus group is only one part of a larger research project. The larger project, called Surviving Psychiatry: From Individual Trauma to Collective Empowerment, is examining goals coming out of our community, how these goals are connected to the everyday experiences of psychiatric survivors and mad people, and obstacles that are preventing people in our community from meeting goals of healing, empowerment or systemic change. I am hoping to come up with a comprehensive analysis of the institutional blocks and social relations, individual psychological factors, and gaps in knowledge or skills in strategic activism that block community goals.

For the purposes of this research, I am framing our community as a diverse group of people who come together from different experiences and social locations. What we have in common is a shared sense of belonging together, in opposition to institutional psychiatry and mentalist culture and an understanding that the oppression faced by psychiatric survivors and mad people is at the forefront of community concern.

As an antipsychiatry activist, I am interested in this research, because I want to contribute ideas about how psychiatric survivors, mad people, and activists can move closer to meeting our goals. I am conducting this research as a student of the University of Toronto as a requirement for my doctoral degree in counselling psychology. This project is being supervised by Dr. Bonnie Burstow, a faculty member in my department at the university, who you might know from her involvement in the antipsychiatry movement over the past several decades.

This is an opportunity for you to participate in a group aimed at developing a better understanding of successes and challenges in our community. This might be of interest to you as an activist who is committed to meeting movement goals and gaining insight into how we can improve strategies and approaches in collective resistance.

The information collected in this study will be posted online at _______ and may be included in future publications or presentations. Your name and other information that might identify you
will not appear in the group transcripts, the final report, or any future publication or presentation. I will ask you to fill out the demographics form, requesting your contact information and information about your social location. The information in this form will be kept strictly confidential. You will be given the opportunity to choose a pseudonym to represent your contributions in the research. If you do not choose a pseudonym, I will choose a name to represent you.

In order to protect each person's right to privacy, I am asking all participants, including you, to respect confidentiality of other group members. This means that personal information that is shared in the group should not be discussed outside of the focus group. At the same time, I cannot guarantee that all participants will respect this agreement.

The group session will be audiorecorded and transcribed, and the information collected in this group will be used for the purposes of my thesis research. The only people who have access to original data are me and my thesis supervisor, Bonnie Burstow. The audiotapes and original transcripts will be kept in a locked filing cabinet in my home and will be destroyed upon completion of the study.

You have the right to withdraw from this study at any point during the research process without any negative consequences. To do so, please contact me, by email or telephone, at _____, or Bonnie Burstow, at _____, or Bonnie Burstow at ethics.review@utoronto.ca or 416-946-3273 if you have any questions about your rights as a participant.

If you have any further questions or concerns, please feel free to contact me or Bonnie Burstow using the contact information provided above.

Thank you very much for your consideration.

Yours truly,

Shaindli Diamend