

Voices

Newsletter of the Psychiatric Survivor Archives of Toronto



Vive la résistance!

It's a new year, and the *Voices* team has got great things in store for you. Inside, you'll find a terrific, collaborative feature on the insights and experiences of contributors to **Toronto's survivor activism scene**, along with archivist **Mel Starkman's** thoughts on PSAT's first decade, **Philip Ashdown's** review of a public lecture on the history of the Parkdale neighbourhood, **Emilia Lunardo's** reflections on Toronto's first mental asylum, and a full reprint of the **Declaration of Principles** ratified at the 1982 International Conference on Human Rights and Psychiatric Oppression.

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“Stick with it. We’re all in it together.”

The Canadian psychiatric survivor movement has had a long and storied history. Earlier this year, we asked a number of survivors, activists, allies, dissident professionals, and other contributors to the community to talk a bit about the lessons they’ve learned while mobilizing around survivor issues; to share some of the insights they wished they’d had when they were first getting started; and to generally reflect on the motley experiences that make up a politicized life. Our interviewees, who hail from a wide range of backgrounds, are: Don Weitz (**DW**), an antipsychiatry activist and psychiatric survivor; Shaindl Diamond (**SD**), a University of Toronto graduate student and feminist activist; Simon Adam (**SA**), a registered nurse and community activist; **R**, a psychiatric survivor who’s active in antiwar organizing; Bonnie (**B**); and Geoff Reaume (**GR**), PSAT Chair and York University professor.

1. Can you tell us how long you've been involved in activism around psychiatric survivor issues? Are there specific initiatives, developments, or debates that you identify strongly with or have been particularly involved in?

B: I have been actively involved for approximately thirty years. I most strongly ally with the antipsychiatry part of the movement. I am particularly identified with the issue of rights, the movement to abolish electroshock, critiques of the DSM and psychiatry, and more general, feminist and other foundational critiques of the system. I am also identified with an attrition stance with respect to psychiatry.

SA: I have been involved in the movement for approximately one year. I worked on the 2010 Mother’s Day march and rally [against electroshock] and the *PsychOut* conference, and, more recently, I have taken up the role of co-chair for the Mother’s Day march and rally for 2011.

SD: I’ve been involved in activism around psychiatric survivor issues for about eight years now. Most of my work has been with the Coalition Against Psychiatric Assault, organizing events such as Inquiry into Psychiatry 2005; the feminist anti-electroshock campaign, “Stop Shocking Our Mothers and Grandmothers”; Psychiatric Survivor Pride 2008; and

most recently, *PsychOut: A Conference for Organizing Resistance Against Psychiatry*. I am also a graduate student in psychology and have provided workshops for psy-professionals looking at the types of problems psychiatric survivors commonly experience in the psy-complex. I always try to bring ideological, philosophical and material concerns from the community into the academic and professional work I do. I have also enjoyed helping out with other exciting initiatives in the community, such as Mad Pride.

R: I don’t consider myself especially active in the movement at this point in my life—I wouldn’t say there’s a single movement—but I follow the issues out of personal interest, and I’m active in the antiwar and alternative globalization movement. I’ve been a survivor for maybe ten years or so.

DW: I got started in 1974 in Topeka, Kansas, where I attended the second Annual Conference on Human Rights and Psychiatric Oppression, which was a very inspiring thing. I met Leonard Frank there, who turned me on to the fight against electroshock a few years later; and Howie the Harp, the legendary activist for homeless psychiatric survivors, who composed the song, “Crazy and Proud.” So, that was very seminal. Judi Chamberlin was there, the author of *On Our Own*. A year before then, in 1973, I had taken a trip to Vancouver to observe, with their permission, and stay with the Mental Patients Association (MPA) of Vancouver—the first survivor-controlled self-help group in Canada, which started in 1971. But I really started to get very involved in 1974. The issues that I was engaged with at first, where I put a lot of my energy in, was against electroshock and drugs and just people being locked up without trial, as they still are. And I was always interested, and still am, in the personal life stories of survivors—not theory. Theory’s important, yes. You have to have a framework to organize in. But I was always more into action. It suits my temperament.

2. What books would you recommend to a layperson who hasn’t yet had any firsthand reason to become critical of psychiatry, and who has spent most of their life internalizing mainstream views of “mental illness”?

B: Thomas Szasz's *The Myth of Mental Illness* is, I think a great place to begin.

SA: Though outdated, RD Laing's *The Divided Self* is a good start. It's very powerful to see a psychiatrist take an antipsychiatry perspective. Another is Robert Whitaker's *Mad in America*. An accessible and historic account of the atrocities of psychiatry and a demonstration that it is a flawed science.

DW: Well, four or five books. Judi Chamberlin's book, *On Our Own*. Thomas Szasz, the dissident psychiatrist who wrote the classic *The Myth of Mental Illness*, and, more recently, *Coercion as Cure: A Critical History of Psychiatry*. Another is Leonard Frank's *The History of Shock Treatment*, and another more recent online book called *The Electroshock*

Quotationary. And that's at endofshock.com.

Another is Bonnie's and my book: *Shrink Resistant*. Irit Shimrat's *Call Me Crazy: Stories from the Mad*

Movement. I think that's a good list to start with, for people who've been indoctrinated into the medical model. Wendy Funk's is another I should mention: *What DiffErenCe Does IT Make?* She got that title from a shrink who told her, after she'd lost her memory from a series of shocks, "What difference does it make?" Imagine telling a person that about memory!

GR: Irit Shimrat, *Call Me Crazy: Stories from the Mad Movement* (1997)—for examples from recent Canadian history about how people who have been in psychiatric facilities have organized to support one another, with stories that reveal how difficult this is and how human mad people really are. Peter Stastny's and Peter Lehmann's *Alternatives Beyond Psychiatry* (2007)—for its compendium of first-person accounts illustrating how people can live with supports that go beyond the medical model. Daniel B. Smith's *Muses, Madmen, and Prophets: Rethinking the History, Science, and Meaning of Auditory Hallucination* (2007)—for an understanding of how hearing voices should be

valued and considered through a person's experience and cultural background, rather than only as a pathological condition that should be eradicated. Jacky Bowring's *A Field Guide to Melancholy* (2008)—for eloquently pointing out that depression is part of life with causes that exclude the simplistic and destructive focus on biochemistry. Gail A. Hornstein's *Agnes's Jacket: A Psychologist's Search for the Meaning of Madness* (2009)—for showing how mad people's experiences are connected to challenging popular prejudices from the asylum era to the present.

R: Isaac Asimov's short story, *Profession*. I'd also recommend the *Star Trek: The Next Generation* episode, "The Outcast."

3. If you could design one mandatory course for all medical students, what kinds of things would it involve?

B: (A) A critique of psychopathology. (B) A history of the wrongs done by medicine. (C) A history of medicine as a hegemonic institution. (D) An exploration of what real medical ethics would involve.

GR: A course of this kind would involve discussion of the recent history of medical ethics and how some physicians violated codes of conduct and others upheld them—this in order to give both warnings from the past (negative) and role models for the future (positive)—while also relating it to the present to make it clear these issues persist today. I would also include a variety of first-person accounts of how people experience madness, to ensure that a diversity of experiences are engaged which integrate race, class, gender, disability, sexual orientation and ethnicity. Students who don't identify with some or all of these perspectives will be able to discuss these issues with their peers on a level that may reach them more directly than if a professor simply lectures at them about key issues like how they treat people in medical circumstances. I would also expect that today's medical students represent a broad diversity of opinions and backgrounds, and would be open to having medical orthodoxies challenged from a variety of perspectives.

ACTIVISM, CONTINUED ON PAGE 6

This article consists of excerpts from verbal and electronic interviews that Eugenia Tsao conducted in early 2011. She is indebted to all participants for their time. Please note that some answers have been lightly edited in the interests of space.

Readers are welcome to write in with their own answers to these questions, selections of which will be printed in future issues.

Notes from a Psychiatric Survivor Archivist

MEL STARKMAN, PSAT ARCHIVIST

PSAT has reached so many milestones at this point: the tenth anniversary of our inception. We have come a long way and stand on the threshold of even more productive service to the community. This newsletter is just one of our successes, thanks to our editors, Eugenia and Erick, and our more-than-willing contributors.

We are currently devising plans for a move to a larger space with which to store more accessions, provide office space, and, most importantly, a reading area that will fulfill the requests of so many researchers who have called on us to study the matters revealed by our unique documents and other materials. We have not been able to fulfill these requests while housed in the Gerstein Crisis Centre.

From a germ of an idea—which is unique in North America, if not the world--PSAT has begun to

grow into a mighty oak with strong roots in the survivor community, and a valuable asset to the community as a whole, particularly the mental health sector.

Our Board has innumerable matters to discuss, and it is fortunate that we have such a capable and enthusiastic membership to tackle important details and policy decisions. It is amazing that, based purely in the efforts of our volunteers, we have come so far in our first decade, especially given that we have had no grants and have been operating solely on the basis of donations, fundraisers and one very generous contribution from a psychiatric survivor.

May we continue to grow and prosper; and, as an archivist, I hope we will be able to adhere to the principles and practices of more established archives. Thank you all for making this possible.

A Review of “Locating Parkdale’s Mad History: Back Wards to Back Streets, 1980-2010” Megan Davies and David Reville Explore the Impact of Deinstitutionalization in the Parkdale Neighbourhood

PHILIP ASHDOWN

Making your dollar go further had a substantial history in Toronto well before Rob Ford arrived on the scene. On the evening of November 4th 2010, the Toronto Public Library’s *History Matters* lecture series focused on the grassroots history of the Parkdale neighbourhood, 1980-2010, with a joint presentation by researcher-activists Megan Davies and David Reville entitled, “Locating Parkdale’s Mad History.” The presentation was supported by the work of the Parkdale branch librarians who made efforts to keep the diverse material in which Parkdale figured on the public record.

Their lecture was both a history of the social work community that came to the aid of the recently “decanted”—a term used in official documents of that period to describe the process of shutting down care facilities—and of the efforts of the recently discharged to stake their claim in their new home. Publications such as *Phoenix Rising*, *The Cuckoo’s Nest*, and the anthology *Kiss Me You Mad Fool* are remarkable achievements given the conditions that prevailed at that time, as documented in the vertical

files of the Parkdale branch; and that persist, in large part, to this day.

A notable achievement of the era was the introduction of some quality control in the housing market. HouseLink and Habitat Services—agencies working with the dogged and dedicated Parkdale Activity-Recreation Centre (PARC)—did improve the quality of living options for Parkdale’s ex-patients, psychiatric survivors, and Mad, the self-identification that Davies and Reville use.

The unique record of this place and period as been maintained by the Parkdale library. It is a record of problem-solving and community action. This well-attended lecture demonstrated that Torontonians want to know more about their city, even those parts and places that barely figure on the agendas of today’s City Hall meetings.

The Toronto Public Library’s *History Matters* series will resume in the fall. To listen to a podcast of Davies’ and Reville’s lecture, visit the below webpage:

<http://activehistory.ca/2010/11/history-matters-podcast-megan-davies-and-david-reville-on-parkdale%E2%80%99s-mad-history/>

The Indelible Legacy of 999 Queen Street West

state was very real in their daily lives as psychiatric patients. There can be no doubt where the ultimate power lay in their lives, and

EMILIA LUNARDO

The doors of Toronto's first mental asylum first opened in 1870 at 999 Queen Street West. The asylum was created to house individual deemed mentally ill, and later began admitting the elderly, immigrants, and others seen as a social burden. Throughout its history, many stories of patient abuse, inequality and inhumane treatment were documented. Many patients' stories were never told, but, thanks to one particular individual, these individuals' lives are finally being revealed.

Geoffrey Reaume is a York University professor who was diagnosed with paranoid schizophrenia in his teens. It was this experience that led him to develop a scholarly interest in madness and the lives of those at 999 Queen West. Professor Reaume documented these stories in his book, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940*, which reveals these individuals' hobbies, the treatments they received, and the abuse they endured. Behind the asylum's walls, power was evidenced through the treatment and classification of patients, and their stigmatization along the lines of race, class, and gender. "Class," as Reaume (2000: 248) notes, "also reflected the limited choice available to patients both on and off the ward, as the access to money allowed for greater luxuries and less hospital-directed labour for a minority of inmates." Race and gender, too, determined patients' roles within the asylum. People of colour were usually assigned so-called 'dirty occupations,' and women were assigned household duties. "Psychiatric patients were employed to keep costs down, an agenda that had more to do with economics than therapeutics" (Reaume 2000: 250). In a facility ostensibly meant to assist those with a mental illness, patients were exploited for their labour, yet never received any payment for their work.

While this treatment paints a negative image of the mental asylum, Reaume reveals that patients retained some personal agency. Some patients very much tried to live 'normal' lives by participating in recreational activities, reading the newspaper, and forming friendships with other patients. "Their activities reveal them as being engaged in some activity while coping with a dull, monotonous ward routine that could numb and debilitate just about anyone after years of confinement" (Reaume 2000: 247). Yet patients' participation in everyday activities did not change the fact that they were prisoners of their illness and the system. "The coercive power of the

it was not with themselves" (Reaume 2000: 249).

Those in charge would often over-prescribe medications, invade patients' privacy, and prevent patients from working on things they enjoyed. These officials "had the power to take a person away from home, to take children away from their mother, to keep an individual confined against his or her will, to confiscate mail, to assist in the recapture of escaped inmates, and to transfer and individual to another facility" (Reaume 2000: 249).

Michel Foucault wrote about these kinds of coercive treatments and power imbalances, and encouraged his readers to think critically about who is empowered to speak in any given circumstance. In the Toronto asylum, coercion was a key tool for getting patients to perform tasks, and it is evident that those who were 'inferior'—the patients—held no power within the hospital. It eventually became clear that Toronto's mental health system was in need of serious reform. In 1998, Toronto's hospital for the insane finally became a public facility operated by the government of Ontario.

The original 999 Queen West facility has been replaced with a new set of facilities and a new address: 1001 Queen Street West. This address houses the Centre for Addiction and Mental Health (CAMH), described on its official website as "Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the area of addiction and mental health." The construction of CAMH has brought with it treatment not only for those with a mental illness, but for those recovering from addiction.

CAMH's website asserts that "staff work with family doctors, home support services, community agencies and other health care providers to make sure that clients and their families can receive assistance in their own communities and homes if possible. Additionally, they address larger issues that arise from four major factors affecting health—housing, employment, social support and income support." It's clear that CAMH is trying to be a more positive institution for those with a mental illness or an addiction. It is working to shed the stigma it has inherited from 999, and has made a greater effort to allow patients to live their own lives.

Toronto's mental health system has come a long way since the early days of 999 Queen Street West, from a past filled with abuse and mistreatment toward a future that may see a relationship of mutual assistance between institutions and society at large. CAMH is a prime example

LUNARDO, CONTINUED ON PAGE 12

ACTIVISM, CONTINUED FROM PAGE 3

DW: Well, I was thinking a combination of Geoff's and Bonnie's courses. First, I think it should be taught by psych survivors—not exclusively, but mainly. Activists, professional allies, and others can be guest lecturers. And there should be a minimum of theory, although it should mention feminist and anti-oppression perspectives for sure, and it should involve a critique of the medical model by survivors and/or dissident health professionals. There should be emphasis on alternatives to institutionalization voiced by people who have been active in developing them—for example a self-help group. And I think there should be some emphasis on exposing the coercion in psychiatry, in the fraud involved in every psychiatric label. There should be a critique of psychiatric labeling, which means the DSM should be absolutely blown out of the water as being a bible of character assassinations. Medical students are not taught about the permanently stigmatizing nature of these labels.

SA: Perhaps medical students and nursing students alike: The course would definitely involve perspectives from antipsychiatry activists, scholars, and survivors. It would include the literature that demonstrates the harms of ECT, the gendered and ageist selectivity of ECT infliction, and accounts from survivors of ECT. The course would provide a social analysis of how harmful psychiatric labeling and stigmatization through the form of diagnosis can be. It would be particularly helpful to have the course delivered in part by a survivor.

SD: It would involve something that would challenge the *us/them* divide, something that would bring medical students out of their role as *doctor* and into the role of fellow human being who, like all of us, have vulnerabilities, emotions, and difficult life experiences; and something that would humanize (in their eyes) those whom they label as “mentally ill.” I would want them to grapple with the nuanced understandings of sanism, psychiatric oppression, and madness emerging from the community, so that they could no longer dismiss us as dangerous crackpots, as we were in the *National Post* article on the 2010 *PsychOut* conference.

“Don’t ask for studies. Demand concrete change.”

I would also expose them to first-person narratives elucidating the atrocities that happen routinely in the psy-complex—like footage from *Inquiry into Psychiatry 2005*, where psychiatrized people gave testimony about their experiences with electroshock and psychiatric drugs, or perhaps the many narratives about psychiatric oppression that exist in cyberspace.

4. Rita Mae Brown once said, “Good judgment comes from experience, and often experience comes from bad judgment.” If you could go back in time to your earliest days of activism and give yourself one piece of advice, what would it be?

B: Don't ask for studies. Demand concrete change.

SA: I'm still in my early days of activism, unfortunately, though if I had to look back and change something, it would be getting involved even earlier than I did.

SD: I would tell myself that there are problems with and legitimate critiques of every political action you will help to organize, but that this shouldn't stop you from engaging in activist work. Actually, I still need to tell myself this on a regular basis. Part of being an activist is taking risks; you are constantly putting forth challenging ideas and propositions. This means that you *will* make mistakes, but hopefully you will learn from your mistakes and come to a better understanding of what needs to be done in the fight against sanism and psychiatric oppression. It's important to stay open to critique, but not to the point of feeling so bad that you don't want to do anything anymore.

R: You have to be careful about burning out. Don't agree to take on anything that you're not personally enthusiastic about—for everyone's sake.

5. Young activists' distrust of established institutions sometimes leads them to devalue age and experience. It has become common for people who are new to social justice work to dismiss the tactical counsel of their elders out of hand, and then go on to repeat the same mistakes as those who have come before them. Do you have any cautionary insights that you would like people who are new to survivor activism to bear in mind as they go about their work?

B: The people in the movement who differ from you are not your enemies. They are still your allies and need to be treated as such.

DW: For those who are just starting to get involved, there should be available a history taught by both psychiatric survivors and activists. Have workshops on the history of any particular movement. Say, "Well, here's where we're at. And here, you want to get involved with us? Learn some early history. Learn what the issues are."

6. Among the most pressing challenges that activists in our community face today is the medicalization of difference in virtually all areas of civil society. In classrooms, courtrooms, change rooms, homes and offices everywhere, people are urged to monitor themselves and others for abnormalcy, and encouraged to seek a diagnosis. In particular, sadness and pain have come to seen as symptoms of biochemical pathology (depression) rather than indicators of systemic problems (a depressing society). What do you think accounts for the depoliticisation of pain in our society, and what are some ways to combat this trend? How can activists succeed in mobilizing a largely apathetic public?

B: The depoliticization can be traced to the enormous success of the medical establishment as a regime of ruling. More people openly rejecting the medical lens and drawing people's attention to it would be good. More space in educational institutions that is devoted to critique of this lens is very important, for academia is one of the ways of gaining credibility for counterhegemonic stances. Humour might be used more to expose the stupidity of this way of understanding the world. It is also important that the public see the concrete personal pain that these lens have created. In this respect, possibilities include truly radical theatre and opportunities to witness.

DW: As long as the medical model is dominant in psychiatry, as long as it's not challenged, then we're going to see more tragedies and much more

demonizing of people because they're different from what psychiatrists think is "normal," which they can't satisfactorily define.

R: One good start could be to expose how deeply consumerism colonizes our lives. For example, show people that poor body image—the basis of so many of today's mental health "epidemics"—is deliberately cultivated by corporations.

"It is also helpful to remind people that, statistically, people diagnosed as mentally ill are no more likely to commit violence against others than the population of people who are not diagnosed."

7. Every time a sensationally violent crime occurs (e.g. a school shooting), the perpetrator's classmates and neighbours come out of the woodwork to lament that they "missed the warning signs." News reports almost invariably portray mental illness as the cause of the event while downplaying sociological explanations. During these moments of public panic, what is the best thing that activists in our community can do to combat the perception that "mental illness" is a synonym for "danger"?

SA: Write to the editors. Get on TV/radio discussion panels. Deliver community educational events. Hold public demonstrations against such reporting. I think adult education is the most effective way to counter this picture.

B: A good question. We can quote statistics showing that there is no correlation between so-called mental illness and doing anything violent (so far not a successful tactic). We can begin to cast doubt on such knee-jerk reactions by *reductio ad absurdum* arguments. One way of doing so, for example, would be by pointing out that while violence is not disproportionately connected with mental illness, masculinity is disproportionately associated with violence and we are not asking people to be alert to the early warning signs of masculinity. Another tactic would be trying to create situations in which the general public have the opportunity to see this community in a very different light.

SD: One thing I try to do is to bring experience back into context in ways that disrupt stereotypes that portray madness as dangerous. There are countless examples of the media reinforcing violent stereotypes of mad people, but one example that comes to mind

ACTIVISM, CONTINUED ON PAGE 8

ACTIVISM, CONTINUED FROM PAGE 7

happens every year on December 6th when the media focuses on Marc Lepine shooting nine women in 1980 at the École Polytechnique in Montreal. People always comment on how Lepine was crazy or mentally ill, which totally erases the context that formed his hatred for women leading to this act of violence. When somebody is experiencing reality differently from others, their perceptions are still shaped by what is happening around them. People do not hate and target women out of nowhere—this happens in cultural contexts where violence against women is an epidemic. Acts of violence happen in a particular contexts, and we need to seriously look at this. It is also helpful to remind people that statistically people diagnosed as mentally ill are no more likely to commit violence against others than the population of people who are not diagnosed.

DW: Well, we don't have to look much further—I'm thinking of the Tucson shootings. He's already been judged mentally ill in the press. That's what they do. They leap to judgement repeatedly with a psychiatric label. Or they consult a psychiatrist who's never examined him.

What we should do in order to combat that is just to get on TV any way we can or find a reporter and tell our own stories. And it's usually the alternative press or alternative media that will listen to whistleblowers, as few as they are, or investigative reporters who are interested in our issues. But I haven't heard of any, or read any reporter or editor that's interested in serious criticisms. They haven't had dissident health professionals like Thomas Szasz or Peter Breggin on the CBC—ever—and this is the so-called balance that the CBC likes to promote.

8. Do you have any thoughts on how to ensure that our community is accessible to, and welcoming of, participants who are marginalized in multiple ways? While psychiatrization touches everyone, not everyone seems to be equally represented within our movement. Can you speculate on why some constituencies appear to be under-represented in psychiatric survivor activism (e.g. racialized minorities, LGBTQ-identified individuals, people with disabilities) despite being highly susceptible to psychiatrization? In your experience, what works to facilitate greater inclusiveness?

B: In each case, we need to pay more attention to what is important to people from these constituencies. For example, people of colour need to hear us integrating issues of racism more obviously in our analysis. On a very simple level, not only do people with disabilities need to know that disability is included our analysis; they need to be shown through our actions that we will go the extra mile to accommodate, even though it may cost us money we think that we can't afford or even if it means that we cannot meet in our favourite places. Correspondingly, we need to reach out to various oppressed communities, and take on their struggles just as we ask them to take on ours.

SA: My suspicion is that the oppressions of racialized minorities, LGBTQ, etc, get in the way of their 'representation' or involvement, or their 'coming out to participate.' Disproportionately more have compromised access to education and social supports, two very important prerequisites to start to get involved.

SD: Yes, I do think certain groups of people are underrepresented in some parts of the movement. This is a question I am addressing in my dissertation research, and I have had the opportunity to hear what other community members think about this issue as well. Here are a few things I have learnt along the way:

Many activists recognize that racialized people are proportionally underrepresented in psychiatric survivor, mad and antipsychiatry groups. When considering why this is, I think it's first important to acknowledge that in the Toronto context, racialized people are organizing around issues of psychiatric oppression, but not necessarily in connection with groups that identify as psychiatric survivor, mad or antipsychiatry. For example, both the Toronto Women of Colour Collective and THRIVE, the Multicultural Women's Coalition Against Violence and Oppression, have addressed psychiatric violence in their events organizing against the various manifestations of violence against women. In speaking to women who have participated in these events, I learnt that some racialized women are more interested in addressing problems of sanism and psychiatric oppression within groups that are committed to working from feminist and anti-racist frameworks that address intersectionality more than some groups and initiatives that identify themselves primarily as

psychiatric survivor, mad or antipsychiatry. Perhaps one way to show solidarity is to attend events organized within other communities and listen to the concerns of psychiatrized people who might not already be involved in psychiatric survivor initiatives.

It is important to learn from marginalized groups and pay attention to how differently situated people are responding to psychiatric oppression. It is also important to consider how racism, sexism, ableism, heterosexism, transphobia, classism and other forms of oppression interconnect with and shape experiences with psychiatry and sanism, and try to acknowledge and address these interconnected issues in our work.

It is also really important to challenge ourselves and other activists when we see problematic power dynamics or ideologies being reinforced in our community spaces. For example, disability activists have pointed out that ableist ideology needs to be questioned more broadly in psychiatric survivor and antipsychiatry spaces. At the *PsychOut* conference, disability activist Withers spoke about how often disability is framed as a negative effect of psychiatric interventions. I would have to say that this is very true from what I have experienced in the community. We have seen this in campaigns against psychiatric drugs and electroshock, and people often quote authors such as Dr. Peter Breggin who use ableist terms such as “brain-disabling drugs.” This kind of approach alienates politicized disability activists who have many overlapping goals with psychiatric survivors. We should really be more aware of and careful about the language we use, dominant ideologies we accept, and how this marginalizes people.

Issues related to identity politics can drive some people away. Contrary to some people’s beliefs, when a psychiatrized person does not identify strongly with terminology such as psychiatric survivor or mad, this does not necessarily indicate a lack of understanding of the abuses and violence faced by people who are viewed as crazy in the psy-complex and elsewhere. For example, I have spoken with people who view psychiatry as oppressive in their lives, but also view their experiences with psychiatry as an extension of the oppression they face within racist-heterosexist-patriarchal contexts, and do not identify so strongly with terms such as psychiatric survivor or mad. This does not mean they object to the terms, but that they do not define their political identities solely in relation to their experiences with psychiatry or

other sanist institutions, as this does not fully capture their political understandings of the systemic causes of their oppression. I have also heard from some survivors that peer support or consciousness raising groups can be alienating when it is presumed that people will connect through their shared experiences of sanism and psychiatric oppression, particularly when they do not see their experiences represented by other members of the group. Again, what is important here is the recognition of how differently situated people experience sanism and psychiatric violence in different ways.

On a logistical note, there are also problems such as language barriers and not having the resources to pay for translation and interpretation services (e.g. sign language interpretation), as well as the tendency for organizations to advertise and meet in places that are already known to community members, but that might not attract psychiatrized people who aren’t already involved. One thing that is awesome is that many more people seem to be conscious about the importance of using accessible spaces for meetings and events, which is very fundamental in fostering inclusivity in our community.

DW: That is so true. Statistically, people of colour are not well-represented at all in the psychiatric survivor movement. And we’ve talked about that sometimes but not enough in the history of the movement, why there’s not more creative outreach to other marginalized, disenfranchised groups—although there is a group here called *Across Boundaries*, which reaches out to people of colour. But I’d reference the fact that so few people of colour are attending *PsychOut* and other conferences. Very few of the many that should be there, that could be there to constructively contribute. Now, I’m not accusing the movement or its leaders of racism, but there is a weakness and there is a failure and I think it’s unfortunate. I have to say it: I think it’s systemic. It’s not an accident; it’s a systemic failure of reaching out to other marginalized and oppressed people to get them involved in antipsychiatry. And it’s not for the sake just of colour—it’s different cultures, different perspectives we desperately need to fight psychiatry.

I’ve been to maybe fifteen, sixteen, seventeen conferences in my life in the psychiatric survivor movement, and I see not more than 5, maybe a little

ACTIVISM, CONTINUED ON PAGE 10

ACTIVISM, CONTINUED FROM PAGE 9

more than 5% of the participants are non-white. That's not acceptable. Why is that? No one is seriously questioning, much less doing anything about it. Now, it's true, to give credit, in *PsychOut*, we did reach out. It was going to be a major speaker, a keynote [Dan Taylor from MindFreedom Ghana, who was invited but unable to attend due to visa problems]. So, we did that. But that's one. That's one example.

9. Do you have any words of wisdom for activists who despair at the overwhelming prevalence of pathologizing, stigmatizing, infantilizing and ghettoizing attitudes in the mainstream media and in daily life? Do you feel more or less optimistic as time goes by?

SA: Right now, I don't feel very optimistic, given the power of psychiatry pitted against the small size of the movements working against it. Words of wisdom: stick with it and we are all in it together.

B: In the words of the activists of the 60s, don't agonize, organize. You feel better as a result and you get more accomplished. It's important to remember as well, that we're not simply acting for ourselves. The question is not only what we live to see in our life times, as critical as that is. It is beyond that: What will our work lead to seven generations hence? It is how have we made it easier for those who follow us.

SD: I think it's really important to have people around you who get where you are coming from, so that you can share your frustration and anger about sanism in all of its ugly forms, and maybe even do something about it collectively. I remember one time I saw some oppressive ads when I was spending time with some of my mad friends, and we ended up doing some culture-jamming, which made us feel so much better.

DW: Get on alternative radio programs, like CKLN or NPR. Because there's a minority of editors that might be potentially interested in hearing us, listening to us, televising us. And we have to search them out and

give them our material, and say these are the issues, this is what's going down in the mainstream.

10. What is the single most frustrating myth about psychiatric survivors that you would like to see debunked and dispelled? What is the single most frustrating myth about psychiatry that you would like to see debunked and dispelled?

SA: The idea of the dangerous mental patient. The idea that human suffering is a disease, a diagnosis.

B: The most frustrating myth about survivors is that survivors are deficient in some way, that they are "lacking" as human beings, in fact, even that survivors differ from other human beings in anything other than that the system got its hand on them. The most frustrating myth arising from psychiatry is that people's problems in living arise from chemical imbalances or chromosomal abnormalities.

SD: I would say that the single most frustrating myth about psychiatricized people is that they cannot be trusted to make decisions about their own bodies. To me, the most frustrating myth about psychiatry is that it is a necessary institution that exists to help people rather than to "deal" with those who are inconvenient in the workings of racist-hetero-capitalist society.

DW: One common one is that we're violent or prone to violence—or much more so than others. This is a common myth among the media and public. Another stereotype is that we're not as able to do various things, you know, we're "incapable" or we lack skills.

Although, curiously enough, they love to romanticize the artists, the so-called mentally ill artists, like Van Gogh, who was labelled schizophrenic, or Nijinsky, the great dancer in Europe at the turn of the century, or Beethoven, who happens to be my favourite composer. He'd be labeled bipolar in less than a week, and prescribed antidepressants, and they'd absolutely destroy his creativity. You probably wouldn't have the ninth symphony. Handel, the same thing. If these composers were alive today, they would be so pathologized. Creativity drummed right out.

Would you like to write for *Voices*? We welcome submissions of essays, news items, poems, and artwork that reflect PSAT's mandate of preserving and sharing the rich history of psychiatric survivors. Contributors retain copyright of their work. E-mail your submission to us with the subject line "Voices submission." You may include an author's bio and/or e-mail address for reader correspondence if you wish. Your piece should either be saved in one of the following formats — .doc, .pdf, .rtf, .txt, .jpg, .tif — or contained within the body of your e-mail. Please do not mail hard copies of your submission. If your piece is selected for publication, we will notify you by e-mail. The editors reserve the right to copyedit submissions for grammar and clarity.

A look in the archives...

The Tenth Annual International Conference on Human Rights and Psychiatric Oppression, held in Toronto, Canada on May 14-18, 1982, adopted the following principles. As we enter our 2nd year of publication, *Voices* is pleased to reprint these principles in honour of psychiatric survivors past:

DECLARATION OF PRINCIPLES

1. We oppose involuntary psychiatric intervention including civil commitment and the administration of psychiatric procedures ("treatments") by force or coercion or without informed consent.
2. We oppose involuntary psychiatric intervention because it is an unethical and unconstitutional denial of freedom, due process and the right to be let alone.
3. We oppose involuntary psychiatric intervention because it is a violation of the individual's right to control his or her own soul, mind and body.
4. We oppose forced psychiatric procedures such as drugging, electroshock, psychosurgery, restraints, solitary confinement, and "aversive behaviour modification."
5. We oppose forced psychiatric procedures because they humiliate, debilitate, injure, incapacitate and kill people.
6. We oppose forced psychiatric procedures because they are at best quackery and at worst torture, which can and do cause severe and permanent harm to the total being of people subjected to them.
7. We oppose the psychiatric system because it is inherently tyrannical.
8. We oppose the psychiatric system because it is an extra-legal, parallel police force which suppresses cultural and political dissent.
9. We oppose the psychiatric system because it punishes individuals who have had or claim to have had spiritual experiences and invalidates these experiences by disparaging them as symptoms of mental illness.
10. We oppose the psychiatric system because it uses the trappings of medicine and science to mask the social-control function it serves.
11. We oppose the psychiatric system because it invalidates the real needs of people by offering social welfare under the guise of psychiatric "care and treatment."
12. We oppose the psychiatric system because it feeds on the poor and powerless, the elderly, women, children, sexual minorities, people of color and ethnic groups.
13. We oppose the psychiatric system because it creates a stigmatized class of society which is easily oppressed and controlled.
14. We oppose the psychiatric system because its growing influence in education, the prisons, the military government, industry and medicine threatens to turn society into a psychiatric state made up of two classes: those who impose "treatment" and those who have or are likely to have it imposed on them.
15. We oppose the psychiatric system because it is similar to the inquisition, chattel slavery and the Nazi concentration camps.
16. We oppose the medical model of mental illness because it justifies involuntary psychiatric intervention including forced drugging.
17. We oppose a medical model of mental illness because it dupes the public into seeking or accepting "voluntary" treatment by fostering the notion that fundamental human problems, whether personal or social, can be solved by psychiatric means.
18. We oppose the use of psychiatric terms because they substitute jargon for plain English and are fundamentally stigmatizing, demeaning, unscientific, mystifying and superstitious. Examples:

PLAIN ENGLISH... PSYCHIATRIC JARGON
Psychiatric inmate... *Mental Patient*
Psychiatric institution... *Mental Health Centre*
Psychiatric system... *Mental Health System*
Psychiatric procedure... *Treatment/Therapy*
Personal or social difficulties in living... *Mental illness*
Socially undesirable characteristic or trait... *Symptom*
Drugs... *Medication*
Drugging... *Chemotherapy*
Electroshock... *Electro-convulsive therapy*
Anger... *Hostility*
Enthusiasm... *Mania*
Joy... *Euphoria*
Fear... *Paranoia*
Sadness/Unhappiness... *Depression*
Vision/spiritual experience... *Hallucination*
Non-conformity... *Schizophrenia*
Unpopular belief... *Delusion*

PRINCIPLES, CONTINUED ON PAGE 12

PRINCIPLES, CONTINUED FROM PAGE 11

19. We believe that people should have the right to live in any manner or lifestyle they choose.
20. We believe that suicidal thoughts and/or attempts should not be dealt with as a psychiatric or legal issue.
21. We believe that alleged dangerousness, whether to oneself or others, should not be considered grounds for denying a person liberty, and that only proven criminal acts should be the basis for such denial.
22. We believe that persons charged with crimes should be tried for their alleged criminal acts with due process of law, and that psychiatric professionals should not be given expert-witness status in criminal proceedings or courts of law.
23. We believe that there should be no involuntary psychiatric interventions in prison and that the prison system should be reformed and humanized.
24. We believe that so long as one individual's freedom is unjustly restricted no one is truly free.
25. We believe that the psychiatric system is, in fact, a pacification program controlled by psychiatrists and supported by other mental health professionals, whose chief function is to persuade, threaten, or force people into conforming to established norms and values.
26. We believe that the psychiatric system cannot be reformed but must be abolished.
27. We believe that voluntary networks of community alternatives to the psychiatric system should be widely encouraged and supported. Alternatives such as self-help or mutual support groups. Advocacy/rights groups, co-op houses, crisis centers and drop-ins should be controlled by the users themselves to serve their needs, while ensuring their freedom, dignity and self-respect.
28. We demand an end to involuntary psychiatric intervention.
29. We demand individual liberty and social justice for everyone.
30. We intend to make these words real and will not rest until we do.

LUNARDO, CONTINUED FROM PAGE 5

of cultural change within the downtown core, and the original wall that used to keep patients from leaving the hospital grounds—now reduced in length but still intact—serves as a reminder of a rich, yet traumatic, chapter in Toronto's history. Although 999 no longer exists, its impact not only on its neighbourhood but on Torontonians in general remains today. Its legacy reveals social inequalities that should make us question, in our own lives, what is considered 'normal' and how the 'abnormal' are treated. Unlike most of 999 Queen West's patients—now, for the most part, long-forgotten—the site itself will forever serve as a reminder of how society views those living with a mental illness.

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Emilia Lunardo is a fourth-year sociology major at York University who is currently completing her undergraduate thesis on mental illness stigma and the media. She has written numerous papers about mental health recovery and related issues, and hopes to continue her work within the field of medical sociology.

Last, but not least!

PSAT is currently searching for vacant office space in which to store its collections and open a reading room. If you know of any available space, please contact Board members Don Weitz (dweitz@rogers.com) or Mel Starkman (meliqstarkman@yahoo.ca) at your earliest convenience. Thanks for your help!