

Identifying and Dismantling Psychiatric Oppression

An Introductory Handbook

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Questions for Inquiry

- In your personal experience, what is “Crazy?”
 - About others?

 - About situations?

 - About your internal experience?

- What is “Mental Illness?”
 - When have you experienced “going mad?” What was it like?

 - When have you been with someone with a “Mental Illness”? What was it like?

- What cultural narratives do we tell about Mental Illness?

- Who benefits?

- Who is harmed?

- What narratives do we tell about psychiatric drugs?

- Who benefits?

- Who is harmed?

Myths and Reality about Mental Health

Myth: Mental disorders are discrete illnesses caused by genetically occurring chemical imbalances in the brain.

Reality: After over 40 years of research, there is little scientific evidence to support the hypothesis that there are significant and detectable genetic causes for mental illness, or that people with psychiatric diagnoses have diagnosable, abnormal brain chemistry. The heads of the American Psychiatric Association and the National Institute of Mental Health acknowledge that psychiatric diagnoses are subjective and lack scientific validity.

Myth: People who have trouble coping socially are inherently inferior either biologically or morally.

Reality: Symptoms of emotional distress are strongly linked to psychosocial causes including poverty, oppression, spiritual development, early childhood trauma, abuse, neglect, bullying, and other difficult relationships. Evidence suggests that individuals' emotional resilience is largely determined by these forces, especially adverse childhood events. Therefore, these problems may be more accurately seen as communal and societal, rather than individual. The problems we face might elicit questions of how people are treated, rather than asking what is "wrong" with someone.

Myth: Mental Illness is a ubiquitous and consistent concept.

Reality: The western, developed world has much higher rates of mental illness diagnoses and worse outcomes than many other cultures. Within our society, mental illness labels and drug treatment are increasingly concentrated in some of our most vulnerable demographics: Children (especially foster children), seniors, the poor, the queer community, trauma-survivors, veterans, and the disabled. When an individual overlaps two or more of these groups, his or her chance of being diagnosed and on psych drugs quickly approaches 100%.

Many indigenous and developing cultures do not conceive of mental illness the way we do, and do not believe in drug treatments as a primary response to emotional distress. Many alternative communities in the developed world also offer alternative narratives of mental wellness.

Myth: People who receive the label of schizophrenia will be ill for their entire life.

Reality: At least one-half to two-thirds of people who receive this diagnosis are able to fully recover, according to medical research, this includes chronic cases. Countless more experience unusual states associated with schizophrenia and thrive without ever entering the mental health system.

Myth: Drugs reduce symptoms of mental disorders and must be taken lifelong, like insulin for diabetes.

Reality: In the short term some psych drugs suppress the targeted symptoms, as well as many other aspects of the person. No psych drug is known to cure any disease. Nor are they known to reliably reduce symptoms or promote functional recovery in the long term.

Patients are usually switched around different drugs and put on several drugs at once, and told that their "illness" is "treatment resistant". Long term exposure to psych drugs, like long term exposure to street drugs, causes dependence, physical disease, and symptoms of mental disorders in many people. This is called iatrogenic illness, meaning "illness caused by the treatment." This process leads to chronic illness and early death in psychiatric patients.

Myth: Individuals diagnosed with a mental illness are more likely to commit violent criminal acts.

Reality: As a demographic, people with mental illness labels are far more likely to be *victims* of violent crime than other groups.

Myth: When people relapse whilst coming off of psych drugs, this is evidence that a person should be on the drugs.

Reality: Individuals coming off of psych drugs face a three-fold challenge: 1) Feeling the original distress that led them to be put on the drug, 2) Relearning coping mechanisms that have not been active during the period of being drugged, and 3) Experiencing the intense neurological effects of withdrawing from drugs on which one has become physically dependent.

Coming off of psych drugs can be a struggle for some people. For many, this means going through a difficult period that requires extra support, and then feeling much better once the withdrawal period is over.

A Definition of Psychiatric Oppression (Sanism)

Psychiatric Oppression, or institutional sanism, consists of systemic discrimination, marginalization, disempowerment, corruption, cultural hegemony, coercion, and violence toward people diagnosed with mental disorders, and in people behaving in ways considered consistent with the idea of a mental disorder. Like other forms of oppression, it is important to consider both the forces of oppression and appreciate the privileges of not being targeted.

“Of all tyrannies, a tyranny exercised for the good of its victims may be the most oppressive. It may be better to live under rubber barons than under omnipotent moral busybodies. The robber baron’s cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end, for they do so with the approval of their own conscience.” — C.S. Lewis

Preamble: Thoughts on “Anti-Psychiatry”

Psychiatry is in the unenviable position of being our culture’s go-to service for handling social misfits. This societal function has been played by many institutions in the past. Psychiatry can be seen as taking over the mantle of early asylum-supervisors and bygone healers who proposed that demon possession, moral corruption, or imbalanced humors were to blame for severe social dysfunction. Whoever happens to be in charge at any given time, this social position is rife with opportunities for abuse, dehumanization, and oppression.

From one point of view, there is no need to blame psychiatry or psychiatrists in particular. We live in a culture that marginalizes, abuses, and oppresses much of its population, particularly people of color, women, queers, the disabled, and the poor. Psychiatrists do the best than can with the resources they have available to pick up the pieces, and put Humpty-Dumpty back together again. Part of the responsibility to remedy this situation lies with all of us, particularly by providing improved advocacy, support, and alternatives to psychiatric oppression in our communities.

Since the early part of the 20th century, psychiatry raised its sails as an optimistic response to a real societal need, and in the 1950s became swept up by wind of pharmaceutical drug profits. We are now seeing that wind may have been blowing in the wrong direction if our goal is emotional wellness and a highly functioning society.

Attempts by academic psychiatrists to construct and categorize various styles of mental pathology have been largely well-intentioned. Efforts to discover biological causes and deliver “magic bullet” drug treatments can be seen as hopeful strategies meant to simplify situations that can be very emotionally difficult, and thereby reduce human suffering. As an avenue of inquiry, psychiatry has an important place in the progression of human scientific endeavors.

In the course of psychiatric history, skilled and well-informed psychiatrists have followed the evidence and selectively used drugs in a relationship defined by informed consent to support the healing process of whole persons. Many people have experienced psychiatry’s role in their life to be beneficial. For a few, their gratitude extends even to the most coercive, violent, and

deceptive practices of psychiatry. It would be unkind, and unrealistic, to argue with or judge these experiences to be invalid.

However, most people who interact with psychiatry do experience it as a vector of institutionalized oppression in at least some of the ways laid out in this document.

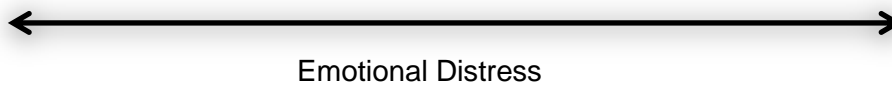
The view presented here is anti-oppression on the social plane of mental health. It is no more “anti-psychiatry” than anti-racism work is “anti-white,” or anti-homophobia work is “anti-straight.” The concern here is when individuals’ human potential is systemically pigeon-holed and squashed by systemic discrimination and coercion. This handbook is designed with the intention to help create a world that is more kind, careful, inclusive, safe, and healing for everyone.

Who is Affected

We might first think of those affected by sanism on one primary axis, that of one's level of emotional distress or "mental illness."

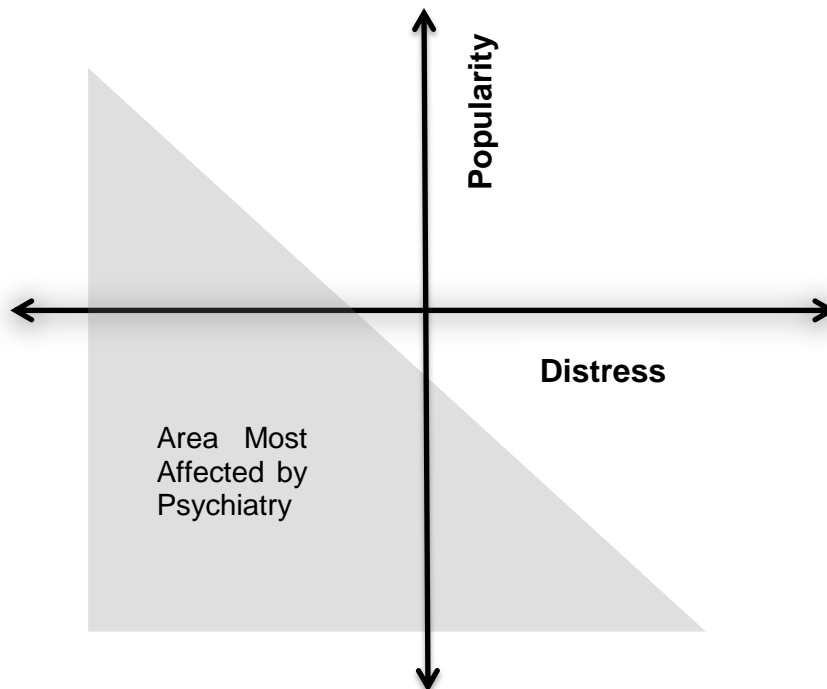
Distraught, Rageful, Suicidal,
Catatonic, Terrified, Dissociated

Content, Peaceful,
Integrated, Balanced



We also make a distinction between "crazy" and "eccentric" that has something to do with social fitness, or popularity. Those who are able to get along well with their culture and social group can experience more distress without being targeted, and those who are unpopular or subject to other forms of oppression may experience harm in the psychiatric system without any initial personal distress.

Popularity = Charisma + Privilege + Resources + Quality of Relationships + Ability to Perform at work, school, and other contexts of satisfying others.



Aspects of Psychiatric Oppression

Discrimination is at work when individuals are disenfranchised, such as being denied employment, loans, housing, service opportunities, religious counsel, and meaningful relationships due to a mental illness label. Many people who have received mental illness labels are afraid to share this history with friends and colleagues because they might be judged and treated worse. Once a person has received a psychiatric diagnosis, they are subject to increased suspicion. Hallucinations, suicidal thoughts, hearing voices, anxiety, withdrawal, excitement, and other experiences common, at times, to most people become “red flags” and further evidence of the person’s mental illness.

People with mental illness labels are far more likely to be bullied, and regularly face media portrayals of being violent, unpredictable, and needing to be rounded up and have their rights taken away.

Many psych patients report a profound sense of alienation, like nobody really cares about them or listens to them. Patients are regularly “gas-lighted” by professionals, who, upon encountering a person’s sense of loneliness and despair, assign it as part of the “illness.” By failing to empathize, they perpetuate the problem.

Marginalization, along with discrimination, serves to shame and disenfranchise individuals with diagnoses or culturally abnormal behaviors.

Due process required in other legal proceedings does not apply to mental health patients. Individuals can have their freedoms, property, and even ownership of their own body taken away without a fair trial, adequate public representation, or reasonable hope of appeal.

Police are more likely to arrest an individual labelled with a serious mental illness.

College campuses are increasingly likely to expel students who have a diagnosis.

People experiencing homelessness, disability, and other disenfranchising situation are even less likely to receive adequate support when they are considered mentally ill.

The voices and stories of people with mental illness diagnoses are regularly suppressed by media, doctors, and families. When people with mental illness diagnoses tell stories that do not agree with the psychiatric perspective, they are often labelled as delusional or defiant behaviors — an aspect of their illness. Only stories friendly to the establishment are allowed in most media.

Disempowerment occurs when medical doctors, a revered, high-status group, along with other mental health professionals, insist that the targeted person is hopelessly disabled. Patients experience being looked down upon as an incurable case and less than fully human. A common message from mental health professionals to patients is that there is no hope of full recovery, that they have a life-long brain disease, and that the only way they can be a part of society is to take powerful mind-altering drugs for the rest of their lives.

Despite the medical trappings of the diagnosis, in almost all cases, no physical tests or brain scans are ever performed. No physiological state correlated with mental illness been

shown to be the cause of an interpersonal problem, nor are states of emotional distress known to be irreversible. Mental health professionals often claim that the person has a “chemical imbalance,” despite the fact that this theory has been disregarded by scientists in the field for decades. When questioned, many doctors have stated that this lie is a “useful metaphor” for what they believe about mental illness. The assessment of having a “broken brain,” is reached based entirely on the individual’s behavior, usually at the worst moments of their life, including, in many cases, being locked up in a hospital.

Patients are usually not told about the poor long-term outcomes associated with taking psych drugs, or their well-documented harmful effects. These include neurological damage, addictiveness and major withdrawal symptoms. This lack of informed consent is medically unethical. Patients have a right to know when drug effects are making their distress worse, a reality often denied by prescribers, and what symptoms to expect with long-term dependence and withdrawal.

Defiance of the authority of psychiatrists and other mental health professionals, or refusal to believe in the medical model of mental illness is often taken as further confirmation of mental illness (“lack of insight”) which puts patients in a double bind: Communicate genuinely and be considered crazy, or lie and suppress one’s feelings in order to appease the psychiatrist, who has substantial power over one’s life.

Corruption consists of unethical and illegal practices by pharmaceutical companies, academics, and clinicians. Top academic psychiatrists who are responsible for the medical model of mental illness are paid large consultancy fees by drug companies to promote the use of psychiatric drugs. Clinical psychiatrists receive kickbacks, consultancies, and gifts from drug companies. These bribes are widely acknowledged and considered acceptable by the psychiatric community.

Pharmaceutical companies illegally market their drugs for uses not approved by the FDA, and share misleading or incorrect information with clinicians. These companies skew, hide, and make up data for their studies. Ghostwriters are hired by corporations to make studies and promotional materials appear independent.

One of the more common practices involves performing dozens of studies that show a drug to be ineffective or harmful but telling no one, and then publishing a single study, sometimes manipulated, that shows positive results. The data from the other studies is considered a trade secret and never revealed to the public. The harm done (both to individual patients and to scientific progress) by these practices has resulted in many successful court cases against the pharmaceutical companies with million- and billion-dollar settlements owed to individuals and states.

Cultural Hegemony is when the dominant power’s conception of sanity and mental illness overpowers that of the individual and less powerful cultures. For instance, in some cultures it is very common to report hearing voices as an everyday experience, while in the United States hearing voices is considered pathological in virtually all cases. Some indigenous cultures responded to emotional distress and interpersonal crisis with dialogue and curiosity. Experiences considered shamanic or spiritual in many cultures are pathologized by psychiatry. Children who defy local rules and norms are highly likely to be given mental illness labels.

World Health Organization studies report that citizens of certain developing nations demonstrate considerably better outcomes for mental health problems than those in the developed world. We, on the other hand, are experiencing an epidemic of chronic and disabling mental illness, correlated with the rise of the current psychiatric paradigm.

Our version of mental illness is now being exported all around the world, with more and more cultures beginning to medicalize mental illness and rely on drug treatments. Notably, some resilient cultures refuse, or simply do not understand, the American model: In France, communities, parents, and schoolteachers are highly resistant to the medical conception of ADHD and to drugging children.

Coercion includes psychiatry's right over the choices and bodily freedom of individuals who have received a diagnosis of a mental disorder. Individuals deemed a potential threat to themselves or others may be "sectioned," and kept imprisoned in a hospital for several days. Those who meet a psychiatrist's criteria for mental illness and are deemed dangerous are committed to incarceration for weeks or months at a time. Some mental illness advocates, such as the Treatment Advocacy Center, argue that the criteria of dangerousness is too strict, and that individuals should be locked up solely on a psychiatrist's assessment of a "need for treatment." This policy, which leads to countless human rights violations, is already in effect in many other countries.

This process takes a very similar form to criminal incarceration, only with less due process, and a greater assault against of the individual's rights. Generally, criminal prisoners are allowed to maintain jurisdiction over the insides of their own bodies, which is not the case for psychiatric patients.

Many psychiatric survivors describe the experience of being in a mental hospital as an elaborate performance in which they play the part of the good, recovering patient in order to be released from imprisonment, all the while resenting their captors. Others take on the belief system of the psychiatry and become convinced that they are, in fact, hopelessly ill, carrying the unjust bondage of the psychiatric system with them out into the world.

During a psychiatric commitment, individuals may be required to take psychiatric drugs. If a person is non-compliant or argumentative, they may be tied down in physical restraints for hours at a time and injected with major tranquilizers. In some cases individuals are coerced into receiving brain damaging electroshock therapy.

Psychiatric coercion continues outside the hospital through "outpatient commitment" laws, by which a judge orders an individual to take drugs under supervision in exchange for the freedom of living in the community.

It is important to recognize that coercion in the psychiatric system happens ubiquitously through "involuntary voluntary" choices. Threats of escalating coercion are made directly toward patients in order to obtain compliance. For instance, "You may come to the psych hospital voluntarily, and you might get out in a day or two, or we will section you and it will be at least 3 days," or "You have the choice to voluntarily swallow these drugs, or we will hold you down and inject you with them." In this way, virtually all encounters between a patient and the psychiatric happen under the shadow of coercion and control.

Violence occurs throughout the mental illness process. Most people with severe psychiatric diagnoses experienced childhood trauma: emotional, physical, sexual, or in the form of neglect. As teenagers and adults, individuals with psychiatric diagnoses are far more likely to be the victims of violence in their communities than their peers.

Individuals who feel marginalized and alienated often deal with fear of self harm and harming others, in what can be a self-perpetuating cycle with those around them (i.e. fear of self-harm leads to reduction of freedoms, which leads to further alienation and frustration, which leads to increased suicidal behavior or lashing out against others).

People are physically restrained and have their bodies chemically invaded in psychiatric hospitals. Many psychiatric survivors say the experience is similar to rape. Sexual, physical, and verbal assaults from staff and other patients regularly occur behind the closed doors of psychiatric facilities.

“First, do no harm,” a primary value of most medical traditions, is not usually practiced by psychiatry. Patients are told disempowering myths about their condition and given disabling, illness-producing drugs, which is a form of institutional violence and control.

Other notes about psychiatric oppression:

-The power of the mental health industry creates tremendous inertia against change. Hundreds of thousands of peoples' livelihood depend on the medicalization of emotional states. While many practitioners would still have useful roles if major change were to occur, some people and businesses might find their service irrelevant in a non-oppressive system.

-Psychiatric oppression is **internalized** by all of us. We fear expressing ourselves in ways that don't make sense to others. We choose not to communicate internal experiences that may cause others to suspect us of being crazy. This internalized oppression is especially potent for those who have received a diagnosis. A great many of us learn to hate the non-normative parts of ourselves, which ironically creates further inner conflict and susceptibility to anxiety, depression, and other extreme states.

Brief Glossary

Sanism — Discrimination based on one's way of making meaning. This extends beyond institutionalized psychiatric oppression. For instance, many religious groups, including atheists, look down on people with other beliefs as less sane. The most dominant conception of sanity in a culture has power over people with widely different ways of making meaning. Sometimes the power is minor and subtle, and sometimes more gross such as in the case of psychiatric oppression.

When one person calls another person "crazy," it is a subjective and discriminatory act, and usually an act of sanism.

Neurodiversity — A broad term used to identify and celebrate the ways in which peoples' brains and thought processes work differently from one another.

Neurotypical/Neuroatypical — Term used by some people who experience non-normative states of mind to distinguish between themselves and those who (mostly) experience normative ones.

Spiritual Emergency — A form of crisis where an individual experiences major shifts in their sense of personal identity and way of making meaning in the world. Often connected with spiritual practices like meditation, prayer, ecstatic ritual, entheogenic drug use, and near-death experiences. Sometimes happens spontaneously or arising out of a therapeutic process.

Mad Pride — A term taken up by some psychiatric survivors and allies to counteract prejudices against people labelled with mental disorders. Many activists emphasize that there are gifts and meaning present in states that are pathologized by psychiatry.

Iatrogenic Illness — Disease and dysfunction caused by the treatment for another medical problem. This phenomenon is experienced by many psychiatric patients who receive drugs and electroshock.

Mad Phobia —The fear of "crazy" behavior in ourselves and others that leads to coercion, aggression, discrimination, and psychiatric oppression.

Privilege and Allyship against Psychiatric Oppression

Psychiatric Privilege consists of an absence of the many causes of confusion, fear, violence, double-binds and other distressing and limiting experiences common to those carrying a psychiatric label, and the ability to impose these same predicaments onto others. One's privilege in this realm increases the higher one's status in the mental health hierarchy, with psychiatrists themselves exercising the greatest privileged. Some examples include:

- No doctor has ever told you, falsely, that you have a chronic, life-long medical condition that will limit your ability to interact socially and thrive in human society.
- Your emotional life is not questioned, investigated, or talked about by strangers and acquaintances.
- You are not told that your emotions/thoughts are symptoms of a medical illness.
- You are not asked if you've taken your meds, or told that you should be on meds.
- You do not fear extended psychiatric incarceration if you become extremely ill or find yourself under arrest (at an activist event, for instance).
- You do not experience other people pathologizing your beliefs or spiritual experiences.
- You feel physically safe around health care practitioners.
- You are not expected to be unpredictable or violent, and if you do act this way, it is quickly forgiven and considered an aberration.
- Mainstream media messages do not suggest that people like you should be rounded up and forcibly detained or drugged.
- You are not treated like an object, a problem, or a disease by authorities and people with power over your life.
- Your assessment of your own sanity and the sanity of others is considered accurate.

Becoming an **ally against psychiatric oppression** means thoroughly investigating ones biases and concerns about mental illness, and learning to empathize with the challenges faced by individuals affected by trauma who express themselves in ways that disrupt or distress others.

- Listen to stories of psychiatric survivors. Some of them are harrowing. Stick with it.
- Listen to the stories of those who have healed and grown through emotional distress with or without the help of the mental health system.
- Explore your own history of emotional distress, reflect on times you have felt socially challenged or crazy.
- Leave behind assumptions about mental illness.
- Encourage a sense that recovery is possible for everyone.
- Cheerlead self-care, self-advocacy, and individual agency.
- Be open to the way each individual makes meaning out of their experience
- Do not impose your own way of making meaning or solving problems onto other peoples experience e.g. “maybe you have a chemical imbalance,” “that’s just a hallucination,” or “You just need to suck it up and come out with us!”
- Stop using words like “crazy” and “insane,” pejoratively, and do not use diagnostic words like “OCD,” “bi-polar,” and “schizophrenic.” Instead, describe specific circumstances and behavior e.g. “My roommate often arranges the silverware drawer is a very specific way,” “My cousin is saying things that don’t make sense to me and some of my other family members.”
- Speak out against psychiatric myths.
- Investigate intersectional implications of psychiatric oppression, and the role of oppressions and trauma in contributing to emotional distress and extreme states.
- Offer support to individuals who choose not to take drugs, or are trying to come off their drugs.
- Be honest with yourself and those in need of support about how much you are available to help. If you become overwhelmed, please be sure to get support yourself.
- Research the history of psychiatry, mental disorders, drug effects, and drug withdrawal.
- Discover alternative paradigms of understanding extreme states, such as trauma-informed care, existentialism, and the concept of spiritual emergency.

Intersections with Psychiatric Oppression

Here are a sampling of subjects for intersectional critique. Investigate and find your own!

—Black and Hispanics are considered an under-treated population (i.e. lots of mental illness and not enough drugging). Brown- and black-skinned people in distress, especially poor men, are more likely to be labelled as “violent,” “criminal,” and “terrorist” rather than mentally ill. Note the differing media coverage between white violent offenders compared to black and arab/persian ones. For instance, there was tension in the media around the Boston Marathon bombers, who had light skin and were given mental illness labels usually not applied to those who commit terrorist-style attacks.

—The “insanity defense” allows primarily more privileged violent criminals to avoid long prison sentences while creating more life-long customers for drug companies, and perpetuating a shameful conception of mental illness that revokes an individual's responsibility for their actions.

—Most people with diagnoses who receive SSI disability are genuinely unable to work, often due to the debilitating affects of the psych drugs. Some convicts and other economically disenfranchised people will “put on” symptoms of mental illness in order to gain SSI income. Others who were at one time disabled do not tell authorities about their recovery in order to continue receiving these useful benefits in support of other endeavors. A person who genuinely needs extra support shouldn't have to accept a severe social stigma or take damaging drugs in order to receive monetary aid.

—Queer and trans experience has been labelled mentally ill since the early days of psychiatry. While homosexuality has been depathologized, transgenderism has not. The queer experience provides a powerfully relevant gateway for understanding the experience of those with mental illness labels. Like queer people, those with mental illness labels are often stigmatized, shamed, and brutalized simply for being different in mind&heart.

—Women make up a significant majority of certain subclasses of mental illness, especially borderline personality disorder. Women are more than twice as likely as men to receive electroshock. Men, on the other hand, are more predominantly diagnosed with certain illnesses, such as antisocial personality disorder.

—Children with behavioral problems of any kind, including now babies as young as six months old, are increasingly likely to be put on harmful psych drugs. Foster children in particular are almost all drugged and pathologized.

—The practice of biological psychiatry props up one of the most profitable industries in the world, pharmaceutical drugs.

—Anti-authoritarians are much more likely to be diagnosed as mentally ill. Doctors, parents, and teachers are using psychiatry to subdue and control future generations of anarchists, activists, cooperators, and entrepreneurs!

Alternative Systems

“The foundation for supportive, healing partnership is a non-coercive non-hierarchical relationship of unconditional positive regard and genuine empathy.”

It is hard for psychiatric leadership to imagine effective strategies that do not begin with the concept of a brain disease, because any such model would be outside of their established paradigm. However, this does not make alternatives non-scientific. In fact, the opposite could be said to be true. Data on Open Dialogue, Soteria, and other low-drug models of care demonstrate substantially better results and less harm than mainstream psychiatry!

The most successful and least harmful responses to mental health crises include many examples of community living and horizontal power structures. Here are a few:

Open Dialogue — In Western Lapland, Finland, individuals experiencing a first instance of severe distress are offered an “Open Dialogue” process with their family and friends. This is facilitated by a pair of trained practitioners who usually come to the person’s home. The system is integrated deeply into the region’s socialized health care system, and uses psychiatric drugs very selectively.

Like council practice and other dialogic forms familiar to alternative communities, Open Dialogue places every participant on an even playing field. The problem at hand is not assumed to be in the individual showing signs of distress, but somewhere within the social system as a whole. Facilitators return as often as is desired to investigate the emotional needs of the entire group until the crisis abates. After more than twenty years of using this technique, new diagnoses of major mental illnesses have dropped 90%.

Open Dialogue inspired practices now exist all over the world, including a pilot program in New York City.

Soteria — In a 12-year study funded by the National Institute of Mental Health, Dr. Loren Mosher experimented with a communal home for patients with severe diagnoses, staffed by peers and with no immediate use of antipsychotic drugs, and compared their outcomes with those kept in a psychiatric hospital.

The long-term outcomes for the group that lived in the community home were substantially better than the hospital cohort, many using no drugs at all, and less than 20% were maintained on psych drugs after moving out of the house. Soteria-style houses are currently in operation in Alaska and Vermont.

Intentional Peer Support — Many health care systems now train and employ peer specialists who have been through their own experiences of emotional distress. In situations where peers are able to act autonomously and non-coercively their presence and support can be enormously helpful. Intentional Peer Support was developed by individuals with lived experience to train others in providing non-oppressive assistance.

Hearing Voices Network — Founded by voice hearers in the U.K. Hearing Voices groups are places where individuals who hear voices, hallucinate, or have intrusive thoughts can get together to discuss their experiences in a non-medical setting. These groups are run by facilitators with lived experience and are open to each person’s personal interpretation of their

internal world. The Network's philosophy stands in contrast to mainstream psychiatry in that they view voices as a normal, understandable human experience filled with meaning, rather than a symptom of illness to be eradicated. Many people claim their lives were changed or saved by having a safe space to honestly discuss their unusual experience.

The Icarus Project — A radical network of mutual support that publishes materials and provides an organizing platform for those who experience madness.

What Communities Can Do

- **Education.** Explore the literature of the psychiatric survivor movement. Read and listen to a variety of personal stories and arguments for the various paradigms. Apply critical theory to what you find. Learn about the effects of trauma. Investigate the side-effects of drugs, potential complications, and best practices for withdrawal (if desired). Research local health practitioners and support groups that are friendly to an anti-oppressive, whole-person approach, and post them with other local resources. Share what you learn with your extended community.
- **Provide a safer space and respite.** Individuals in distress sometimes need support, and too often the only place they can go is to the emergency room or the hospital. Within the limits of your community's emotional and physical resources, consider providing housing, food, transportation and friendship to those who need it. When doing so, explain your expected limitations as clearly as possible up front, so that you do not exceed your resources and the individual needing support does not feel betrayed.
- **Be a wellness hub.** Basic self-care is extraordinarily important to individuals struggling with their emotional well-being. Sleep, food, and physical activity are essential ingredients of any wellness strategy. Make healthy food available to those who are having trouble cooking for themselves. Invite people who aren't feeling well to dancing, singing, yoga, sports, and other community events. Make your space a reliable for a full night's sleep if someone in the house is struggling.
- **Involve marginalized people** in community building, social justice, spiritual practice, and volunteer efforts. Many folks who find themselves ostracized from mainstream society are hungry for sense of purpose and community involvement. It may be helpful to invite someone who is isolating or having trouble maintaining relationships to events where connection and meaning-making are happening.
- **Facilitate genuinely open dialogue.** Active listening, council, theatre of the oppressed, non-violent communication, and other intentional group processes are applicable to emotional and interpersonal crises. Become willing to sit through confusing and charged situations with an open heart and an open mind. Simply participating in group process where one's voice matters can be immensely healing for an individual with a history of disenfranchisement.
- **Learn how to be a better helper.** Become trained in Emotional CPR, Non-Violent Communication, Co-Counseling, Intentional Peer Support, meditation, yoga, and other embodiment or healing practices. One's ability to be of service to those in severe distress is directly related to one's own groundedness, kindness, personal development, and resilience. Consider that when you outsource a difficult situation to the professionals, the results are often further oppression and alienation.
- **Always take care of yourself first.** A burned out helper, no matter how well-intentioned, can lead to co-dependance, betrayal, and even an unexpected descent into your own madness. Please take care of yourself and acknowledge you limitations, while also striving to be an effective ally. Do not put yourself in a situation in which you feel genuinely unsafe

unless you are prepared for the consequences.

- **Speak up.** If you have lived experience of psychiatric oppression, share your story! One way oppression is able to continue is by shaming and silencing its victims. When you're ready, let others know about your experience in psych hospitals or with psych drugs and diagnoses, positive and negative. When we talk openly about these issues, we empower others to do the same. Sharing stories is ultimately how hearts and minds are changed.

Resources

Web (these sites have links to many more resources!)

<http://madinamerica.com> — Advocacy, News, Blogs, Resources, and a Practitioner Directory

<http://beyondmeds.com> — Personal psych survivor blog with rich archives

<http://mindfreedom.org> — Activist organization

<http://psychrights.org> — Legal defense organization

<http://theicarusproject.net> — Radical Mental Health Support Network

<http://openparadigmproject.com> — High-quality video testimonials

Film

Beyond the Medical Model – Western Massachusetts RLC

The Virtues of Non-Compliance – Western Massachusetts RLC

(<http://westernmassrlc.org/rlc-film-productions>)

Coming Off Psych Drugs (and other films) by Daniel Mackler

(<http://wildtruth.net/dvd/>)

Open Paradigm Project — Online. Interviews and short films

(<http://openparadigmproject.com>)

Books (a short list)

Anatomy of an Epidemic by Robert Whitaker

Mad In America by Robert Whitaker

Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare by Peter Goetzsche

The Myth of Mental Illness by Thomas Szasz

Your Drug May Be Your Problem (and many others) by Peter Breggin

Rethinking Psychiatric Drugs: A Guide to Informed Consent, by Grace E. Jackson, MD

Agnes's Jacket: A Psychologist's Search for the Meaning of Madness, by Gail Hornstein, PhD

Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It, by Sharna Olfman and Brent Dean Robbins

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Soteria: Through Madness to Deliverance, by Loren Mosher and Voyce Hendrix with Deborah Fort