The Withering Away Of Psychiatry: An Attrition Model For Antipsychiatry

Keynote Address

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PsychOut: A Conference for Organizing Resistance Against Psychiatry, OISE, Toronto, 2010

I would like to begin by reading a statement by theologian C.S. Lewis:

> Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive….The robber baron's cupidity may sometimes sleep, his cupidity may at some point be satiated, but those who torment us for our own good torment us without end for they do so with the approval of their own conscience…Their very kindness stings with intolerable insult. To be 'cured' against one's will and cured of states that we may not regard as disease is to be put on a level with those who have never reached the age of reason and those who never will (C.S. Lewis, 1970, p. 292).

For over 35 years, I have been an antipsychiatry activist. While the quotation today is one with which I think that all of our community can agree, and so one that I wanted to start with, my speech today comes out of that antipsychiatry background and perspective.

Antipsychiatry is a very particular perspective. It differs from the perspective of many people at this conference which is just fine, for a vibrant movement needs multiple perspectives and the fact that so many perspectives are represented at this conference is encouraging. To be clear, antipsychiatry—the perspective from which I speak--is not one that I ask be adopted or expect to be adopted by my sisters and brothers here today who hold diverging views. The point is, we form a community--the community of people who unite to combat psychiatry. It is a wonderful community, a vibrant community. Our community encompasses differences, and we need those differences. We need all of us--antipsychiatry activists, mad activists, professionals, survivors, artists—if we are to bring about the life-enhancing more tolerant society for which we are all striving.

It is critical that this be clear from the outset. As I suggested in my opening remarks on first day of this conference, one error that has tended to plague our community, as indeed it plagues most every social movement, is that we have often fallen into vilifying others in the community with different perspectives, which is not good, or tried to convert each other, which is also not good. The fact is that we are not each other's worst enemy. The fact is that there is far more that unites us than divides us, and we need to hold onto that. The fact is, trying to convert each other is not what good allies do. My hope and trust is that we can be good allies—that we will work together where we can and in what ways we can, and where we cannot, that we will agree to take a pass, but that we will do so respectfully, that we will do so, that is, while preserving our relationships so that on all sorts of other fronts we can continue to work together.

None of this means that people who are part of particular constituencies should not try to develop their perspectives. That, in fact, is precisely what I am trying to do in this keynote. I am using this keynote to flesh out a model for one such constituency—the antipsychiatry constituency. I do so because I am antipsychiatry, and I believe in the importance of the antipsychiatry agenda. I do so because at the moment, I see this constituency as in trouble, and as far as I am concerned, we need all of our community at the top of their game.

As I look over our diverse community and how it has operated over the last couple of decades, I would have to say, I see greater clarity and greater progress in other constituencies. For some time antipsychiatry *per se* has been floundering.

One reason it is floundering no doubt is precisely that it has not always been respectful of other parts of our community. And I would like to believe that those days are over. It is floundering more significantly because the powers lined up against it are becoming increasingly stronger,

increasingly more entrenched. The power of psychiatry, its continual growth, its ever more tenacious entrenchment in the state is a brutal reality and not one for which we bear responsibility. I would like to suggest, however, that antipsychiatry is also floundering because it has no model or models to guide its action.

The point is, antipsychiatry is not a new movement or constituency. A movement can proceed quite nicely for a long time on passion, sincerity, vision, and ever-sharper critiques. If that sufficed to win the battle, however, we would have succeeded long ago for we have always had such attributes in abundance.

There comes a time, moreover, when not only does that not suffice, you start to move backward. That is the nature of movements. You have successes for a while. You have successes even without being shrewd activists. You have successes almost no matter what you pin your wagon to—the politics of compassion, or the politics of entitlement like the ones associated, say, with human rights battles. And I know because I have had such successes—been there, done that. However, inevitably the people in power who have something to lose by your winning push back with all the strength that their position in power affords them. And when they do, that is when you need to learn how to be really good activists. Correspondingly, that is when you absolutely need to bring something to the table to help guide action. That is the ultimate purpose of this keynote. The purpose of this keynote is to start fleshing out the beginnings of a much needed model for guiding antipsychiatry.

Before I go any further, I know that some people are not exactly sure what I mean by "antipsychiatry" and are not exactly sure what makes an antipsychiatry perspective different than the perspective held by various others at the conference. As that difference plays a pivotal role in the model, it is critical that I clarify.

All of us here today are profoundly unhappy with psychiatry. If we were not, we would not come to a conference of this nature. What distinguishes an antipsychiatry stance is not simply that it is critical of psychiatry. It is that its adherents hold that psychiatry is unqualifiedly untenable, untenable as it stands today, untenable even if it improved itself substantially. To put another way, what distinguishes antipsychiatry from other critical positions is the conviction that critiques of psychiatry are sufficiently conclusive, compelling, foundational, and damning to render psychiatry as an institution inherently undesirable and irredeemable (see Burstow, 2006b).

This position arises from the bitter experiences of survivors and their writings—writings that go back to *Madness Network News*, *Phoenix Rising*, and continue to this day. More formidably, it rests on a number of foundational critiques. I will not be going into them in depth, but they include: Szasz (1974) and Leifer (1990), who demonstrate that the foundational philosophic and scientific concepts of psychiatry are flawed, Breggin (1991) and Colbert (2001), who demonstrate that the treatments are intrinsically damaging, systemic thinkers like Mirowsky (1990), who demonstrate that the entire system of diagnostic categorization lacks validity and coherence, and labeling theorists like Goffman (1964), who as far back as 1964 unmasked psychiatry as a form of social control.

The goal of antipsychiatry is quite simple—nothing less than the abolition or end of the psychiatric system. Herein lays its ultimate distinction. While people critical of psychiatry but not fully antipsychiatry may take certain kinds of changes as sufficient—the advent of informed consent, less use of drugs, a kinder gentler industry, or diagnostic categories which are less overlapping, for example—as clarified in documents like the CAPA's fact sheet, antipsychiatry

holds that no changes will be sufficient, for the institution is too flawed and dangerous simply to be tinkered with.[i]

A vital question arises from this goal. Namely: If the abolition of psychiatry, however conceived, is the goal, in light of that goal, how might antipsychiatry activists proceed?

The question is far from simple. The fact remains that while a rigorous antipsychiatry position entails some type of abolitionist stance, no one should be under any illusion that any demands or well worded critiques will suddenly lead to the closing of institutions or the cessation of damaging treatment. And in fact, demands that psychiatry be curbed in any more than a mere reformist way are themselves likely to lead to terror on the part of the general public and an increased emphasis on the myth of the dangerous mental patient, who must be kept under control by all available means. The point is that we are up against a very complex system, with huge vested interests, with the complicity of the state, and with the blessings of a fearful general public. We are also up against thousands of years of prejudice against people with different ways of thinking and processing—prejudice, which, as theorists and members of the mad movement such as Esther (2000) correctly point out, predate the medical model and predate psychiatry, but have been made far more formidable by the veneer of science. Additionally, it should be added, some who use psychiatric services are legitimately worried that without psychiatry, they will be out in the cold.

All that being the case, there will be no quick "win" on this issue. It is in this larger context that I ask: What might be used to guide action? If abolition on some level is the goal, what might be used as a model or touchstone in deciding what to do, what not to do, what to support, what not to support?

In foraging about for how to conceptualize a model, I have been reminded of a movement which has much in common with antipsychiatry—the prison abolition movement. While prison abolitionists uniformly agree that some people (a very small number) may need to be confined, and the details are still to be worked out, prison abolitionists too take abolition as the goal. Moreover, they too have been struggling with a situation where the general public approves of and indeed considers essential the very industry, approach, and complex machinery which the abolitionists hope to dismantle. Additionally, in their case too, the problematic institution in question is upheld by the state, it is complex, and it is not going away over night. Moreover, albeit to a lesser extent, in their case too, some inmates voluntarily seek out its "services", with people, indeed, committing crimes precisely so as to get back behind bars.

What distinguishes the prison abolition movement is that it has long had a model. Now, indeed, it has had a number of models, but the most widely accepted one by far is called "the attrition model".

The attrition model for prison abolition was spelt out as early as Knopp (1976) and has been reaffirmed and modified over the decades (e.g., West and Morris, 2000). In the early ground-breaking book that announces the model, Knopp et al. state, "We have structured an attrition model as one example of a long range process for abolition. 'Attrition' which means rubbing away or wearing down by frictions reflects the *persistent* and *continuing* strategy necessary to diminish the function and power of prisons in our society" (p. 62).

The attrition model as articulated here has at once united prison or penal abolitionists and given them a long-range basis on which to plan. Anyone who was ever been active in prison abolition

will not fail to recognize the hallmark question that typically arises when a new action or campaign is considered: "Will it move us any closer to the long run goal of prison abolition?"

An attrition model assumes that:

- nothing as extensive and entrenched as the institution in question can be changed quickly
- something as ambitious as abolition takes place slowly and for the most part by attrition—by gradual but persistent rubbing away and wearing down.
- not all change that *seems* positive has the capacity to bring a movement closer to the abolitionist goal and indeed, on the contrary, some of what *looks promising* would actually undermine the long-term goal in question.

Herein lies a conceptualization which holds promise for antipsychiatry.

My intent in this keynote is to do for antipsychiatry what was long ago done for prison abolition. The purpose of the keynote is to construct, articulate, and help readers make sense of the bare bones of an attrition model. In no way am I suggesting that it is the only possible model. Nor am I suggesting that an attrition model *per se* is straightforward or absolute. It is clear, however, that an unpopular movement which is at odds with the state and prevailing hegemony as well as with a massive and entrenched industry begins at a serious disadvantage. It is further disadvantaged if it has no vision about how to move closer to the goal which it espouses.

In presenting the model, I am aware that my most focal audience are the sisters and brothers here today who are antipsychiatry or who verge on it. What I can promise people from other constituencies, however, is I'll not be forgetting you.

That said, we come to the model. It proceeds by questions—what I call "defining questions". While the number is somewhat arbitrary, let me suggest there are three related questions that antipsychiatry activists operating from an attrition model need to ask when making major decisions. The first is the most pivotal question. The next two are auxiliary questions that might best be thought of as derivative of the first. The three questions are:

1) If successful, will the actions or campaigns that we are contemplating move us closer to the long-range goal of psychiatry abolition?
2) Are they likely to avoid improving or giving added legitimacy to the current system?
3) Do they avoid "widening" psychiatry's net?

To shed light on these, the first is the kingpin. Say that an action or campaign being considered is worthwhile on other grounds, but we have no reason to believe that its success will move us closer to the goal of abolition. In that case, someone else might take it up, but it would not be the proper focus of abolitionists. To be clear, abolitionists may or may not choose to endorse such changes or campaigns, depending on whether or not it undermines the long run goal among other things, but they would not become active in them. The point is that an attrition mandate would require that only changes that are abolitionist in nature and not mere reformist be actively pursued.

Now looked at superficially, this guidance would appear to rule out any actions not directly related to major changes. However, that is far from the case. Part of the beauty of the attrition model is precisely that it is predicated on the passage of time. In other words, time must be

factored in, and certain types of minor changes which build over time have the potential of shifting worldview.

By way of example, any action which helps de-medicalize the language used about people who process differently or live in alternative realities or are in emotional turmoil could be seen as an abolitionist type change, for if enough of the language used shifted over time, it would chip away at the impression that psychiatrists work so hard at maintaining—that such states or ways of being are "medical issues" and hence the proper domain of doctors. The language of the mad movement is an example of what could be supported in this regard. While antipsychiatry activists in past have been critical of mad language as not antipsychiatry *per se*, this model would ask antipsychiatry activists to take another look.

The next question complicates what might have initially looked simple: While question 1 asks, if successful, would our campaign or intended actions move us closer to psychiatry abolition, question 2 asks: Are they likely to avoid improving or giving legitimacy to the current system?

While an offshoot of question 1, question 2 raises the bar. If a campaign or action is likely to lend legitimacy to the current system, it would make no sense for abolitionists to support it, for it undermines the ultimate goal. In fact, if lending legitimacy to the current system are among its primary consequences, even if otherwise benign, it would not be sensible for an antipsychiatry group to even endorse it. Examples of activities sometimes engaged in by people who combat psychiatry which this question would rule out are: sitting on task forces making recommendations on how to improve psychiatric institutions; taking part in reformist agendas such as those associated with organizations like the Canadian Mental Health Commission; taking part in any events or initiatives sponsored by psychiatry—including purely cultural ones for they too lend it legitimacy, indeed, making psychiatric facilities appear like friendly community centres—a valuable part of the life of the community.

Question 3 asks: If successful, would the actions or campaigns that we are contemplating avoid widening the net. What is meant by "widening the net"? It means allowing more and more people and more and more situations to fall under the auspices of psychiatry. You can see why this would not be desirable. Widening the net of psychiatry is tantamount to helping psychiatry grow as opposed to helping it wither.

What is the intent of question 3? The intent is that no initiative be adopted whose success carries with it the likely consequence of widening the net—that is, of placing more people or people at more times under the auspices of the psychiatric system. Correspondingly, where such initiatives originate from within the system, for the most part, they should be actively resisted.

An obvious example of a campaign which would widen the net which originated from within the system was the push for community treatment orders.[ii] Despite the rhetoric behind them, it was clear from the outset that community treatment orders would widen the net because they would drastically extend psychiatric control both temporally (past an inmate's release date) and spatially (extending the grasp of the hospital further into the community). Antipsychiatry activists, psychiatric survivors, and others critical of the system immediately saw what was at stake and while unsuccessful, quickly mobilized against the initiatives.

Psychiatric measures like this which constitute obvious power grabs fortunately are fairly easy to identify. By contrast, measures originating from within the community critical of psychiatry which *inadvertently* widen the net are not so easy to identify. Nonetheless, they too fall under

the purview of this question, and while resistance would generally not be in order, for we do not obstruct our allies, they should not be supported or endorsed. An example of an action that would err in this regard is getting on the bandwagon clamoring for “mental health services” to be brought into an area when “mental health services” largely means psychiatric or services controlled by psychiatry.

Questions 2 and 3 may often prove difficult to hold onto, for they have the potential to place us at odds with what appears as progress, but this is precisely why they are important. Quite simply, they let us navigate tricky terrain. An example.

Let us say, for instance, that there is no service in a major city which offers emotional support for women who have undergone the shattering experience of giving birth to a stillborn child. The community responds by pushing for the creation of a service, and willy-nilly, it is decided that it will be psychiatric. Alternatively, let us say that there is a psychiatric service for women who have experienced still birth, but that the service is seen as deficient in some way, and the community begins pressuring to have that way addressed—say, to have the service in question expanded or otherwise improved. Given that services are direly needed for women facing this devastating life experience, one feels drawn to support both of these initiatives, for on some level, progress is happening. As abolitionists, however, it is important to keep in mind that supporting such changes means a) helping psychiatry get bigger, b) helping psychiatry become firmly entrenched in yet another area, and indeed, helping psychiatry appear benign, and c) placing an entire group of vulnerable women in more jeopardy from psychiatry than they were previously—for the inevitable depression could result in drugging, institutionalization, and even electroshock. Correspondingly, it essentially cedes the ground to psychiatry in yet another area, relegating any other services including self-help to becoming at best an alternative for those seen as least affected and at worst an adjunct to psychiatry.

These two questions, in other words, help us see what we might otherwise fail to see. Difficult though it may be to hold onto the last two questions, accordingly, the questions are pivotal for they keep us from going off course.

Together, the three questions, along with a knowledge of how psychiatry operates suggest obvious directions for abolitionists. What goes beyond that, they also provide antipsychiatry with one way of prioritizing—and let there be no mistake about it, we need to prioritize for we cannot do everything.

How does one prioritize using these questions? In a nutshell, the method is as follows: Assume that the action or campaign being considered will be successful or at least reasonably successful, then evaluate from there. The closer to abolition some actions or directions would bring us, short of there being other objections to them, or reasons to prioritize other campaigns, the more focal they should be to antipsychiatry organizing. Correspondingly, anything that actually attacks psychiatry’s power base is particularly important, so should be given top priority.

To spell out what some of those top priority actions, directions, or campaigns might be—and people familiar with the terrain will recognize most of these—particularly apropos and indeed, more central than they are currently, would be actions or campaigns which put the state on the defensive when it comes to psychiatry or weakens the state’s unilateral endorsement or funding of psychiatry. The reason why this direction is singularly important is the pivotal role of the state in psychiatric rule. Psychiatry has the power which it does only because it is an extension of the state, is part of the apparatus of the state, and as such, is additionally handsomely funded by

the state. Loosen the tie-in with the state, eliminate all or a sizable part of the state's sanction or support, and psychiatry's size and power to harm begins to evaporate.

Examples of actions or campaigns that might be taken up in this regard—and most of these have long figured in our community arsenal and indeed figure in this conference—include: directly suing the state for damages—and hats off to survivors and family members at this conference who are suing; suing hospitals for damages; challenging the constitutionality of laws which the state has enacted to empower psychiatry; appealing to a power outside the state, whether it be the U.N. or some other international body. And kudos here to work of people like my fellow keynote David Oaks. Other less foundational but also critically important measures on the same continuum include:

- demanding moratoriums on new psychiatric hospital constructions
- pressuring for the end to involuntary commitment
- initiatives which support increased patients' rights or the upholding of current rights
- advocating cutbacks on funding for psychiatric services and increased funding for more benign services
- waging campaigns to de-fund private psychotherapy delivered by doctors, or what I think might well serve us better, to fund equally psychotherapy delivered by others (psychiatry could not have the power which it has today without the state giving it a virtual monopoly).

Many of the other initiatives that survivors and other critics of psychiatry commonly take up would also be focal. Included, in this regard, would be consciousness-raising, for consciousness-raising can clearly help us as a society move toward attrition. Included are attacks on other parts of the psychiatric industrial complex—not the least of which are pharmaceutical companies, on which psychiatry fundamentally rests. And how apropos that there are workshops at this conference about going after the pharmaceuticals! Thank you, David Carmichael. Included as well are thought-through critiques—foundational critiques in particular.

By the same token, actions which are abolitionist in nature with respect to any of the current "treatments" blatantly qualify. This, of course, would include the rigorously abolitionist campaigns currently waged by heroic survivors and their allies to ban electroshock (for more detail, see Weitz, 2008). However, it would also include actions, campaigns, and recommendations that are not immediately abolitionist with respect to current treatment, but which are likely (if successful) to contribute to attrition.

An example in this last regard are a number of the recommendations put forward in a report submitted by a panel which oversaw Toronto-based hearings into psychiatric drugs in 2005. None of the recommendations in the report were abolitionist in the immediate sense of the term. If enacted, most, however, would further the long term work of attrition.

Take, for example, the recommendation "all doctors who prescribe psychiatric drugs be required by law to review the choice of drugs and the amount of the drug administered….doctors in particular be required biannually to consider less powerful drugs, drugs with less negative effects…smaller doses, and withdrawal itself." (Burstow, Cohan, Diamond et al., 2005). Clearly, if measures such as these were enacted, they would contribute to the weakening of psychiatry and the gradual loosening of the psychiatric drug stranglehold. Note, in this regard, that besides that any substantial loosening of the drug stranglehold is desirable in and of itself,

psychiatry's claim to jurisdiction over madness lies largely with the drugs. Any attack on the drugs is in the long run an attack on psychiatry's relevance.[iii]

Many, albeit not all, of the examples articulated so far are obvious. What is particularly useful about an attrition model, however, is that it helps activists and analysts engage in the reasoning, weighing, and balancing needed when confronted with choices that are not at all obvious, or what is not uncommon, where disagreement arises. And such guides are essential to better functioning.

To offer a practical example of how attrition-type reasoning helped an antipsychiatry group work through a difficult and contentious issue, I would highlight a situation that arose recently in the Coalition Against Psychiatric Assault (CAPA). A request came from a member-at-large to endorse a bill most everyone here is aware of—the New York bill banning involuntary electroshock on children under 16.[iv] As the request came during the summer when CAPA was not meeting, it fell to the executive to decide. Initially, the CAPA executive was seriously split.

Initially, most of the executive did not want to endorse because CAPA's own position is the complete abolition of electroshock, also because they feared that any new law of this nature would lend legitimacy to electroshock. On the other hand, the rest of the executive and the member-at-large were convinced that the initiative should be endorsed because if such legislation were passed, it would stop some people from being electroshocked, also because it moves in the direction of the abolition of shock.

To be clear, this dispute predates any articulation of an attrition model for antipsychiatry. Attrition, nonetheless, was at issue from the beginning, and it is a careful focusing on attrition that allowed this question to be resolved. One of the reasons given against endorsing drew on a principle inherent in the attrition model—that such a new law would lend legitimacy to the electroshock industry. *All* of the reasons to endorse connected with attrition principles: That is, it prevents some people from being electroshocked, or to put it another way, would narrow the electroshock net. Additionally, it would begin chipping away at electroshock. The point is, if electroshock is not good for children, it could be argued, it is also not good for the elderly. Accordingly, the successful passing of such a bill would take New York one stage closer to abolishing electroshock for other populations and potentially ultimately for everyone.

The principles of attrition allowed us to quickly work through what began as a divisive and hotly debated issue. It was determined that the worry that such a new law would lend credibility to the electroshock industry was ill founded. Additionally, it was agreed that such a law would protect some people, narrow the sway of electroshock, and lead in the direction of electroshock abolition. Significantly, all members of the executive followed the logic. What is also significant, none of these deliberations weakened or any way altered CAPA's own commitment to personally launch only ECT actions which call for complete abolition. However, it did allow us to work through the endorsement issue and quickly transit from a seemingly irresolvable standoff to endorsement of a bill which merited our support.

The three questions which I have been discussing this morning are the definitional ones, and indeed, are the questions that ensure that antipsychiatry initiatives are compatible with the ultimate antipsychiatry goal. This notwithstanding, given the complexity of the issues, given the vulnerability of some who access psychiatric services, and given our broader commitments as human beings, of course, these are not the only questions that antipsychiatry activists should be asking when contemplating new actions or campaigns. While it is beyond the scope of this keynote to discuss these, besides questions of strategy, additional questions which I would

recommend organizations or individuals holding an attrition model ask themselves include:

1) What sorts of non-psychiatric services, what sort of help—self help, for example, or withdrawal centres—are we advocating or supporting?
2) Are we finding ways to link up with others in the critical of psychiatry community—psychiatric survivor organizations and mad groups in particular?
3) Given that psychiatry is not the first oppressor of the people deemed mad, what measures are we taking to avoid helping pave the way for another oppressor to replace psychiatry?[v]
4) Is the initiative that we are considering compatible with the creation of a more caring society?
5) Does it leave any vulnerable people in the lurch?
6) Does the initiative that we are considering in any way empower the people most affected or most at risk from the psychiatric system (past psychiatric patients, current psychiatric patients, people who would appear to have psychiatry on their horizon)?
7) Are we paying sufficient attention to the special jeopardy in which psychiatry places otherwise oppressed populations? Women? People who are homeless? Racialized people? Lesbians and gays? Transsexuals—transsexual youth in particular? Arguably, most importantly of all, the elderly?[vi]

As regards this last item, the point is that psychiatric oppression intersects in horrific and manifold ways with all systemic oppressions, and it is critical that it be critiqued and attacked with that awareness. Hence the profound significance of such developments as feminist antipsychiatry and the very particular agendas, mandates, and priorities which these open up.[vii]

At this point, I have given you some idea how this model can be used to determine what to actively take up and what not take up, what support, what not support. I have shown also how it can be used to establish priorities, and what some of those priorities might be. At this juncture I want to enter trickier territory. I said at the beginning that use of the model would inevitably lead to a reexamination of some of the types of activities that some of us would have supported in the past. I do not want to dwell on this, for I know many of these continue to be supported by people who are here today, but I do want to touch on some of the areas where the model would encourage rethinking. One such area is some of the measures taken up and understandably taken up with regard to different oppressions.

Notwithstanding the enormous importance of paying rigorous attention to systemic oppression and notwithstanding the legitimacy of differing priorities, there have long been initiatives related to oppressed groups that an attrition model require be looked at more critically. These include:

a) pressuring for the removal of specific noxious diagnoses that particularly or uniquely oppress members of an otherwise oppressed group and
b) advocating for culturally sensitive psychiatric services.

To begin with the first, the critiquing of specific diagnoses is not only unproblematic, it is a critical part of consciousness-raising, on which all attrition models depend, and as such, it is mandatory for antipsychiatry. Indeed, it has quite rightly been one of the hallmarks of feminist antipsychiatry. Whether as women, or as racialized people, or both, we want the damage done to our communities acknowledged and stopped. Correspondingly, oppressed populations have ample reason to want specific diagnoses removed from the books for they uniquely pathologize these populations and make it easy for psychiatry to intrude. Included, in this regard, are such historical diagnoses as ego-dystonic homosexuality and hysterical personality disorder

(currently histrionic personality disorder), which have oppressed the lesbian and gay and the women's community respectively, current diagnoses as "gender identity disorder", which are oppressive to the trans community.[viii]

That women, lesbians and gays, and trans people work to have such diagnoses quashed is hardly surprisingly. The primary question here is not whether women, gays and lesbians, or trans people should organize against such diagnoses, or even whether people generally critical of psychiatry should organize against them. It is whether or not mobilization against such diagnoses is a proper antipsychiatry initiative. Herein the attrition model sheds its own light, albeit I have no questions that intersecting identities makes this issue particularly complicated for many.

Ultimately, for an attritionist, the question largely boils down to, how does it measure up to the definitional questions? That is, do the successes of such campaigns contribute to the erosion of psychiatry? Do they avoid widening the net? And do they avoid improving or lending legitimacy to psychiatry? Now the question of widening the net is unclear. However, enough of these campaigns have "succeeded" to demonstrate that there are no encouraging answers to the other questions. A number of diagnoses that we as women and as lesbians and gays rightly find oppressive have been struck down, and yet these successes have not impeded psychiatry, changed it significantly, or remotely resulted in less diagnoses. On the contrary, the number of diagnoses continues to skyrocket (see in this regard, Kirk and Kutchin, 1997 and Kirk and Kutchin, 1994). Given psychiatry's ingenuity in hiding old unpopular diagnoses behind new labels (for a discussion of this tendency, see Burstow, 1990), and given its ability to turn acknowledged oppression into a syndrome, it is often unclear what is achieved for the actual population in question. At best, they constitute somewhat of an improvement, albeit not the kind which contributes to attrition; and at worst, they only appear to improve, drawing people who began as critical into their terrain in the process. What is also problematic, such campaigns give legitimacy to psychiatry for they tacitly acknowledge its authority by the sheer act of appealing to it. Moreover, the apparent success of such campaigns has lent psychiatry the further credibility of allowing it to appear progressive. As such, involvement in such campaigns is questionable for abolitionists, albeit progressive professionals with antipsychiatry leanings such as Caplan have long engaged in them, and continued discussion would be important.[ix]

A similar problem arises with respect to campaigns for more culturally sensitive psychiatric approaches—and what is particularly problematic—for the creation of new culturally sensitive psychiatric programs. Again, it is totally understandable that populations affected by psychiatric racism, or sexism, or transphobia would push for such changes. And given the dearth of funding for services not under the auspices of psychiatry, it is totally understandable that communities which are not mainstream—especially those subject to significant transgenerational trauma and/or insidious trauma—would ask for the creation of culturally sensitive psychiatric programs, whether it be the trans community or the Aboriginal communities.[x] Nonetheless, such campaigns are in conflict with all three major tenets of an attrition model: That is:

1. They do not move us closer to abolition.
2. They do not avoid improving or lending legitimacy to the current system; in fact they are precisely reformist changes which serve to improve psychiatry and give it greater credibility.
3. They widen the net, allowing more and more members of the populations in question to fall under psychiatric auspices, and now with the active cooperation of their community.

As such, campaigns for such services are at odds with psychiatry abolition, and arguably hazardous for the communities in question.

If an attrition model became a standard part of an antipsychiatry toolkit, inevitably, other types of mobilization which currently may look benign or a reasonable tradeoff will likewise start looking increasingly problematic or minimally incompatible with an abolition mandate. The question would be to weigh carefully, to be open to reconsidering, to factor in other questions as needed, and what is particularly important, to understand that allies who make different decisions remain our allies.

Throughout this keynote, I have been demonstrating how an attrition model can help antipsychiatry activists make choices, establish priorities, and rethink directions and initiatives. While I do not suggest that is equal, in ending, I would like to suggest that there is something in this model for other constituencies in our community as well. Now I do not wish to overstate my hand here, for it could sow division as well. If held with sensitivity, this model might nonetheless be of some assistance in easing some of the tension between antipsychiatry activists and others in our community and in creating bridges. It might foster clearer communication and understanding, for example. Additionally, it might enable antipsychiatry organizations to support and join with others in more initiatives.

Significantly, while not identified as antipsychiatry, many of the initiatives, focuses, and actions specific to other critical constituencies have the potential of whittling away at psychiatry, and as such, could be supported by the antipsychiatry community far more enthusiastically than they have been in the past. An example is the creation and defense of a mad culture, which to date, sadly, has received little support from antipsychiatry. The attrition model provides a way of recognizing points of meeting that are obscured by other types of abolitionist stances, for these become visible when approached from the vantage point of slow but persistent wearing away. It also provides others in the larger community with a view of what might be added or what modifications might be made to turn an action inimical to antipsychiatry into one which antipsychiatry groups can actively support or minimally endorse. While I would not wish to overstate the case, the model also might be of more direct assistance to the broader community. The point is, while other constituencies legitimately have other priorities, I can see the value of groups coming from a different perspective touching base with such a model from time to time.

Bottom line: We all of us have this in common. None of us are deliriously happy with psychiatry. All of us minimally would like it smaller, would like it curtailed, would like room for more benign help to take root. In other words, all constituencies in our community in some way favour some type of withering. Accordingly, groups with other perspectives may be served by at least occasionally have these three questions be among the ones which they factor in when choosing actions or campaigns.

That said, I have a proposal for my fellow delegates to this conference. Take it, if you will, as an experiment. As you sit in the paper sessions that follow, as you listen to speakers and panelists, as you take part in workshops, as you try to tease out directions in the plenary, every so often let the three questions which make up this model come to mind. And if you find they shed any light, take them home with you, and let them continue to shed light in the weeks, months, and years to come.

In ending, let me also invite anyone so minded to come up with your own models and to share them, whether it be models for antipsychiatry, models for the mad movement, models for the

psych survivor movement. The reality is, we need a plethora of workable models if we are to bring about the more caring the more tolerant society for which we are all of us fighting. And let there be no mistake about it. Besides that they have the lion's share of the power, people who successfully make this world a living hell for many many others are very good at what they do. *We* need to be equally good.

This historic conference is a major step in that direction. My hope is that we all of us continue to build on the serious and very necessary work that we have begun here together. Thank you.

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Endnotes

[i] In 2008 CAPA created a myth/fact sheet to correct misimpressions about antipsychiatry, as well as to help bring the community together. For CAPA's Antipsychiatry Fact Sheet, see http: capa.oise.utoronto.ca/Fact_Sheet.html.

[ii] For an insightful critique of community treatment orders as well as a compelling read, see Fabris (2006).

[iii] For a highly informative exploration of the role of psychiatric drugs in entrenching and propping up psychiatric power, see Scull (1977).

[iv] Sponsored by Assemblyman Ortiz, the bill may be found at http://assembly.state.ny.us/leg/?bn=A08779&sh=t.

[v] Earlier oppressors include the church and businessmen. See in this regard, Szasz (1977)

[vi] For an examination of the special jeopardy of oppressed populations, see Breggin (1991) and Burstow (2003). For an examination of the massive psychiatrization of the elderly and its tragic effects, see Breggin (1991). For a revealing look at ageism in the administration of electroshock, see Weitz (1997).

[vii] See, in this regard, Smith (1987), Chesler (1972) Grobe (1995), Burstow (2003), Blackbridge and Gillhooly, 1985, and Chan, Chunn and Menzies, 2005.

[viii] For a discussion of various diagnoses which have historically served or currently serve to pathologize people from the LGBTQ community, see Burstow (1990). For a discussion of diagnoses oppressive to women, see Unger (2004) and Caplan (1995). For the articulation of the diagnosis gender identity disorder, see *DSM-IV-TR* (American Psychiatric Association, 2000, p. 576 ff.).

[ix] For Caplan's own account of her involvement in this regard, see Caplan (1995).

[x] Transgenerational trauma is trauma passed down from one generation to the next. Insidious trauma is the every day trauma of living in a world in which you are oppressed. For further elaboration on these terms, see Burstow (2003).