FROM PILLS TO PRAXIS: PSYCHIATRIC SURVIVORS AND ADULT EDUCATION

Bonnie Burstow
Ontario Institute for Studies in Education

Abstract

This article explores how adult education might adapt so as to include and serve psychiatric survivors. It lays an antihegemonic foundation for education with this learner community, including an antipsychiatry perspective, and particularly emphasizing the perspectives of the psychiatric survivor movement. And it rejects current deficit models, emphasizing radical education. Adaptations that are suggested so as to accommodate psychiatric survivors generally include: use of large lettering in written resources, exercises and resources to help learners feel safe, programs that accommodate sporadic attendance, and advocacy. The importance of adult educators working on their own biases and limitations is stressed, as is the validity of alternate realities. Radical components which are recommended include telling one's story, discussing literature and films which critique the mental health system, learning about rights, doing codification exercises, including survivors as staff and as board members, building community, and learning about and potentially linking up with current resistance efforts. Literacy work is discussed and is extended to include reading the world. Non-domesticating life skills such as learning to cope with anxiety attacks are recommended and contrasted with domesticating life skills. And adult basic education which helps survivors protect themselves from being committed against their will is defined as critical.

Résumé

Cet article examine la manière dont la formation permanente pourrait s'adapter afin d'intégrer et de servir les personnes psychiatrisées. L'étude pose des fondements anti-hégémoniques pour la formation destinée à cette communauté d'apprenants, à partir d'une perspective fondée sur l'anti-psychiatrie et, plus particulièrement, à partir des perspectives qu'offre le mouvement des personnes psychiatrisées. Elle rejette les modèles de déficit courants et met plutôt l'accent sur l'éducation radicale. En général, les accommodements suggérés pour

The Canadian Journal for the Study of Adult Education/
La Revue canadienne pour l'étude de l'éducation des adultes
17, 1 May/mai 2003 1-18
ISSN 0835-4944

venir en aide aux personnes psychiatrisées comprennent les éléments suivants : l'utilisation de gros caractères dans les documents écrits, des exercices et des ressources pour aider les apprenants à se sentir en sécurité, des programmes qui permettent les présences sporadiques, ainsi que la promotion et la défense des droits. Outre la justesse des réalités alternatives, on met en valeur l'attitude des formateurs d'adultes qui travaillent à changer leurs propres préjugés et limites. Dans le cadre d'une éducation radicale, on suggère la possibilité de raconter son vécu, de discuter des documents écrits et filmiques qui critiquent le système de santé mentale, de faire l'apprentissage de ses droits, de faire des exercices de codification, d'intégrer les personnes psychiatrisées en tant qu'employés ou membres de la direction, de travailler à établir un esprit communautaire et de se mettre au courant des efforts de résistance qui ont cours, tout en essayant de s'y joindre. Le travail d'alphabétisation est abordé et étendu à l'interprétation critique du monde. Des connaissances pratiques telles que la manière de réagir aux crises d'anxiété sont recommandées et comparées aux connaissances élémentaires de la vie quotidienne. En outre, on définit comme cruciale la formation permanente de base qui aide les personnes psychiatrisées à se protéger des situations dans lesquelles elles se sentent entraînées contre leur volonté.

Over the last few decades, adult education has been progressively committed to inclusion and liberation. The focus of this article is an oppressed learner community that still tends to be overlooked and "domesticated" (Freire and Giroux, 1985) in adult educational programming and theorizing—psychiatric survivors.

The comparative neglect of this learner community and the inadequacy of standard conceptualizations about it are palpable. There is only a smattering of adult education books which mention psychiatric survivors. Except in adult basic education and not systematically even there, little attention is paid to how to make programs accessible and relevant to psychiatric survivors—never mind how to make them empowering. Horsman (1999) and Rogers (1997) are among the few adult basic educators who theorize in this area; and while each discusses accommodation, neither addresses empowerment. To date, few if any articles in a Canadian adult education journal, including this journal, have identified psychiatric survivors as a community to serve. Outside the auspices of the ministries of health and social services, there are few programs for this learner group. Correspondingly, for the most part, programs that exist are problematic. Most are run by mental health professionals who lack insight and training in the pedagogy of the oppressed. And regardless of who plans or facilitates the

programs, a deficit model tends to be the norm. Psychiatric survivors are conceptualized as fundamentally flawed, as lacking in skills, and as the locus for change. While clearly representing an advance, even psychiatric survivor-led training, such as the training which transpires in the new field of survivor-run businesses, remains within a limited liberal paradigm.

The approach to survivors as learners is almost invariably conservative, liberal, or some combination of the two. Conservatives strongly adhere to the medical model. They assume that psychiatric survivors are deficient, that drugs can help but that inherent deficiencies place severe limits on what survivors can achieve and what it is realistic for them to attempt. Educators with a combined liberal and conservative perspective are more optimistic about what can be achieved. Nonetheless, they draw on the medical model, even when they question it in limited ways; and they still conceptualize survivors as the problem and the change target. Even a particularly progressive program such as George Brown College's Redirection through Education,[1] is essentially liberal, and as with all liberal programs, much of the education is still domesticating.[2] For example, in Redirection through Education, counselling is mandatory; the life skills taught are not problematized; and there is no commitment to social change. Even with the best of the programs, antipsychiatry principles are not integrated, despite decades of survivors pointing to this as a necessary direction.[3] These and other deficiencies are the context in which this article is written.

The ultimate purpose of this article is to effect change in adult educational theory and scope so that we that we can better serve this learner population. More immediate purposes are:

1. to raise awareness about the nature and needs of this learner group;
2. to provide guidance on how to make our programs accessible;
3. to provide an anti-hegemonic foundation for programs;
4. to provide some directions for programming—radical programming especially.

The article is grounded in my own experience. For over two decades, I have been a radical feminist therapist, a supervisor of social workers and

---

[1] Redirection through Education is a community college program for psychiatric survivors at George Brown College in Toronto. It helps survivors improve their communication and work skills. See Gilbert (1995).

[2] Domesticating education is education to adapt. It is contrast with liberatory education, which helps oppressed groups take charge and name the world in order to change the world. For further details see Freire (1970).

[3] See, for example, Shimrat (1997).

community workers who work with psychiatrist survivors, an adult education professor committed to the marginalized, an antipsychiatry activist, and an active ally of the regional, national, and international psychiatric survivor movement(s). My multifaceted experiences within these roles underpin this article.

The Antipsychiatry Grounding for this Article

Psychiatry is predicated on the belief that people called "psychiatric patients" have diseases called "mental illnesses" which put those afflicted and those around them in danger if the diseases are not controlled. Dangerousness itself is a quality often attributed to oppressed people, and as with other oppressed groups, it has not been substantiated here. The disease theory is similarly unproven, though we tend to forget that fact, for it has become hegemonic and part of the apparatus of governing. That is, it has become part of the "normal" way of thinking about people with certain problems in living. Correspondingly, it is ensconced in law and reflected in our social institutions—the mental health laws that we have passed, the ministries that enforce them, the "hospitals" and staff that medicalize and regulate this area of "deviance".[4]

As psychiatric researchers such as Breggin (1997) demonstrate, psychiatry treats people for chemical imbalances which have *not* been demonstrated and in the process creates chemical imbalances that *can* be demonstrated. The neuroleptics are a case in point. The official stance is that "schizophrenics" have an excess of the neurotransmitter dopamine. In the absence of any proof that people so labeled have such an excess, psychiatrists prescribe people so diagnosed neuroleptics to impede dopamine transmission. The result is a reaction known as a Parkinsonian reaction. (Parkinson's Disease, significantly, is created by *insufficient* dopamine. See Burstow, 1992). Significantly, as the American Psychiatric Association itself testifies, up to 50% of people on neuroleptics for over five years develop tardive dyskinesia – irreversible neurological impairment (American Psychiatric Association, 1980). What is happening here is that people with normal chemistry are being rendered chemically imbalanced; and people with no neurological impairment are being neurologically impaired. To be clear, no one is denying that people given these drugs may become calmer in the process and may be less trouble to others and even to themselves. The

[4] Sociologists known as 'labelling theorists' have argued that mental health establishment is essentially in the business of regulating deviance. In this regard, see Conrad and Schneider (1980).

fact that drugged people are calmer, however, in no way mitigates injury or makes a flawed model sound.

The current position of the psychiatric establishment is that antipsychiatry is outdated and that its claims have been disproved. The official line is that chemical imbalances and other markers for mental illnesses have been established. A number of renowned psychiatrists, psychologists, and social workers have done extensive and meticulous meta-analysis, combing through thousands of psychiatric research reports, and their findings show the opposite (see, for example, Cohen, 1994b; Ciompi et al., 1992; Breggin, 1997; and Colbert, 2001). As late as 2001, on the basis of an extensive meta-analysis, psychologist and researcher Ty Colbert (2001, p. 11) concluded, "The only well established fact concerning the biology of mental illness is that absolutely no pathophysiology of any kind has ever been found for mental illness."

The consequences of the flawed model and the coercive system that accompanies it are horrendous. On a physical level, the consequences include: neurological impairment, permanent brain damage, impairment in motor functions (drooling, shaking, involuntary movements, shuffling gait), cognitive impairment, dulling of affect, and blurred vision, to name just a few.[5] As survivors and their allies have documented, on a psychological and social level, the consequences of the mental health system *per se* include loss of esteem, dependence, drug addiction, traumatization, loss of will, difficulty learning, poverty, homelessness, stigmatization, inability to concentrate, and, in many instances, a life reduced to managing "symptoms", "adjusting the meds", and going in and out of "hospital" (the "revolving door syndrome). [6] Additionally, a common consequence of being subjected to the system are the various trauma associated with life in psychiatric institutions—trauma from electroshock, from being tackled by staff, from being locked in solitaire, and from being put in two and four point restraints.[7]

Other Grounding for this Article

As already discussed, the adult education grounding for this article is the pedagogy of the oppressed (e.g. Freire, 1970), the literature on inclusion, and the literature on working with the psychiatrized and the vulnerable (e.g. Gilbert, 1995; Horsman, 1999). Other professional grounding outside adult

---

[5] For further details, see psychiatrist Breggin (1991) and Breggin (1983).

[6] See, for example, Shimrat (1997); and see the stories in Burstow and Weitz (1988).

[7] See, in this regard, Burstow and Weitz (1988).

education includes structuralist social work, feminist therapy, radical psychology, community work, and community development.

A basic tenet of structuralist social work, radical psychology, and feminist therapy is that psychiatric survivors' unusual ways of coping and unusual beliefs have validity. The coping and the beliefs in question are grounded in vision and constitute creative responses to trauma and to oppression. Significantly, as works like Burstow (1994) show, most people who end up in psychiatric institutions were already victims of violence. Their responses to the violence include the terror, alternate realities, and "deviant" behaviour traditionally seen as symptoms of "mental disease". The challenge is to validate the realities and help survivors deal with triggers, work through trauma, and combat oppression (see Colbert, 2001; Cohen, 1994a; Burstow, 1992.)

Radical community workers see homelessness, unemployment, and poverty as centrally implicated in the "symptoms" of psychiatric survivors. Community development workers are focused on the creation of alternate structures and supports within the community, whether it be support groups or alternative businesses. In this last regard, see Church (2000).

Complementing and sometimes mirroring these professional perspectives and emphases are the various perspectives, activities, and literature associated with the mad movement. For two decades now, the psychiatric survivor movement, also called the "mad movement", has produced its own literature and created its own praxis. The various perspectives include antipsychiatry—especially the human rights dimension, liberal inclusionism (being included as stakeholders in the decision-making process around mental health policy), and community economic development. Mad and antipsychiatry movement initiatives include: protesting; organizing regional, national, and international campaigns against treatments such as electroshock and coercive practices such as community treatment orders; telling and publishing their own stories of psychiatric oppression; creating mad theatre; making deputations; creating self-help groups; sitting on governmental committees which decide on mental health policy; and creating alternative survivor-run businesses (see, in this regard, Shimrat, 1997, Church, 2000, Everett, 2000, and Everett, 1994). Survivors and their allies have been very clear that the movement and its initiatives have been enormously empowering for psychiatric survivors. This being the case, learner needs associated with these different perspectives and initiatives provide a particularly important direction for adult education for psychiatric survivors.

A sense of movement priorities may be gleaned from policy statements made at the Highlander Conference of 2000. In March of 2000, Support Coalition International (a worldwide coalition of psychiatric survivor groups) held a historic international conference in Highlander, attended by thousands of representatives. It issued a statement called a "Call to Action". It subsequently reissued the exact same statement at the second Highlander Conference held in March of 2001. The Highlander Call to Action is the closest we have to an official position of the international psychiatric survivor movement. It reads:

> We call upon all people committed to human rights to organize and fight against the passage and implementation of legislation making it easier to lock up and forcibly drug people labeled with psychiatric disorders, legislation that is creating the backwardness of the twenty-first century not just in back wards but also in our homes. We call upon all people committed to human rights to work together to build a mental health system that is based upon the principle of self-determination, on a belief in our ability to recover, and on our right to define what recovery is and how best to achieve it. We call upon all people who have used mental health services to heal each other by telling our stories. We call for the creation of literature and other arts that use our truth to educate, to enform, and to validate our culture and our experience. We call upon elected officials, political candidates, and those with power over our lives to recognize and honor the legitimacy of our concerns through their policy statements, legislative proposals, and their actions; and we hereby give notice that we will do whatever it takes to ensure that we are heard, that our rights are protected, and that we can live freely and peacefully in our communities. (Support Coalition International, 2000)

This statement provides some direction for our work as adult educators.

Adult Education with Psychiatric Survivors: A General Orientation

Insofar as accommodating this learner group is a goal, even where radical education is not intended, there are different types and different levels of challenges which this learner group presents. Some of the challenges in question arise from the difficulties which learners face solely or largely as a result of psychiatry. Included here are the challenges involved in working with learners who may have low self esteem, who are frightened, who have reason to distrust authorities, who are so institutionalized that they may forever look to the educator to tell them what to do, who may have difficulty reading because their vision is blurred (drug reaction), who have little

patience, who have trouble staying still (drug reaction), who have a diminished attention span (drug reaction), who may have enormous trouble remembering what you said yesterday (possibly electroshock, possibly drugs, possibly trauma),[8] and who may need help transiting from a patient to a learner identity (see Gilbert, 1995).

Added to these challenges are challenges related to problems which largely have origins other than psychiatry, though psychiatry may compound them. These include the challenge of working with people: who hear or see what you do not hear or see (conventionally called "hallucinations"), who live in alternate realities (conventionally called "out of touch will reality"), who may act in ways that others deem inappropriate, who may easily get triggered into anger, vulnerability, or terror, who may not be able to attend classes regularly, whose conduct may upset other learners, who may not feel easy about attending any programs outside of local centres in which they have come to feel comfortable, who may not have eaten that day because they have already spent the disability allowance.

Some of the foregoing can be addressed on a pragmatic level. Insofar as a large number of survivors expectably have blurred vision because of drugging, ensuring that any written material used has extra large lettering is important. Insofar as it is hard for some of the learners to sit still and to concentrate for long periods—especially those heavily drugged—it is important that there be frequent breaks. As Horsman (1999) points out, insofar as a number of learners cannot turn up regularly, whether because of "hospitalizations" or any other reason, it is important to have programs organized around or which readily lend themselves to sporadic attendance. Insofar as there are particular hangouts in which survivors are comfortable and many are uncomfortable elsewhere, it is important that a range of adult educational programs be run in these centres and advertised at these centres and that bridging relationships with the centres be maintained. Insofar as some survivors are likely to be hungry, and the learning situation permits, providing food is wise. And insofar as self confidence and concentration are issues, a more relaxed pace is often in order.

Where work is done in groups of any sort, some one-to-one time is necessary. As community workers and educators such as Gilbert (1995) point out, survivors frequently need time alone with the facilitator. What is important here is that the educator make the extra time, listen to their fears,

---

[8] For details on memory impairment from electroconvulsive therapy, see Breggin (1979).

angers, or frustration, be able to empathize, and be able to bear witness to the stories of abuse or of pain or of confusion that the learner may need to tell.

Other dynamics require more from the adult educator. Survivors have reason to distrust authority; and it is incumbent on the adult educator to earn their trust. Ways of being trustworthy and therefore earning trust include: being flexible, patient, respectful, and empathic; spending some time listening to stories that may have no apparent relationship with the material that you intended to cover; and not dismissing accounts of how others—including professionals—are treating them, even where time frames are "off", literal and figurative truths are confused, or reactions seem exaggerated. It is likewise critical to ensure that people can be themselves—that they are not judged because they live on the street, have unconventional appearances (whether because of poverty or drug reactions like involuntary twitches), or make unusual statements. Being trustworthy, additionally, involves seeing past the label to the human being, allying with the learner—not the mental health system—and doing the personal stretching necessary to be able to take in and validate realities other than your own.

The issue of alternate realities and unusual behaviour is particularly important. Where a psychiatric survivor with an alternate reality is in a learning group where other participants have little familiarity with survivors, others may react intolerantly. For example, they may dismiss or ridicule someone who refers to their "voices". Besides addressing this problem when it occurs, adult educators can be preemptive by modeling openness. And here, it is important to go beyond the pseudo-respectful "tolerance" of the conservative and liberal models. Insofar as the educator ostensibly accepts that alternate realities have their own type of validity, most other learners will follow suit. Educators, in this regard, have the opportunity not only to help the individual learner but to extend the limits of what is considered normal. Doing so, correspondingly, is part of our radical commitment to "humanize the world" (Freire, 1970).

With alternate reality and behaviour, of course, adult educators find themselves face to face with their own prejudices, their own fears of people who are different, and their own limitations in understanding reality. It is important to work on ourselves here—to accept that there are different ways of being in the world. It is important to see the strengths and the soundness in ways of thinking and in behaviour that might initially seem strange or frightening—whether it be self-mutilation, or talking to people that others do not see, or believing that the CIA is out to get them. Adult educators need to understand that there is meaning and reason in worldviews, beliefs, and ways

of coping that conflict with conventional reason. This is partly because traumatized people often confuse the literal with the figurative and, generally, there are figurative truths behind seemingly "bizarre" beliefs.[9] It is also because, as with others who live at the margins, survivors have added wisdom; and herein lies a strength that liberals overlook and that needs to be affirmed and appreciated. Survivors have wisdom that cuts through everyday mythology and the arbitrary conventions that people more centrally located accept uncritically. The challenge is to be open and to be willing to question, explore, and affirm.

The significance of trauma more generally is a challenge for the adult educator. The adult educator needs to understand something about trauma and learn how to recognize when a learner is triggered. Adult educators working with this community need to know how to help learners who are being triggered ground themselves. As discussed in detail in Burstow (1992), Herman (1995), and other works on trauma, you can help by inviting learners to breathe, reassuring them that no one here is going to hurt them, and, in extreme circumstances, reminding them who you are and what is happening can help. Asking learners about what triggers them will give you some idea what to avoid, though occasionally, the list is so long or the trigger is such that avoidance is impossible. In that eventuality, helping them devise strategies for dealing with the triggers is particularly important. Related work that may be intermittently important include: helping learners become aware of their triggers so that they can recognize when they are being triggered; helping survivors develop individualized strategies for dealing with triggers; having a "cooling out" room where survivors can go when in need; and helping learners vividly picture a "safe place", then inviting them to use this imaginary place as a resource should the need arise.

There are various other skills which adult educators may need to develop. Examples are: learning to tolerate more interruptions than they may be used to; not personalizing anger directed at them; becoming adept at dealing with conflict which may erupt; becoming skilled at drawing limits; becoming adept at striking a balance between the rights and needs of more vulnerable and/or disruptive learners and the rights and needs of other learners in our programs; and establishing workable boundaries with learners who have a hard time with boundaries. The frequency with which such issues come up when I am supervising workers tells me just how critical such skills are and just how difficult they are to hone.

---

[9] For examples of understanding and validating alternate realities, see Burstow (1992).

Where the program is part of a large institution with resources and protocols, such as a community college, counsellors should be prepared to devote extra time to helping this learner population. By the same token, as seasoned counsellors who work at community colleges tell me, where conflicts arise between the learner and the institution, whether because the learner has done something deemed inappropriate or for any other reason, the counsellor needs to be prepared to assume a fairly time-intensive advocacy or mediator role. Correspondingly, whatever the organization, there are times when both teachers and counsellors need to be prepared to act as advocates both inside and outside the organization.

A more structural approach to accessibility, and one which the survivor movement has long emphasized, is including survivors in planning and facilitation (see Church, 2000; Shimrat, 1997). Where survivors are included as board members, tutors, consultants, and teaching staff, survivors have authority figures and models with whom they can more easily identify and relate. And survivor concerns are more likely to be up-fronted and appreciated.

Radical Education *Per Se*

There are radical components is some of the foregoing. But what has been outlined to date will not itself facilitate community empowerment. Hard hitting radical education is more often possible where survivors are the focus of the program or the sole learners.

Radical education begins with the interests and agenda of the learners. As most survivors are extremely eager to tell their stories, a good place to begin and to keep returning is helping people tell their stories, whether through speaking, drawing, writing, or creating theatre pieces. Naming the world is empowering for anyone, but especially people whose realities have been invalidated by the term "mentally ill". Psychiatric survivors have been told they are invalid (sick, not valid). Telling their story is part and parcel of reclaiming validity and fulfilling their ontological calling to name the world in order to change the world (see Freire, 1970). And it is so recognized in the Hylander Call to Action. As such, telling is an intrinsic part of radical praxis.

As their world has been invalidated and intruded on by psychiatry, critiques of psychiatry are one of the important educational resources. These can be found in survivor magazines like *Phoenix Rising* (Canada) and *MindFreedom* (United States). Educational critique, entertainment, and some degree of community building can be achieved by watching and discussing films, videos, and plays which problematize some aspect of the mental health

system or of the mentalism in our society.[10] Insofar as the group further elaborates on and problematizes what is found in the film, they might go to the next stage of taking up tasks to be done.

Community and community change work can be facilitated by highlighting current problems facing the community (amendments to mental health legislation which further strip survivors of their rights, for example). It is similarly facilitated by timely information about current survivor initiatives. Examples are meetings about police violence, survivor planning sessions to oppose incoming legislation, meetings to plan new alternative businesses or evaluate current ones, and celebrations—especially educational ones like Psychiatric Survivor Pride Day. It is facilitated as well by creating links with educationals provided by the survivor movement or the antipsychiatry movement and supporting these educationals where feasible.

As articulated at Highlander, legal and human rights education itself is a particularly important part of radical education with survivors, for just as psychiatric infringement is enshrined in the law, so are limitations on it. Survivors typically want to know what their rights are, how to use the law to protect themselves and their friends, and what jeopardy is involved in proposed legislation; and survivors will ask for such education if they know it is a possibility. Bringing in lawyers who specialize in mental health and human rights law is recommended. By the same token, as people who are at risk of being denied disability or being evicted from their apartments, many survivors want education in the welfare rights and tenant rights areas.

Critical and reliable information on psychiatric drugs is equally important given the enormous role that these drugs play in survivors' lives; and again survivors actively request such information. Resources in this regard include: books specifically written for psychiatric survivors (e.g., Breggin's *Toxic Psychiatry*), survivor magazines, survivor listservs, survivor books, and relevant videos. Topics that survivors frequently choose to learn more about in this regard include: a) myths and facts about psychiatric drugs; b) how to come off psychiatric drugs in ways that do not land them *in* hospital. Accurate information on the dangers posed by the most popular current psychiatric drugs (Prozac, for example) is also a "hot" item.

Some of the education in question can occur in individual classes within large educational programs which are not consistently radical. More focused conscientization work is more likely to happen in community settings.

---

[10] "Mentalism" is oppression against people who are deemed "crazy" or "mentally disordered".

As with other oppressed communities, of course, conscientization work *per se* must be grounded in lived experience—in familiar situations. As Burstow (1989) shows, Freirian codifications work well in this regard.

An example of a codification that I have used effectively with psychiatric survivors shows a well dressed male doctor pointing to a passage in the *Diagnostic and Statistic Manual of Mental Disorders* (DSM), while a woman inmate in her pajamas looks on. Others show forced drugging, electroshock, and use of restraints. Themes that survivor co-investigators typically identify and expound on at length once they feel comfortable enough to do so include: drugging; violence by psychiatric staff; police violence; humiliating education (e.g., occupational therapy, sheltered workshops, etc.); infantilization (e.g., being relegated to pajamas); sexism and psychiatry, institutionalization; labels; and societal stigmatization.

Additional components of radical education that are highly relevant to this learner group include: education about poverty and how it is created; and education about racism, sexism, ableism, and homophobia. Correspondingly, other movements that learners may want help accessing include: the anti-poverty movement, the women's movement, anti-racism, the gay rights movement, and the disability rights movement.[11]

Ongoing collaboration with antipsychiatry and mad movement representatives is a particularly important direction that adult educators could take and one that could culminate in extensive radical education for this learner community. Where the learners are open to it, and in my experiences, they almost always are, inviting movement leaders to make presentations on alternative businesses, self-help groups, psychiatry, or community economic development is a way to raise awareness about critical issues facing survivors and help survivors link up with the movement people and movement initiatives. Helping facilitate these linkups, I would add, is particularly important, for empowerment does not occur in isolation. Survivors need

---

[11] In their statement of concern, significantly, the representatives at Highlander explicitly draw the connection between the psychiatric survivor movement and other human rights movements. Note, in this regard, the following statement quoted from the Statement of Concern issued at Highlander: "We are compelled to share our collective struggle and claim our place as a civil rights movement along side of those who have been similarly discounted, disenfranchised, and marginalized: people of colour, gay, lesbian, bisexual, and transgendered people; people with physical disabilities; women, people belonging to religious, ethnic, and linguistic minorities; Jews and others now at risk of ethnic cleansing; and people forced to live in poverty." Support Coalition International (2000b).

community; and ultimately, it is from the community itself taking charge and acting that fundamental social change will occur.

Further and deeper collaboration could emerge from ongoing dialogue between adult educators and movement representatives. And I recommend that we invite such a dialogue. One particular promising direction that might be taken is co-creating educationals specifically intended to address the learning needs of the movement itself. Content would have to be established through dialogue, with adult educators taking direction from movement members. Content which I can tentatively suggest as a result of my ongoing dialogue and involvement include: leadership workshops, classes on the running of workplace collectives, courses in popular theatre or participatory research, conferences on organized resistance and movement building, and workshops to address divisions and conflict within the movement. As allies, additionally, we could serve the survivor movement simply by sharing learning resources. The sharing of Highlander is a good start.

Dialogue might similarly be initiated with radical social workers and community development workers who specialize in this area. And some of the adult basic education spelt out in the next section might be planned in concert with them.

Psychiatric Survivors and Adult Basic Education

Adult basic education is one area where an effort is made to include and accommodate psychiatric survivors.[12] Additionally, there is a greater likelihood of adult basic educators being sensitive to survivor issues, given the commonality between psychiatric survivors and other adult basic education learners. As Horsman, (1999), Alden (1982), and other adult basic educators indicate, not just psychiatric survivors but a very high percentage of adult basic education learners overall are poor, have trouble getting decent work, have a history of violation, are insecure in formal learning situations, have low self-esteem, and have been traumatized.

Psychiatric survivors legitimately need traditional adult basic education programs. Survivors who were psychiatrized as children often did not finish school or had difficulty learning to read and write. Correspondingly, as seen in Burstow and Weitz (1989), the memory loss from electroshock can result in the loss of basic skills such as reading. Hence the importance of literacy work. Additionally, as the popularity of programs like Redirection through Education show, many survivors want training to increase their

employability, get off "disability", and thereby have a fuller life. It is proper that there be such adult basic educational programs for psychiatric survivors. The accessibility issues discussed earlier, of course, apply here. Such programs, additionally, might be radicalized by helping people to read the *world* at the same time that they read the *word*. Literacy programs, for example, could include writing one's story, reading critiques of psychiatry, reading about capitalism and about racism, reading about the alternative businesses, and so forth.

The same qualifications that adult basic educators like Gee (1990), Alden (1982), and Horsman (1999) stipulate with regard to adult basic education programs for other populations apply here. Competency-based approaches and approaches involving standardized testing are inappropriate and are likely to traumatize. Prioritizing the language of the elite is alienating and deskilling. We should not be sacrificing learners to serve the needs and agendas of corporate capitalism. Correspondingly, given the biases against this population, it is particularly important not to leave survivors with the impression that if they upgraded, good jobs and decent wages would be theirs for the asking. (In this regard, see in particular, Gee, 1990.)

The area of life skills presents further dilemmas. Life skills for psychiatric survivors make sense, but it matters what is focal, how it comes to be focal, and how the learning proceeds. It is important to pay attention to survivors' wishes and life styles. More fundamentally, something is not a life skill just because it is conventional and is mandated by those with power. Significantly, many survivors have no interest in or need for the domesticating packages that come their way—keeping a clean house, for example (see Burstow, 1989).

Contrasting with these hegemonically identified "life skills" are life skills that survivors want and that could legitimately be the focus of these educationals. Examples are: how to deal with anxiety attacks, how to regain credibility with people who dismiss them, and how to protect their rights. There are others, additionally, that could be useful even though there is some danger of domestication—communication skills, for example. Teaching these critically, of course, involves problematizing not simply passing on the middle class and otherwise dominant framing.

---

[12] The literacy programs at St. Christopher's in Toronto are a prime example. For details, see Rogers (1997).

"Critical" Adult Basic Education

It is clear from the enormous attention given it in adult basic education that adult basic educators tend to prioritize conventional literacy as the education most needed by the populations that they serve. What is most critical to daily life, however, varies with the conditions faced. The question arises: What constitutes "critical" adult basic education for psychiatric survivors?

While there is more than one possible answer here, one helpful way to define it is as education which enables them to protect themselves from the loss of self which occurs when they are institutionalized against their will.[13] Why I conceptualize such skills as adult basic education and why I call it critical is that the skills in question are ones that most people do not even have to take cognizance of and yet they are foundational for a full life.

It is beyond the scope of this article to outline programming for such skills in any detail. However, I can name some general principles and provide some examples. An example of the type of skill needed is being able to distinguish who to trust and who not to trust with what information. From time to time, most of us have thoughts that most others would find strange or dangerous; and those thoughts (whether self-destructive or irrational by conventional standards) could put us in jeopardy if we expressed them to the wrong person. Somehow, we grew up sufficiently able to read the world that we knew who to trust and who not to trust with such thoughts. By contrast, I have had many clients who were hospitalized repeatedly because they did not have such skills and who successfully avoided hospitalization once they acquired them.

Correspondingly, while people from dominant groups are particularly privileged in this regard, most people can sufficiently read the social cues of the larger society of which they are members that they have a good feel for what is expected and what would shock. They roughly know, for example, where they can yell and where they cannot yell. In this regard, most people are what Garfinkle (1984) calls "competent practitioners of the social world". By contrast, many survivors have more difficulty deciphering; and this difficulty puts them in jeopardy. Again, life skills which help them read the world (society) in this particular way could help.

Once again, these social constructions, these expectations, and the ways in which they are held should not be presented as optimal or "normal". Radical pedagogy requires us to critique society in the process of helping

---

[13] For insight into this interference and the traumatization that results, see Burstow (1994) and Burstow and Weitz (1988).

survivors learn to read society. Otherwise, what is intended as help domesticates and undermines the radical thrust.

Many of the educational components which I have discussed in other sections could be theorized as critical adult basic education, for they help survivors protect themselves—the education on how to exercise one's legal rights, for example. What constitutes critical adult basic education for any particular group, of course, will vary in accordance with the specific learners themselves; and as with all other educational areas, ongoing input and direction from the learners that we are trying to serve is essential.

Concluding Remarks/Invitation

In this article, I have outlined some measures that adult educators can take to include and accommodate psychiatric survivors. And I have begun to delineate radical adult education for psychiatric survivors.

I invite my colleagues to further theorize this area and to adopt some of the measures outlined. I invite you, moreover, to enter into dialogue with the survivor community and its allies and to join in writing this new chapter in the pedagogy of the oppressed.

References

American Psychiatric Association. (1980). *Task force report: Tardive dyskinesia*. Washington: APA.

Atonuccio, D. et al. (1995). Raising questions about antidepressants. *Psychotherapy and Psychomatics, 68*(3): 31-44.

Breggin, P. (1997). *Brain-disabling treatments in psychiatry*. New York: Springer.

Breggin, P. (1991). *Toxic psychiatry*. New York: St. Martin's Press.

Breggin, P. (1983). *Psychiatric drugs: Hazards to the brain*. New York: Springer.

Breggin, P. (1979). *Electroshock: Its brain-disabling effects*. New York: Springer.

Burstow, B. (1994). *When women end up in those horrible places*. Video. Toronto: Burstow.

Burstow, B. (1992). *Radical feminist therapy*. Newbury Park, California: Sage.

Burstow, B. (1989). Conscientization: A new direction for exinmate education. *International Journal of Lifelong Education, 8*(1), 25-45.

Burstow, B. and Weitz, D. (1988). Shrink resistant. Vancouver: New Star.

Church, K. (2000). Strange bedfellows: Seduction of a social movement. In. E. Shragge & J. Fontan (Eds.), *Social economy: International debates and perspectives*. Montreal: Black Rose.

Ciompi. L. et al. (1992). The pilot project "Soteria Berne". *British Journal of Psychiatry, 161*(supplement), 145-153.

Cohen, D. (1994a). *Challenging the Therapeutic State, Part II: Journal of Mind and Behaviour, 15*.

Cohen, D. (1994b). Neuroleptic drug treatment of schizophrenia. *The Journal of Mind and Behaviour, 15*(2), 139-15.

Colbert, T. (2001). *Rape of the soul: How the chemical imbalance model of modern psychiatry has failed its patients*. Tustin, CA: Kevco Publishing.

Conrad, C., & Schneider, J. (1980). *Deviance and medicalization*. Toronto: Mosby.

Everett. B. (2000). *A fragile revolution: Consumers and psychiatric survivors*. Waterloo: Sir Wilfred Laurier Press.

Everett, B. (1994). Something is happening: The contemporary consumer and psychiatric survivor movement in historical context. *Journal of Mind and Behavior, 15*(1), 55-69.

Freire, P. (1970). *Pedagogy of the Oppressed*. New York: Seabury.

Freire, P., & Giroux, H. (1985). *The politics of education*. South Hadley: Bergin & Garvey.

Garfinkle, H. (1984). *Studies in ethnomethodology*. Cambridge, UK: Polity Press.

Gee, J. (1990). *Social linguistics and literacies*. London: Farmer Press.

Gilbert, R. (1995). *The George Brown College of Applied Art and Technology program review*. Toronto.

Herman. J. (1992). *Trauma and recovery*. New York: Basic Books.

Horsman, J. (1999). *Too scared to learn*. Toronto: McGilligan Books.

Rogers, J. (1997). *Am I welcome here?:A book about literacy and psychiatric experiences*. Toronto: St. Christopher House Literacy Program.

Shimrat, I. (1997). *Call me crazy*. Vancouver: Press Gang.

Support Coalition International. (2000a). The Highlander call for action. *Dendron, 43*(5).

Support Coalition International. (2000b). The Highlander statement of concern. *Dendron, 43*(5).