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Burstow, B., LeFrancois, B.A., & Diamond, S. (Eds.) (2014). *Psychiatry Disrupted: Theorizing Resistance and Crafting the (R)evolution*. McGill-Queen's University Press.

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This ground-breaking collection represents a significant challenge to psychiatry and is an inspiring collaborative venture between academics, activists, and psychiatric survivors from Canada, England, and the United States. It would be a great text for undergraduate and graduate students in fields like psychology, sociology, social work, disability studies, and women and gender studies. It explores various arguments for opposing psychiatry and can assist those training in mental health professions to raise their health care practice to a higher standard of accountability.

As many of the contributors emphasize, the dismantling of psychiatry will be slow given that it is enforced and promoted by myriad institutions. But these remarkable essays could initiate significant ripples in academia and healthcare if researchers, students, and mental health professionals embrace their critiques and suggestions for action. As stated in the forward by stellar activist and psychologist Paula Caplan, this "treasure trove of a book [offers] many avenues for activism" (xv). After reading this book, "no one can claim that they want to act but don't know what to do" (xv).

The book's preface by revolutionary writer and psychiatric survivor Kate Millet aptly sets the tone for the mind-freeing, truth- telling chapters that follow. In theorizing about psychiatry, the authors use an intersectional approach and explore how sanism intersects with other forms of social discrimination, such as sexism, racism, colonialism, classism, cis-genderism, and ableism

(7). Personal narrative is interwoven throughout. A recurring emphasis is on strategizing by coalition building between movements that are critical of psychiatry (8).

While each chapter is valuable and imparts important knowledge and information, some chapters drew more of my attention. In Chapter 3, “The Withering Away of Psychiatry: An Attrition Model for Antipsychiatry,” Bonnie Burstow presents the attrition model for prison abolition, a continuous, long-term strategy of slowly diminishing the presence and power of prisons in society, as instructive for the abolition of psychiatry. She argues that members of the community who are critical of psychiatry—antipsychiatry activists, mad activists, professionals, survivors, and artists—need to be better allies and more tolerant of each other’s differences to better diminish the power of psychiatry (35). She gives helpful direction on how anti-psychiatry activists in particular can act in keeping with their view that psychiatry is inherently irredeemable while at the same time lend support to those whose views of psychiatry are less critical.

For example, Burstow refers to the language of the mad movement which is not anti-psychiatry *per se* but which offsets medical language (40). People who identify as mad may refer to themselves with non-medical language, as, for example, people who are neuroatypical or who hear voices. Burstow argues that since mad language undermines the power of psychiatry, under an attrition model it can be supported by those who are anti-psychiatry (40). She seems right that it would help to wear down psychiatry if the antipsychiatry community gave greater support to the mad movement.

It might be objected by antipsychiatry activists that those who identify as mad sometimes also use diagnostic language that reinforces psychiatry, and refer to themselves as, for instance, autistic, borderline, or psychiatrically disabled. Some people who identify as mad say it is important to use language in an inclusive way which invites coalition and not to insist on the use of particular terms. Margaret Price, for example, states: “I use *mental disability* as an umbrella term encompassing cognitive, intellectual, and psychiatric disabilities, mental illness, m/Madness and a/Autism, as well as brain injury or psychiatric survivorship. *Mental disability* is not intended to replace any of these more specific terms or to erase differences, but rather to enable coalition.” (2015, p. 280, emphasis in original). Further, Merri Lisa Johnston (2015) refers to madness and disability but also gives some legitimacy to borderline personality disorder. However, using language in an inclusive way in some situations and contexts and not mandating non-medical frameworks and abolitionist perspectives could, in inviting coalition, promote more solidarity between those who are critical of psychiatry to different degrees. This could effectively contribute to a complete shift to non-medical ways of conceiving problems in social living.

In Chapter 6, “Developing Partnerships to Resist Psychiatry within Academia,” by Peter Beresford and Robert Menzies, the authors refer to some instances of successful alliances between academics and activists within academia, such as the 2008 “Madness, Citizenship, and Social Justice Conference” held at Simon Fraser University, which publicly challenged psychiatry. That such a conference received funding, such as from the Social Sciences and Humanities Research Council of Canada, is heartening given that, as the authors note, academia generally promotes psychiatric understandings of problems in social living (85). Academics who embrace psychiatry are typically rewarded with grant money while scholars who question dominant conceptions of normalcy and deviance risk underfunding and a lack of career advancement.

The authors encourage progressive academics to mentor students who are users, consumers, survivors, and/or members of mad communities (90). It is also important for those in secure academic positions to reach out to more marginalized academics who criticize psychiatry, such as those who are in contract positions or unaffiliated with academic institutions. Some academics in mad studies and disability studies may find themselves more marginalized because their scholarly work presents stronger challenges to the status quo and because they are socially oppressed in more ways, such as in terms of race, class, or income. The editors in the introduction lament the book's absence of the perspectives of some groups, such as groups targeted by racism (12). It is not clear why the perspectives of racialized people could not have been included. It would seem that there needs to be more outreach and affirmative action so that racialized scholars can become better known.

Chapter 8, "Disability, Divisions, Definitions, and Disableism: When Resisting Psychiatry is Oppressive," by A. Withers is very interesting theoretically, though a bit hard to follow. One argument is that psychiatrized people should identify as disabled. According to Withers, many people who have been psychiatrized do not identify as disabled because they mistakenly believe people who are marked as disabled have an inherent problem instead of a socially constructed one (119). Undoubtedly, disability is commonly misperceived as an inherent impairment. However, many people who have been psychiatrized may be reluctant to identify themselves as disabled because they do not feel that the kinds of barriers and harms that they experience are ones that are best addressed on a social model of disability. For example, many girls and women are forced to be psychiatric patients not because they are psychologically different from the norm, are, for example, neuroatypical, but because they are gender deviant and/or lesbian. They may think they are best helped by policies, programs, and legislation which address sexism, homophobia, and violence against women.

Withers insightfully argues that the depathologization of homosexuality in the DSM, while important, left unchallenged psychiatric pathologization in general, and was only helpful to homosexuals who were less at a risk of being otherwise psychiatrized, such as white, middle-class homosexuals with more conventional lifestyles (125). This point acknowledges that people from marginalized groups, such as those who are racialized, poor, or trans, are more likely to be psychiatrized, and subject to social control. Thus it would seem their life challenges would not necessarily be best understood and addressed using a social model of disability but by measures that address different forms of social discrimination. Finally, the DSM includes mental illness categories that could be applied to people who are only experiencing mild to moderate difficulties in social living. It is unlikely that these people experience themselves or are regarded by others as disabled, and perhaps are more on a par with people experiencing mild to moderate allergies or colds. Moreover, the conception of mild to moderate problems in social living as psychological disabilities implies a wide conception of disability. This conception, it could be argued, secures for those who are relatively well off access to a limited amount of resources and benefits for which those who have more serious psychological disabilities must compete. As Joanna Moncrieff argues, psychiatry's ever-widening net distorts "health care priorities, leading to neglect of the needs of those with the most severe forms of mental disturbance" (2009, p. 1).

Chapter 12, "Taking it Public: Use Art to Make Healing a Public Narrative," Rosemary Barnes and Susan Schellenberg argue for richer ways of understanding emotional pain than mental illness. Schellenberg is a gifted artist who suffered a breakdown and was diagnosed with schizophrenia. She could have her art shown more in galleries, but she wanted to have her art displayed at Women's College Hospital and then at Centre for Addiction and Mental Health (187). While art that explores emotional suffering is typically perceived by the public as therapy, the authors, interestingly, do not see this perception as problematic. On their view, since psychiatry continues to be the dominant approach for the treatment of emotional suffering, art that explores emotional suffering needs to be better appreciated as a very valuable or important way of healing. They argue that private stories of healing made public through art events provide counter-narratives of mental illness (188). The authors recommend reviews of public arts events featuring artists exploring emotional suffering which would help to displace the medical model as the dominant frame of such suffering.

My only concern with this wonderful chapter is that it could be interpreted as promoting the view that art works exploring severe emotional pain should be understood only as narratives of healing and not also as works meriting aesthetic critique. Certainly, it is ableist and sanist to relegate art that explores trauma and insanity only to hospitals and mental health centers and not consider it appropriate for art galleries. This is not the authors' view but the authors are claiming that art by trauma survivors should be taken more seriously as embodying a valuable approach to emotional pain. This is different from saying the art should be taken more seriously as art.

The collection *Psychiatry Disrupted* is theoretically rigorous, substantive, and timely. It complements powerfully *Mad Matters: A Critical Reader in Canadian Mad Studies* (2013), another recent collection and excellent text for undergraduate and graduate courses in humanities and social sciences. Whatever limitations the book has, these are easily transcended as the editors encourage readers to build on their work, "to pick up a thread and add to the tapestry" (15). Let the revolution continue!

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