



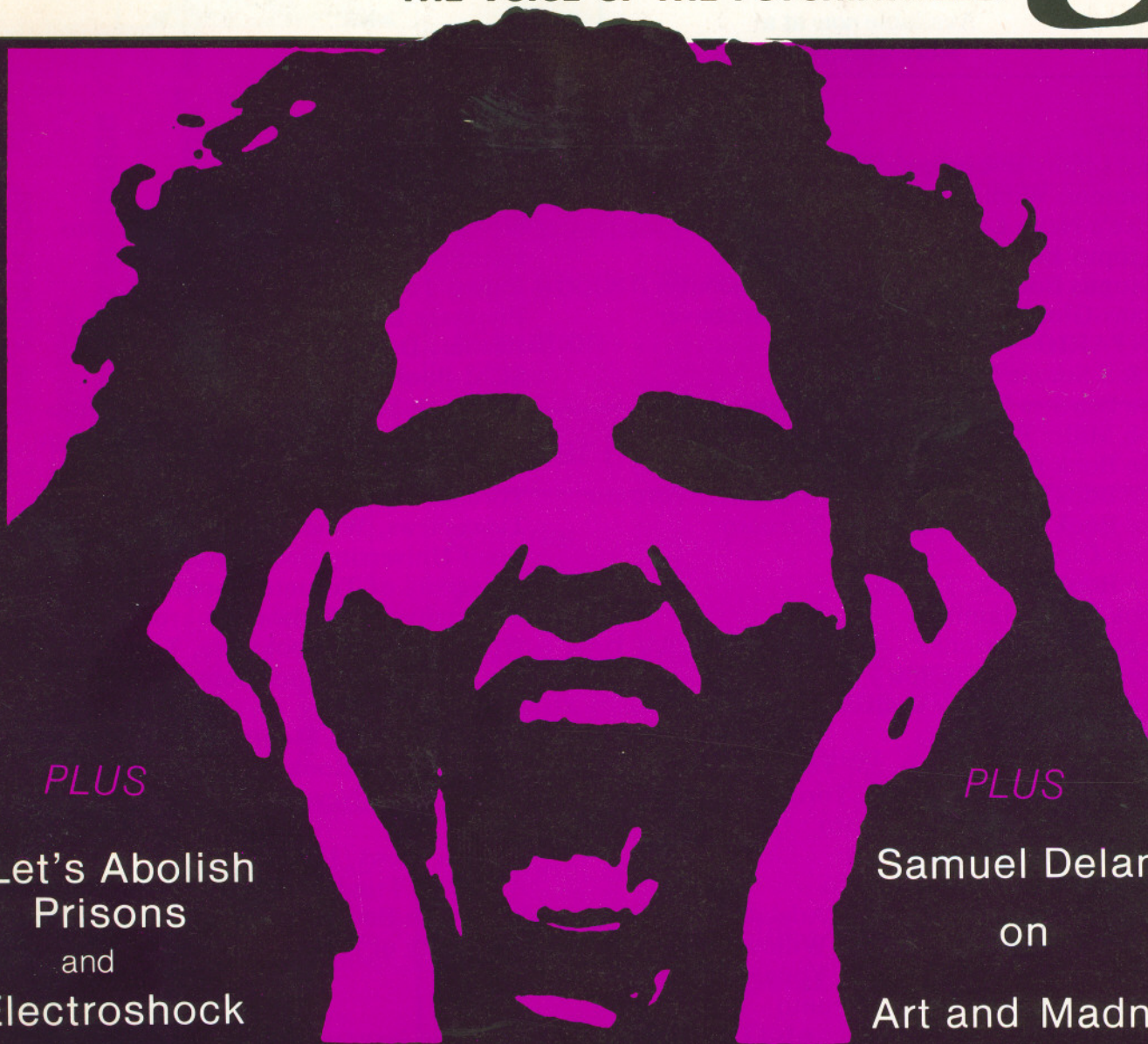
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RISING

THE VOICE OF THE PSYCHIATRIZED



PLUS

Let's Abolish
Prisons
and
Electroshock

PLUS

Samuel Delany
on
Art and Madness

'MAD WITH' THE TRUTH

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Through the fire



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We will not accept any advertising which in any way supports forced drugging, electroshock, involuntary confinement, or psychiatry's medical model of mental illness.

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FALL ISSUE

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EDITORIAL

Getting Off Drugs

In this issue we want to begin discussion of a very important area which we hope to deal with in more depth and more personally in future issues: the question of withdrawal from psychiatric drugs. Getting off these powerful drugs—the major tranquilizers and antidepressants—has not been adequately discussed in the medical-psychiatric literature, by the media, or, so far, by alternative groups such as ourselves. If the risks of taking such chemicals as Thorazine, Haldol, Modicate, Mellaril, Tofranil, Lithium, etc., are still not generally known, what is involved in withdrawing from such “medication,” after weeks or months or years of taking it—has been expressed, and understood, even less.

We hope that this article on withdrawal will be of some practical help to those of our readers who are presently taking, or withdrawing, or considering withdrawing from psychiatric drugs. We appreciate the seriousness of someone's fear of coming off these drugs—the very real pain and distress that may be experienced, the very real anxiety that whatever distress or difficulties were being masked, will recur. But while we recognize the fears and suffering that can be met, we do not agree with many psychiatrists' favourite refrain: “If you stop taking your medication, you'll end up in hospital (or: unable to cope, etc.) again.” We *know* this is not so: some of us have withdrawn ourselves; we know of others who have done so. We know that the possibility and benefits of withdrawal—with understanding and with emotional, moral, practical and sometimes medical support—are perfectly real, too.

We wish we also had supportive doctors and drug-free housing to recommend, and we'd like to start working towards such alternatives. Please write us if you know of any people or places who are willing to help. But, above all, please write us with your individual experiences, because in this area where we *have to* build our own resources, everyone's experience is valuable—and valid.

Growing Pains

PHOENIX RISING is not just a magazine—it is a network, it is an activity, it is a service. We reach people, isolated either in institutions or in the community, with words of understanding and support, when no one really notices, perhaps, or cares about them. We strengthen the experience of those who are already in contact. We offer information, vital information about “treatments” and services, rights and legal recourse, to those who either have no access to it, or are being misled. We suggest new ideas and alternatives, and present others of which we've heard. But above all, we give people who have either entirely or in part considered themselves as alone, as isolated and—usually—“wrong,” a chance to express themselves, a voice, as well as, by response a chance to learn how many sympathetic people there are, actually, who have had the same or related experiences. These things we have always done.

We're growing. Subscriptions increase daily. We now have readers all over the world: Canada, the United States, the Caribbean, Central and South America, Europe—South Africa, Australia and New Zealand. Also, more and more of our subscription requests are coming from people in institutions, psychiatric or penal. We believe that this is as it should be, a major part of the service that we must provide. But unfortunately, because our subscriptions to people who are institutionalized are free, our very growth is costing us.

Also we're growing in direction, as well as in size. We've just, for example, helped organize the first international anti-shock demonstration; we are beginning in this issue to provide information and—eventually, we hope—alternatives such as support networks and drug-free housing, for people who wish to withdraw from psychiatric drugs; we have researched a drug booklet for Canadian consumers of psychiatric drugs; we are hoping to be able to provide overnight shelter for ex-inmates who have nowhere to go here in Toronto this winter; and we have always wanted to set up a crisis centre, or at least crisis support lines.

It is in the nature of what we are as a network, an activity and a service as well as a magazine, that our growth is costing us, and the more we grow, the more it will cost. Or rather—the more we can afford, the more we can, in fact, grow. We believe that anyone who extends support to us in any form is part of what we are—our activity, our service, our network—and so we are deeply grateful to anyone who can help us now; help with these things we are just beginning, and help us reach out still further than we have.

We are experiencing growing pains—please help us if you can by sending a donation in the attached envelope.

- up to \$25.
- \$25-\$50: one year's free subscription to *PHOENIX RISING*.
- \$50, or more: two years' free subscription to *PHOENIX RISING*.



write on

NOTE TO READERS: Phoenix Rising assumes any correspondence sent to us may be reprinted in our letters section unless otherwise specified. Please tell us if you would like your name withheld if your letter is printed. Letters without names and addresses will not be accepted.



I would like to thank you people for another free issue of *Phoenix Rising* magazine. Many of the patients here at Oakridge, Penetang, appreciate the news and information.

In regards to the latest issue, Volume 4, No. 1, there is an article by Bonnie Burstow on patients' rights in Ontario which I am interested in.

In the past eight months I have been trying to find out exactly where the W.L.G. patients' rights begin and end.

I have purchased a complete copy of the Criminal Code of Canada, with amendments, as well as the Ontario Mental Health Act. I haven't been able to acquire a copy of the Canadian Mental Health Act since there doesn't seem to be any such Act.

Regarding the article by Ms. Burstow, there is reference to a section 66, with amendments that are unproclaimed.

While I am writing to you, I would like to share some of my views and opinions about the Mental Health System and the hospital I am in presently. The therapeutic programming here at Oakridge has become a little more bearable and humanistic. Changes in programming and policies began approximately two years ago when a former patient laid several charges against the institution and staff. Since that time there has been much public and political pressure on this institution in particular.

This institution has responded by slowly lessening the intensity of its rigid and coercive programming. We no longer have the (I.C.U.s) intensive care units where the patient was kept awake all day and night until he broke down. It is very rare to see the drug-induced confrontation groups anymore, unless a

patient requests it and even then it may be refused. However, you can still see the use of handcuffs and legcuffs for what I feel are overly extended periods of time (from two to four days at a time) and also seem to be for overly exaggerated reasons at times.

There are still changes to be made, in my opinion. What we need is a definite set of rights for mental patients; rights which will allow us to feel more human rather than subjects of what seems to be a dictatorship at times. Rights should also be explained to the individual on his arrival so that a person knows exactly where they stand.

One of my greatest concerns with the Mental Health System is the extended periods of time a person is detained, in the various institutions, under a Warrant of the Lieutenant-Governor.

It seems to me that the system is not geared to properly deal with the rate of speed of progress that many patients make. Many people whom I have encountered in therapy tend to recover from their insanity and gain a good understanding of their illness within a one to two-year period. In the meantime, we are held back from making any further progress at other institutions, while we remain confined in one place for stagnating periods of three to five years or more.

I have heard complaints of a lack of funds in the Mental Health System but if the system took a closer look at what's going on, I am sure it could cut costs in some areas and transfer the funds to other areas. If you consider the cost of keeping one person locked up in an institution and multiply this amount by the many people who are stagnating for extended periods of years, you would find there are a lot of wasted taxpayer dollars. Then there are the people who would like to get into these institutions but are turned away because there is no room.

In my opinion, the Mental Health System needs to be restructured to accommodate both the rate of speed of progress of the individual patient, as well as making room for people who need the use of these facilities.

Being a mental patient myself, I don't even have the right that is granted to all Canadian citizens, including those in penitentiaries, that is, the right to vote for the political party that may decide to institute the appropriate and needed changes in the Mental Health System.

Gerald M. Vaughan,
Penetanguishene, Ontario.



The reason I am writing you is because my life and health is in immediate danger of imminent death and great bodily harm, and there is no one else I can turn to because the courts will not do anything and the legislators will not do anything. I need you to come to my help, aid and rescue because I am now going through great cruel and unusual punishment.

I am an innocent man, a victim of being in the wrong place at the wrong time and looking too much like the man who actually committed the crime. I was found guilty of rape and armed robbery, and I did not have the necessary money to hire a private attorney to do all things necessary at the trial. He did not research or investigate before trial and during the trial, the courts kept throwing my case out.

When I first came to prison I was very bitter and angry because I am an innocent man in prison and as a result of my anger and bitterness I was in a lot of fights with prisoners and officers. As a result of these many fights, I accumulated a bad disciplinary record. As a result of my bad prison record I was transferred here to the Menard Psychiatric Centre where they treat you like a guinea pig.

For the past two years the prison psychiatrists have been experimenting with me. Every week (Wednesday) a bunch of wild officers come to my cell and tell me that Warden Stephen Hardy and Dr. N. Vallabhaneni have ordered a shot (injection) for me which is two (2) cc of the drug Prolixin. If I refuse to

take the injection then they spray the chemical mace in my face, blinding me. Then they open up my cell door and begin to kick my head, neck, shoulders, chest, back, stomach, buttocks, groin and legs for twenty minutes. Then they choke me around the neck for ten minutes while the prison nurse runs inside of my cell and injects the drug Prolixin into my body, without my oral or written consent. Prolixin is a drug that was originally used to slow down race horses after a race, and I have now been receiving this drug for about a year and a half. It gives me all kinds of side effects like vomiting blood, blurred vision, blurred speech and hearing, restlessness, insomnia, nervousness, mild heart attacks, mild strokes, and many more side effects. The Cogentin that they give me, which is supposed to stop the side effects, really does not stop them. Giving me the Prolixin, Thorazine, Haldol and the other antipsychotic drugs is causing great danger to my mind and body.

Moreover, the drugs are not justified because I am a born-again Christian and I have not had a serious disciplinary ticket in over a year. But I do not have anyone to turn to for aid and assistance except you. Please hear my cry for help and do something to come to my rescue. I need as many people as possible to write the Director and tell him to cease and desist from giving me any more antipsychotic drugs like Prolixin.

Please publish this appeal to your readers to send a letter to: Michael P. Lane, Director of the Illinois Department of Corrections, 1301 Concordia Court, Springfield, Illinois, USA, 62702. I would also like a couple of pen pals to write.

Albert J. Sullivan
Box 87, A01419
Menard, Illinois
62259



Correction:

The statement on page 47 of the last issue of Phoenix attributed to Samuel Delany was in fact made by Allen Markman.

PHOENIX on TV

PHOENIX RISING is hosting a seven-part series on MacLean Hunter Cable TV. The first program was aired at 8:30 PM on Wed., Nov. 2nd, and the next program will be at the same time on Wed., Nov. 16th. Thereafter they will be shown once a month through June.

Metro Police Raid Home—Information Withheld

On June 13, 1983, Metro Toronto Police executed a search warrant for a Cambridge Ave. home, claiming to be looking for evidence relating to the October, 1982 bombing of Litton Industries. A total of nine criminal charges were laid, none of which had anything to do with the ostensible reason for the raid. Topping this off, the Crown has refused to divulge any information on the reasons for the search—they are trying to invoke a rare privilege to seal this information. This of course makes one wonder what they have to hide.

WE HAVE THE RIGHT TO KNOW . . .

- why a search warrant was issued
- to what extent physical and electronic surveillance is used in this and similar situations
- why mailing lists, magazine galleys, personal letters and books were seized
- why the Crown would want to withhold information vital to the ability of accused persons to defend themselves in a court of law

The residents of the house were active in various movements—feminism, prisoners' rights and anti-militarism. The cultural and political work that was engaged in was by no means clandestine or violent.

WE HAVE THE RIGHT TO KNOW . . .

- How real is the constitutional right to protection from unreasonable search and seizure?
- How real are our supposed fundamental freedoms—freedom of thought, belief, opinion & expression, freedom of communication, peaceful assembly and association?

We are appealing to the Ontario Supreme Court for access to the information used to obtain the search warrant. If the Crown succeeds in sealing this information, the police will be free to raid the homes and offices of any political organization, be it trade union, peace or women's groups, and not have to defend their motives in a public court. Access to such information is paramount if we are to believe that police are accountable to the public and to those whose privacy has been invaded by police actions.

PLEASE HELP WITH THIS TIMELY AND IMPORTANT CASE. Donations for legal fees can be sent to: **RIGHT TO KNOW FUND**, Acct. No. 733, Bread & Roses Credit Union, 736 Bathurst St., Toronto, Ontario.

The Manufacture of Madness

An Interview with Samuel Delany

Allen Markman of WBAI, The Madness Network radio in New York, interviews Samuel Delany, author of Dhalgren, Heavenly Breakfast, Nova, Tales of Neveryon, and Triton: he's a four-time Nebula Award winner and he's also won a Hugo Award.

Markman: You're here to discuss madness and art.

Delany: We had talked before about madness as a social problem. A lot of the things that make it a problem are precisely those things that indeed make us think about it as a problem per se. It's always seemed to me that madness was really basically three kinds of problems: what it feels like when you're undergoing these experiences, how people feel about you once they have identified you as mad by whatever set of formal or informal codes they use to do this, and then the problem of the actual institutions that have been set up to deal with this in society that separate the mad away from the rest of the society to deal with them as "patients" or sometimes as "clients" (the euphemism that seems to have grown up in some circles).

Markman: What it feels like—the psychological aspect, the true psychology of it, how it feels to people who are undergoing it. This has been variously described as—the British Anti-psychiatrists call it an experience, a trip, something you live through and emerge through at the other end stronger and better. People have countered this by saying it's horrible, it's something that nobody wants to go through and something that everyone should try to avoid.

Delany: It's probably not one single experience. The overt symptoms that we see would make one feel that it's probably a number of inner experiences. The person who becomes garrulous and proceeds to talk all the time and can't be quiet is probably having a very different inner experience than the person who withdraws, doesn't communicate at all and goes "catatonic." I am very unhappy with most of the technical terms for it because they come out of the medical model, which contours a great deal of what we talk about when we talk about madness...there's a good deal to criticize very profoundly.

Markman: There are some aspects of the medical model that the psychiatric profession seems to ignore such as the right of medical patients to refuse treatment.

Delany: Of course, the medical model is not the only model that contours the discourse of madness. There's another one that is perhaps as profound and universal. The only word I can think to call it is the madness model itself. That's the idea that somehow everyone is a little bit mad. It's an idea that you find in *THE PSYCHOPATHOLOGY OF EVERYDAY LIFE*, Freud's book in the '20's. You find it back in *ERASMUS OF ROTTERDAM IN THE DAYS OF FOLLY*, "folly" being the old word for madness. It goes back basically to medieval times. What it ends up saying is that any time anyone does something that is mean, cruel,

immoral or even mistaken they are somehow participating in the experience of madness.

Markman: Or they're somehow crazy themselves.

Delany: Yes, exactly. I don't happen to think that this is the case.

Markman: No, it's a reformulation of the Judeo-Christian idea that people are born evil and there's no exception to this.

Delany: And in some it gets out of hand.

Markman: One of the characteristics of the 20th century has been the reformulation of all this moral language into pseudo-medical psychiatric terminology. People don't say that other people are bad anymore. They say that they're "sick." This sounds pretty harmless on the surface but actually it constitutes a debasing of the language.

Delany: Even from the very beginning, from when it was originally medicalized, it's always had this uncertain status between crime and sickness. The historian Michel Foucault discusses the Great Confinement, when the poor and the mad were all taken off the street and put into what were essentially jails. At a certain point, they were transferred from these jails to the old leprosaria and, one by one, the various classes were let out, all except the mad, who stayed in the leprosaria, which became most of the great mental hospitals in Europe. Many of them that began as leprosaria were abandoned in the 13th, 14th century.

Markman: What about witchcraft? Madness was also simply considered sin. If you were somebody like Joan of Arc, in France you were considered a Saint; in England, a Witch.

Delany: Historically, the medical model goes back at least to the ancient Greeks. Hippocrates and Galen treated the mad.

Markman: The humoral theory.

Delany: That was the time when madness was first medicalized. This stayed all through the Christian era. But during the Christian era, the medical model was attacked by an eastern model that purported that madness was a gift from God or a gift from heaven.

Markman: Divine madness.

Delany: The idea that the mad were holy. These two fight it out through the early middle ages and then both of them fell away along with the general loss of knowledge that did occur here and there throughout Europe in the Middle Ages. What I was talking about as the madness model comes up in about the 10th, 11th century, the idea that everybody is somewhat mad. The problem with that model is one that a guy named Stanley Fish has talked about in another context entirely: the problem of normative models. A normal/abnormal model of anything tends to trivialize both sides. You say that this is normal and that anything that's away from this belongs to the abnormal but what finally doesn't exist is there is no such thing as normal or abnormal because the split itself is an invalid split. This seems to be what has happened.

Markman: Statistically, these terms mean something that's just usual and unusual. That's not what we're talking about when we talk about normal and abnormal. We're making a moral statement.

Delany: I'm now going to raise my hand over my head and move my middle finger. I've done an absolutely abnormal thing. Chances are that statistically that hasn't been done by

most people in New York City today. But that's not what we mean when we talk about normal or abnormal.

Markman: Nor is it what we mean when we talk about deviance. When somebody orbits the earth and they're the first person to do it they're not considered a deviant. It's unusual. In that sense it's abnormal but it's not deviant. Deviance is when you do something society disapproves of.

Delany: Exactly. To reduce the idea of normalcy to a set of statistics is when it falls down. Obviously, there is a great deal of ideological weight and political weight on the two concepts that far outweigh any kind of statistical reduction.

Markman: Moving along in history, we're getting to the mad doctors. We're moving up to that era where leprosaria were turned into asylums and mad doctors started to get powerful. They were called alienists or asylum keepers and they formed an organization that later became the American Psychiatric Association. Their journal used to be called the Journal of Insanity. To go into psychiatry's humble beginnings, the different streams of psychiatric history, from one area, we have the mad doctors, the soul healers and the asylum keepers. Then we have the neurologists like Freud and the psychologists. Then there are the sheer quacks like the phrenologists who would be able to tell your future and your personality by feeling the bumps on your head, and animal magnetism which became hypnosis. We have Charcot with his theory of hysteria.

Delaney: Pinel.

Markman: Pinel was one of the asylum keepers. Charcot was a theoretician of hysteria. Do you know very much about hysteria?

Delany: I know Freud and Breuer but I don't really know too much.

Markman: The original theory that women had...the shifting of the womb. It's a very old Greek notion that the womb shifted around and made women act in a certain fashion. In the 19th century, the term hysteria meant that women would either become "paralyzed" or "blind" or "mute" and then the doctor or Charcot would come over and effect a miracle cure. Hysteria, after Charcot, became a true disease, a true mental disease much like malingering has. It's a "disease" where if you fake being sick, you're genuinely ill. It's a logically interesting type of "disease." Maybe we can go into the whole idea of what "mental illness" is. What you call madness has now in modern parlance become "mental illness."

Delany: Just from personal experience, it always struck me—and later it was interesting to have it confirmed by the writing of Laing—that in many senses since there are actual institutions set up to deal with the mad, since there is all this apparatus around it, one has to learn how to maneuver through this apparatus. I know when I was about 12 I was first diagnosed as exhibiting severe attention-getting behavior. It consisted of the fact that I couldn't learn to read or write. Later on when I was over 20 this all became called dyslexia but when I was 12 who knew from that? So I was sent to a psychotherapist for my severe attention-getting behavior. I stayed in psychotherapy of one sort or another pretty much all through my adolescence. At the same time, I remember when I got to high school there was a girl I knew who disappeared from school at the end of the first year. She turned up in Hillside Hospital. I used to go out and see her there and we used to spend time together and she was a very bright girl. I liked her very much and she was interested in music and so was I at the time. We spent a lot of time together. I would go and see her. She'd get passes and we'd go out on nebulous kinds of dates.

I stayed in psychotherapy in one form or another—I wasn't really out of it for more than three or four months until the time I was 23. I was working very hard during a period then when I was writing a lot and I had all sorts of the problems of somebody who had gotten married at 19 and the kinds of emotional problems that come out of that. Eventually I was losing touch. I was going to the subways every day and sitting there and holding onto the bars of the subway and feeling quite terrified of the whole experience. A policeman with a billy club very gently pried me loose and said, "Why do you come here every day, young man?" (I was all of 23.) I said, "Because I'm afraid of the subways." He said, "If you're afraid of them, why do you come here?"

Markman: A very good question!

Delany: Which is something which hadn't occurred to me at that point. I left thinking about this problem and I went to see a friend of mine who was in therapy. At this point, for the past six months or so, I hadn't been in therapy myself so I went to see his doctor. I walked into the office and the doctor said, "What is your problem?" And I said, "I'm terrified of the subway." I don't think the doctor was really listening to what I said. He was just looking at me because I looked pretty strange at this point, too. He said, "Would you like to go into the hospital this afternoon or this evening?" and I said, "This evening," and I did. At the same time I remember it was very much a choice that I felt was open to me. It was something that I saw coming. I could say because of my other experiences. I had known people in hospitals before. I'd known kids in Hillside. It was all waiting in a kind of way. Then I spent a couple of months in the day-night program at Mount Sinai.

Markman: That's something that I hadn't heard of before.

Delany: It was an experimental thing.

Markman: It's probably an experiment that hasn't been repeated. It sounds like the prison programs where you go to work during the day and sleep in jail at night.

Delany: That's the same kind of thing. It was very pleasant. It relieved a lot of the home pressure I was under and, at one point, I remember the doctor asked me if I thought that I could leave. I immediately began to "hear voices". I did. I really did. I said, "Probably not because I'm hearing voices." He said, "OK, you can stay for another two weeks." The voices went away and I left. I remember a couple of days, maybe a week later...it was early in the morning, about 5 o'clock in the morning and I suddenly decided that I wanted some ginger ale. So I went out to buy some ginger ale. I was crossing 7th Avenue and Avenue B, which was where I lived, at 5 o'clock in the morning. There was not a car in sight. I started to cross the street and the light was red and I was halfway across the street and I suddenly thought, "I'm crossing against the light; I must still be sick." I went through this incredible kind of...then I did a doubletake on myself. I said, "Wait a minute. There are no cars coming. All you're doing is crossing the street. So the light is red. You're not sick." At that point I realized I was in a spiral which had started from the time I was 12 when I first went to a psychotherapist, that had moved on through this, that had ended up with my being hospitalized for awhile that could easily lead me to rehospitalize myself again.

Delany: I had created the schema where anything that was not just absolutely "normal" I would entify as being "sick".

Markman: You didn't create it. You absorbed it.

Delany: I absorbed it and at that point I had to do something about it. I had to stop thinking of myself in these particular terms.

Markman: What we're talking about now is the manufacture of madness.

Delany: Exactly. At this point I also had to say to myself, "You can't do this to yourself anymore." I never went back into therapy.

Markman: You had enough of it for your entire life.

Delany: I also realized I was just going to have to deal with things in a slightly different way and I wasn't going to. I couldn't let myself fall into this waiting social schema that was there. The profession of mental illness was not one I wanted to pursue.

Markman: You're talking about the initiation rites of becoming a mental patient and how you become a manufactured psychiatric product—the mental patient.

Delany: That's how these schemas begin to fit. They're rather insidious. That doesn't mean that one is not necessarily in a great deal of pain from time to time...or that, indeed, that what happens in a therapeutic session cannot be of great help. One isn't saying that. Yet, nevertheless, there's always something in excess of that and the schema is there always to catch the excess and reinterpret it, pull it back....

Markman: Why is it that society needs mental patients and psychiatrists? Why do they need professional patients and these professionals who call themselves psychiatrists? I know it's an organic outgrowth of our society and I know that the freer a society is the more that psychiatry flourishes.

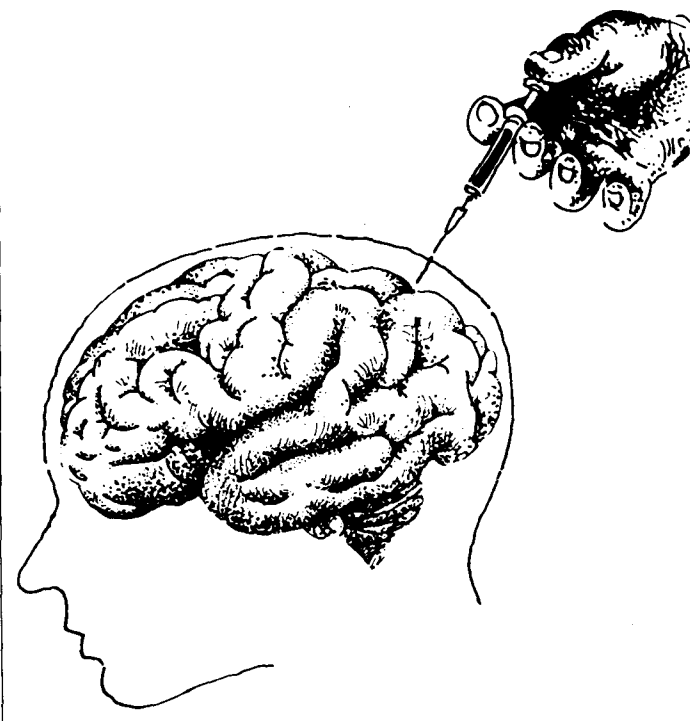
Delany: There are a number of reasons. The bottom line is that there is some behavior that is probably dangerous to people that people pursue and we entify somehow as mad behavior—somebody runs around the street with a knife...

Markman: Dangerous or disturbing—mostly disturbing.

Delany: The bottom line is there is some behavior that is overtly dangerous. Then there's a whole area of behavior around this that is not overtly dangerous but is very disturbing. What happens is that people assume that there is a very direct correlation between the dangerous behavior and the disturbing behavior. The whole thing becomes generalized.

Markman: There's the disturbing question of ex-mental patients collaborating with their institutionalization, where they act in a certain way so they can get institutionalized and get the benefits, however dubious, of the system.

Delany: From the time that I was in Mount Sinai I remember strange things that stay with me. For instance, one young woman who was in my therapy group who was absolutely incapable of talking when she was in the therapy group. She was a black girl, about 18 years old. She had been living on the roof of her apartment building for some weeks before she had been brought in. She had this complete terror of talking in therapy. When she wasn't in the therapy group, she was as lively as she could probably be. I remember one day when every single person was in the therapy group except the

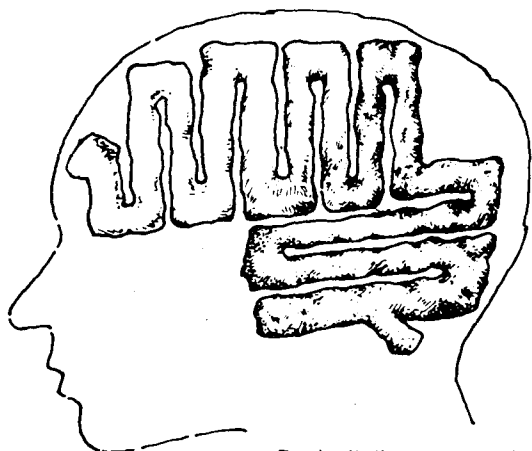


doctor...we were all sitting around in the occupational therapy ward making our little baskets and weaving our little potholders and B. was talking away. I made the point; I said, "B., it's interesting; here you are, you've got every single person here and you can talk and everything is fine." She said, "Yeah, I know." I said, "Well, what about when you have your own sessions with Dr. Gross? Can you talk then?" She said, "Yeah, when I'm having a personal session with Dr. Gross, I can talk just as well." You get this configuration with the exact same group of people plus this one person who's in this position of authority now whom we can deal with on a one-to-one basis...

Markman: I don't understand that. All I know is ten years ago when I was a "patient" at the Institute of Living in Hartford, Connecticut—the largest private institution in the world—I was rejected from group therapy. They didn't even get me into one session. They sent me to an evaluation committee. First they wanted to videotape me to see if I was photogenic enough for the group. I became very hostile. I have a copy of my clinical records. They said I became "intellectually Provocative."

Delany: What a word!

Markman: I wrote something on it called "I was an intellectual provocateur." Eventually I just refused treatment, all treatment. I said I'm here against my will—which wasn't true but they weren't letting me out. They were refusing to discharge me. After I signed a three day notice they threatened me. I was 18 so I was able to sign a three day notice. They threatened me with commitment. My parents started giving me...they didn't threaten me but they thought I'd better withdraw the sign out letter. I was nervous. I withdrew it. I started planning my escape. I started "participating" in activities. I took on the role of Judas in Jesus Christ Superstar in a patient production. This sounds like a B movie but it's true. I was very cooperative. I continued to be "intellectually provocative". As a result of this they gave me grounds privileges and telephone privileges. I called my friend and I said, "Get me out of here." A few weeks later he drove over. I just packed a shopping bag and we went to another state. My family couldn't do anything about me and the doctors couldn't do anything about me. I was out of state. They had to "discharge" me within a week.



Dessin d'Elisabeth Knölniger

You're right when you say you have to learn how to manipulate both in and out. It's very important. But there are people who are too dull or too stupid or too drugged to understand how to play the game. Then there are people who have so much experience in playing the game that they decide after awhile that if they weren't victimized by psychiatry they would have to solve the problem of what to do with their lives. So they'd rather be victimized even though it's painful for them because it gives them an identity.

Delany: One of the things that I was always struck with was the differences in the general life experience of the people who are the doctors and most of the people who are the patients.

Markman: That's especially true in state hospitals, in public hospitals. But it's even true in the private hospitals.

Delany: Just to go into my own admittedly rather brief and somewhat distant experience—because it was 15 years ago—I do remember at one point realizing that the doctor who was in charge of most of the group I was telling you about before is somebody who had gone to high school, college, immediately gone into the air force, came out of the air force and gone immediately into medical school and then did his internship and residency—somebody who had never been out of a structured situation from the time he was in high school. Everything had always been a very clearly structured situation. Over half the people who were his patients were on social services of one sort or another. This, of course, was not a state hospital. The people that he was dealing with were people who'd never been in anything near a structured situation for so long. That was half of what the problem was. People like B. who had been living on the roof. The reason she had been living on the roof was because the violence in her own apartment was so much that she couldn't stand it. There was a case where people were fighting all the time.

Markman: She was living a public life at home. She was out on the streets and up on the roof a lot. That may be why she had difficulty with a public therapy session.

Delany: Exactly. The kind of structure that one gets used to in "normal" situations and the kind of lack of structure one lives in if one is socially marginal in any way, shape, or form, the kind of lack of structure you get used to in making your own structures almost precludes communication. When two people from these kinds of situations try to talk about things with any kind of normative basis, they're frequently talking two different languages and it's very hard to communicate.

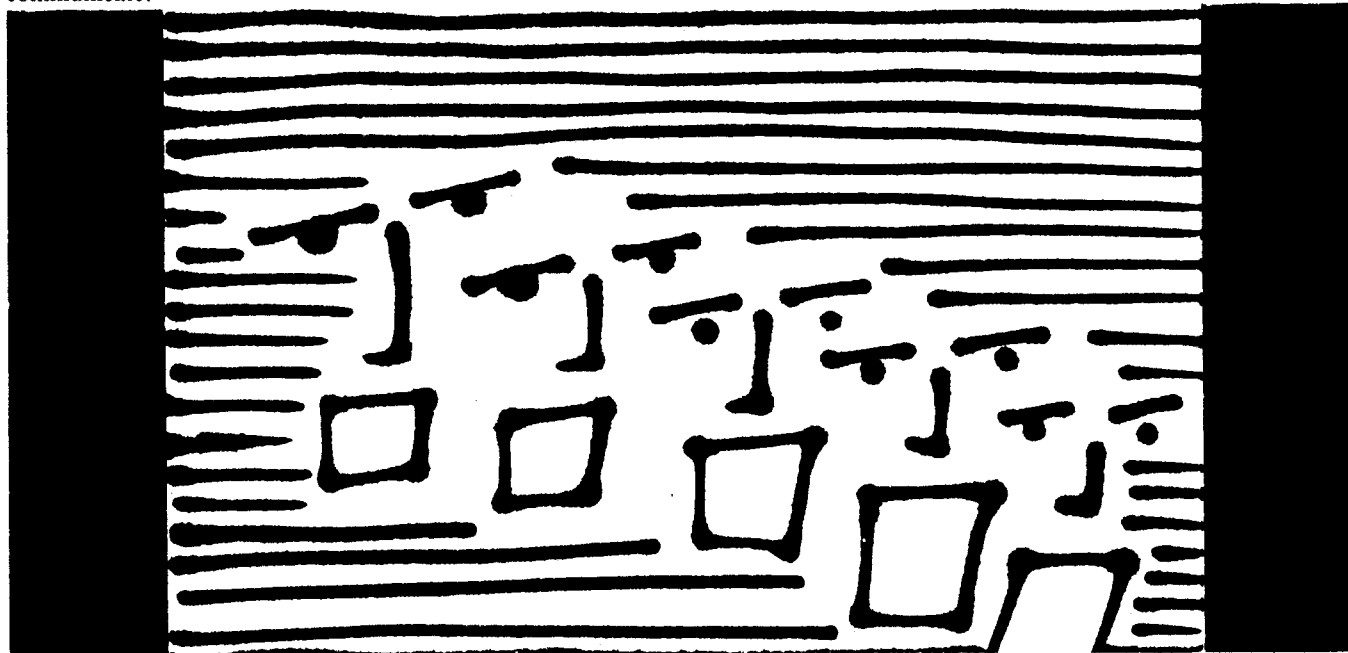
Markman: Let's assume they were from the same class background and they did have similar experiences. This does happen. There are psychiatrists, physicians, in fact, who get into hospitals as patients. I have met quite a few of them in my institutional career. Even then communication is difficult because even if they're speaking the same language the patient is on the receiving end and the doctor is pitching. The doctor is always in a position of power and the patient is always in a position of powerlessness. This is how psychiatry operates. This is true all over the world. The people who really understand the way psychiatry operates know that it's a political situation. A good example: Earl Long, the governor of Louisiana some years back, was acting in a bizarre and very grandiose fashion, making bizarre speeches and there was a group of important politicians who wanted him disposed of. What they did was institutionalize him. His wife had him committed to a Louisiana state hospital. He knew how psychiatry worked. This man was a consummate politician. He fired the head of the hospital system and installed his own person. He was immediately released.

Delany: When one wants to compare this to those famous experiments where various and sundry doctors had themselves committed and found they couldn't get out...

Markman: This was the Rosenhan study. They were actually students. They found that—one person was there over 50 days—they had an immense amount of trouble. Apparently, they hadn't backed themselves up enough legally to get these people out. They thought it would be simple. We would just prove we were social scientists and they'll let us out. In fact, what happened was that the staff of these institutions felt that these people were truly "ill" and the true patients realized that these were researchers.

Delany: This particular split is the one that one always wants to hold up to people: the fact that the experience of madness is not entirely imposed from the outside. There is something to the experience itself that is real, that is autonomous and that is in excess of all of these models and institutions. Until it's dealt with, madness itself is not really being dealt with. It's only being shoved around. At the same time, the nature of the imposition is such that the gap between those researchers and the truly mad, if you will, is what's wrong with the entire system.

Markman: That is chiefly an historical problem. Originally, the mad-doctors were in charge of people who were...mad to the extent that anybody... would say, "There's a madperson."



They would run around rending their clothes. They would talk gibberish. There are people today who the ex-mental patients say are "freaking out". That's their term for what the psychiatrists call "psychosis" and what anybody else would call crazy. There are people who are so disordered in behavior and in speech that nearly everybody calls them crazy. There's a word in every language for this. Psychiatry used to deal solely with those people. Some of them had physiological problems, others had problems of function. Then what happened is psychiatry started increasing in importance and enlarging its purview and started to deal with people who not everybody could agree were mad and some people would vociferously argue were totally normal. Now they've started to deal with people who nobody would argue are crazy: people who are overweight, underweight. That's another "disease". We have bariatric psychiatrists who specialize in a "disease" called anorexia nervosa, which means starving oneself to death. There are people who eat themselves to death—bulimia. Then there's nicotinism (smoking). Psychiatrists deal with that sort of behavior and, of course, they deal with political questions which have nothing to do with psychopathology. Yet they try to use psychopathology to encompass historical problems.

Delany: Another area that you shouldn't leave out in this kind of overview is that in the 19th Century the asylum became the place to put any young lady who did anything that you didn't approve of, especially if it had anything to do with sexuality.

Markman: There's a wonderful quote made by one of my favorites, Francis J. Braceland, a former head of the American Psychiatric Association. His name was on the building I stayed at in the Institute of Living. He's a big man at the Institute of Living, one of the doctors there. In 1961, he testified before a senate subcommittee on Constitutional Rights of the Mentally Ill. It was a wonderful quote. Thomas Szasz cites it in "Law, Liberty, and Psychiatry" (page 61)

"If a man brings his daughter to me from California because she is in manifest danger of falling into vice or some way disgracing herself, he doesn't expect me to let her loose in my hometown for that same thing to happen."

"Falling into vice" in this case might have been a young white woman who wanted to have sexual relations with a black man or simply prostitution. Dr. Braceland's response is that she's an adult and she needs "treatment". That's a psychiatric problem. This view hasn't disappeared. Fathers can still put their adult sons and daughters in psychiatric hospitals for engaging in behavior that disturbs them. There are many examples of this. Years ago, there were feminists who were institutionalized by their parents for walking around in bloomers and holding up signs.

The freer the society is, the more psychiatry is needed, That's why I laughed when I was at the American Psychiatric Association convention last year. Not inside. I was outside picketing with 200 other people. A foreign psychiatrist...got very angry. She was one of the few who got openly angry at our signs. She yelled at Judi Chamberlin, the author of "On Our Own: Patient-Controlled Alternatives to Psychiatry". She said, "You people have too much freedom, too much freedom." What this psychiatrist didn't understand was that if freedom in this country were really restricted, the role of psychiatry would have to be narrowed. Then there would be other mechanisms to take care of all this unwanted behavior like they do in the Soviet Union. They take away your internal passport....Psychiatric treatment in the Soviet Union is not enforced leisure like it is here. It's enforced work because they have a labor shortage there. We have tremendous labor surplus. So psychiatry takes people out of

the labor pool in the U.S. and puts them back in the labor pool in the Soviet Union.

Delany: One of the things that one has to remember about these various models that come up, the medical model or the madness model itself...

Markman: I call it the pediatric model.

Delany: ...the pediatric model is a much better term for it. On the one hand, these models are a response to those three problems we talked about before: the experience of madness, people's attitudes toward madness, and the institutions. It is also a response to many other things as well: what is politically expedient, what is considered scientific knowledge at a particular time, what's theologically in the air.

Markman: Mental illness makes a lot of historical sense. The history of the concept of "mental illness", of "psychiatric disease", makes a lot of sense. What has been argued, though, by people like Thomas Szasz, is that it makes absolutely no logical sense. It's logically absurd to argue that something as intangible, as abstract as mind, can become ill. It's a misplaced metaphor. What's dangerous about this kind of misuse of language is that psychiatrists mistake the metaphor for fact and they call for the doctor. The analogy Szasz makes is that if you're watching television and you get the opera instead of a football game you call the television repairman.

Delany: My seven year old daughter is just going through that period where she's learning to distinguish when something goes wrong at the station from when something goes wrong with the set. It is a learning process because a four to five year old will always call daddy in to fix the television set because there's a sign saying, "We're sorry. Due to technical difficulties..." When they get to seven or eight, they begin to be able to make the distinction. This is one of the reasons why I think that doctors frequently follow the pediatric model themselves.

Markman: You're one of the few persons who has read Gilbert Ryle. He talks about errors of category.

Delany: Category concept mistakes.

Markman: This falls into a category concept mistake.

Delany: Very much so. I don't know why this keeps coming back to me. It's not something I read but something that was recounted to me supposedly somewhere in one of the Galen accounts of Hippocrates, one of the earliest cases of something that may indeed be madness when a king of somewhere or other decided that he was a goat and proceeded to stay out in the field, would eat grass and baa all the time. Not Hippocrates but an old witch woman who called in. She said, "I think I can do something about this." They said, "What would you suggest we do to this king?" And she said, "First, let him go out in the field and eat the grass and I will go out with him." She would go out with him and apparently sit around on the grass and baa at him back. Eventually he said, "Why are you baa-ing?" She said, "I'm a goat." He said, "No, you're not. You're a human being." At least they got him talking again. And she listened to him for about three months. He finally decided he was not a goat and came back. This is possibly the first recorded instance of psychotherapy. So much of what is therapeutic about therapy is creating a space in which somebody can examine those particular contradictions in their own behaviors that they're set up to examine at that particular time.

Markman: What a peculiar term for a certain type of conversation—psychotherapy!

Delany: Exactly. When you start with the medical model: neurosis is an inflammation of the nerves; psychosis, an inflammation of the mind.

Markman: When you get five or ten psychiatrists together

they can barely agree on the time of day. If you show them videotapes of a particular person, even another psychiatrist, and tell them to "diagnose" what's wrong with this person, they'll always come up with a "diagnoses". Very rarely will one agree with the other. You'll have ten different "diagnoses". In that regard, it's nothing at all like medicine. Also, there's this democratic system for determining what's a "disease" and what isn't. In medicine, you can't get the American Medical Association together and vote on whether tuberculosis is an illness. This is absurd and impossible or, at least, very improbable. In psychiatry, though, you can get the American Psychiatric Association together to actually vote on whether homosexuality is a "disease".

Delany: I knew you were going to bring that up.

Markman: I think this is fascinating.

Delany: Yes, it's both fascinating and a little scary.

Markman: You don't know whether to laugh or to cry.

Delany: You have this complete muddle. I read recently—if I had done my homework I would have gone and actually looked up the article and gotten the name of the book. Someone has just recently come out with an attempt to make a more careful diagnostic pattern for "mental illness".

Markman: The DSM III?

Delany: Yes.

Markman: It's mammoth...they got rid of the neuroses in the original draft of the DSM III and the Freudians were up in arms (however many of them are left). They made a lot of noise and they reinstated the neuroses. I don't know if they put them in parentheses. Instead of just saying that this is a developmental or character disorder, they added that it's a neurosis. They wanted to abandon Freud altogether. A certain faction wouldn't stand for it. This is also something I don't think is too important in physical medicine. Generally, people agree on physical diagnostic categories. There's not too much debate, or they'll agree to disagree. But in psychiatry, these things erupt into fiery arguments and quarrels.

The elusive nature of "schizophrenia" is another interesting thing. They say it's the most dreaded, the most dangerous mental disease, the thing that everybody wants to avoid getting, or catching (if one believes in the schizococcus). It's so elusive. It's like the soul. It leaves the body upon death. If you ask a pathologist to determine who's a schizophrenic and who isn't by examining the cadaver, they'll laugh at you because "schizophrenia" is the thing that leaves the body after death. It's very mysterious. There's no such thing as a dead schizophrenic. Cadavers can have tuberculosis, broken arms, edema. Schizophrenia completely disappears. So does homosexuality and republicanism.

Delany: And all those things. The thing about all these things is that they only started disappearing about 1896. Before then you could find them. There are medical texts full of people examining the brain and showing the lesions on the brain that were supposedly what these things were, which makes the whole thing even weirder.

Markman: Look at all the research. This country is spending hundreds of millions of dollars on research on the causes and cures of "schizophrenia". It's totally absurd because they're considering it as a disease. They come up with all these findings that no other group can replicate. The latest fad is called the PETT scanner. This is a machine costing millions of dollars that pumps positrons into one's head. A computer analyzes this and maps the functions of the brain. They claim that in people who are called "schizophrenics"—people who "have schizophrenia"—the computer-generated patterns are far different from their normal subjects, and they further claim that after they give these people phenothiazines—major

tranquilizers—the patterns are normalized. There's one PETT scanner so nobody else can test this.

Delany: I like the idea of people talking about madness yet there is still this kind of constraint. Even we here are always looking to another metaphor other than mental illness or something outside of the medical model and, at the same time, always falling back into it. These models that we're talking about tend to hold back the progress of any real development.

Markman: Where has this development been going on? From my experience, it's been going on in literature more than any place else. I've learned more from reading novels and short stories about people who are supposedly mad and reading books by ex-mental patients published by Vanity Presses than I have from reading Dava Sobel in the New York Times or Karl Menninger or any number of psychiatrist. Your right about that.

Delany: One of the things I was always struck with—and again it goes back to my own personal experience—is that when an organ is working properly, let's say the eye, you're not terribly much aware of it. You're aware of what you see but you're not aware of the eye itself while you're seeing. In the same way, when your mind is working properly, you're not aware of the mind per se. You're aware of what you're thinking about but you're not aware of the mechanisms by which you think about it. And there are certain situations—and this goes back to that initial question you talked about.

Markman: The mind is not an organ. It doesn't secrete thought like the kidneys secrete urine.

Delany: No, of course. But the point is it does have a function. There are times when you get into certain situations that are somewhat similar. Again, it is only an analogy and an analogy can only be taken so far. When you get a cinder in your eye suddenly, you become aware of the eye itself in a way that is very different from the way...you're not aware of your eye when you're ordinarily looking.

Markman: There's a lot of difference...I'll get away from mind because that's a very disturbing concept. Let's go to the brain. It's a very unusual organ. It is an organ like the eye. It's there. You can feel it post mortem. It has a location unlike the mind. But when you get a cinder in your eye you can feel that. When you get a scalpel in your frontal lobe you can't feel that. It's hard to describe the psychological effect of that type of intrusion.

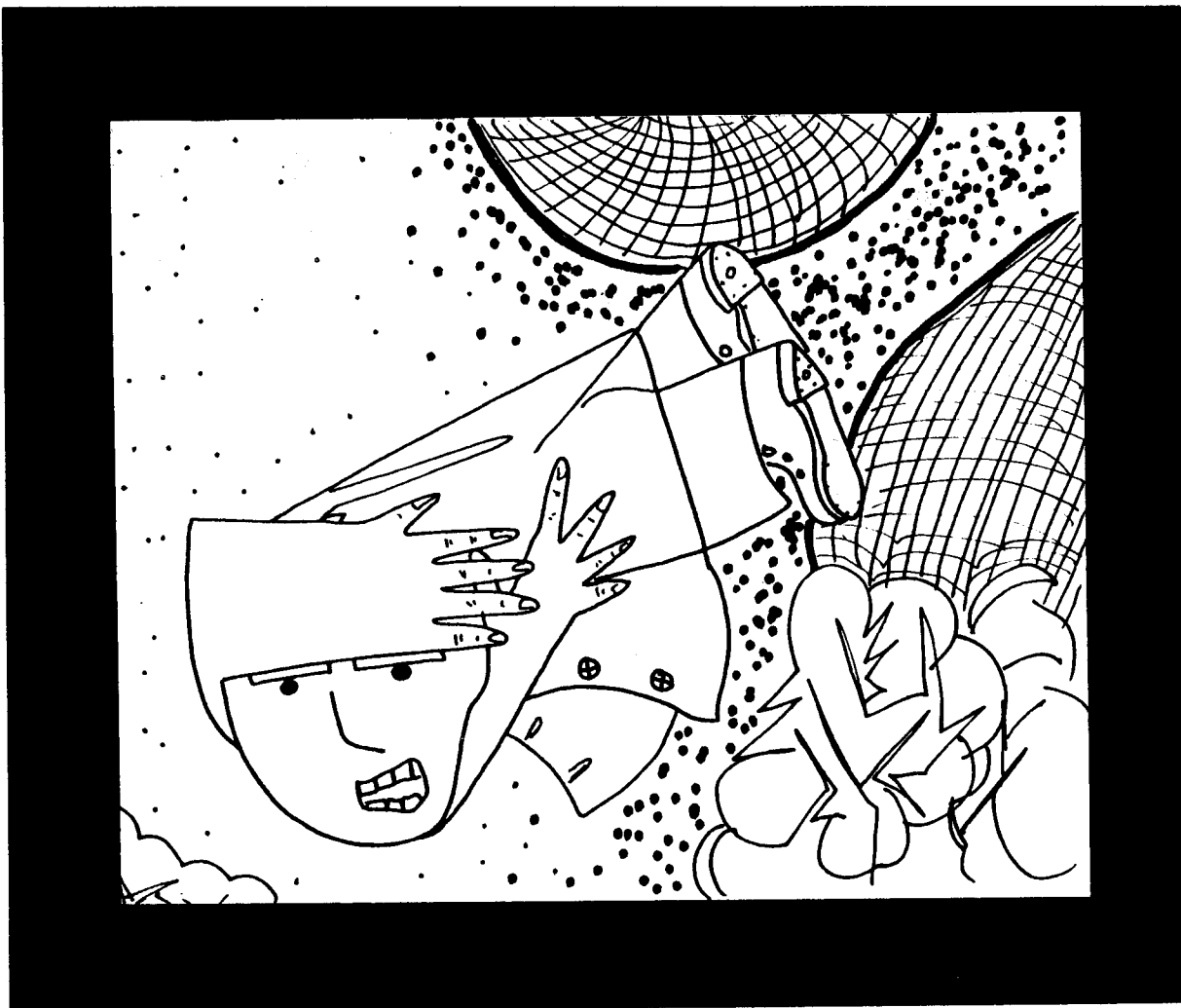
Delany: You don't feel it necessarily as pain. One of the things I do remember when I've had periods that can be talked of as "mentally ill"—that's the way they are standardly discussed—was that these would be periods where...I was aware of my mind functioning and not functioning the way it ought to as the same way as all you can talk about when you have a cinder in your eye is the fact that the vision is distorted. You're not really talking about what's wrong. If one was having minor hallucinations, they were not what was important about the particular state.

Markman: It's a state of altered consciousness.

Delany: It was something that was always very hard to describe and, at the same time, if I had established any rapport with another patient, it was because through some means we managed to hit on something that at least for the time being had both recognized...

Markman: If you were to talk to someone else who has also gone through an altered state of consciousness they're your peer, so to speak. You have more in common with them.

Delany: And yet at the same time, when you try to rotate this discourse and have it between you and the authority figure—the doctor—it could be very frustrating and it would just stop.



Markman: It's meaningless to them because there are no credentials backing it up and no authority...

Delany: I know as a writer trying to write about things like this that you find yourself searching for metaphors and yet even the idea of trying to use the cinder in the eye goes basically back to the medical model again. You have a sense that ultimately it's going to hold the thing back more than...you look for a new metaphorical system that will be more accurate and convey more of it.

Markman: The metaphor I've stumbled upon is natural occurrence. You might say "act of God" if you were more religious. When it does happen—when I undergo an alteration of consciousness—my body slows down and I perceive things very much differently. I become dreadfully afraid. It's a natural occurrence like a hurricane or snowstorm or monsoon and I merely have to await the passage of time until it abates and clears up. It's like meteorology to me. I find this to be very helpful in dealing with day to day life, to accept this as a given in my life. I don't try to look for explanations of why my personal weather is worse than other people's and why the cloud is over my head every eight or nine years and why isn't it over their head. That doesn't lead anywhere. I'm not looking for medical solutions because I did that for a very short period of time when I was younger and I realized what a farce it was, a panacea. (Szasz came up with a word for a disease—all which psychiatry has to offer—a panapathogen.)

Delany: You get that kind of logic with the people involved with things like the Bermuda triangle. What you assume is that there is that which we know and then there is that which we don't know. You assume that there is one cause for every single thing that we don't know and you end up with a vast conspiracy system which is what a good deal of psychiatry tends to be.

Markman: Psychiatry has a lot to do with the Bermuda triangle and flying saucers. You find that reality tends to be inverted in the psychiatric schema, turned on its head or inside out.

Delany: Let me ask you specifically what you mean.

Markman: Logic is inverted. You'll say something to a psychiatrist and he'll refute that and say that the opposite is true. This is usually called mind fucking. It's the quality of inversion that's characteristic of psychiatry.

Delany: There's certainly that idea that everything has the same logical weight as its negative. You do X behavior and it's because of Y. You do the opposite of X behavior and it's also because of Y because you're overcompensating for the one. This becomes an edgeless field where you can send all sorts of double messages. All of the kinds of things that psychiatry itself has unearthed in double binds and what have you become the tools by which psychiatry as an institution proceeds.

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Why Restraint?

By Pat Murtagh

There is a usual "common sense" argument given for the use of restraint in mental hospitals—that it is necessary for the protection of staff and other inmates from violent individuals. How true is this assertion? Just how far does this cover the use of restraint and seclusion *as practiced* in mental hospitals today? One suspicious fact is that the percentage of patients "requiring" special handling can vary anywhere from 4% to 66%, depending on hospital policies. Some of this variation is due to the different patient populations at different institutions, while still more of it can be ascribed to different medication regimes. Despite this, however, simple "staff policy" accounts for a lot of the difference. This can be seen from the fact that restraint is applied for reasons other than violence in anywhere from 25% to 55.7% of the cases, once again depending on institution. The later high figure was found by R. Plutchik and co-workers in a study of a municipal university affiliated psychiatric hospital.

A recent study published in the February edition of the *American Journal of Psychiatry* throws a little more light on the subject, and the light is none too flattering for the mental health establishment. Paul Phillips and Suhayl Nasr studied the restraint and seclusion procedures at the Illinois State Psychiatric Institute (ISPI) over a six month period. The first point that comes up on page one of this study is the fact that a comparison of the records for a six month period before the state of Illinois passed a "mental patients rights amended" Mental Health Code shows no difference as compared to the same records after the passage of the new law. In other words, the legislation which was supposed to safeguard patients' rights was mere windowdressing. Phillips and Nasr do not come out and state this directly, but the inference that can be drawn from their work is unmistakable, whatever their loyalty to the system.

The second interesting aspect of this study is the reasons for restraint. These workers found that 61% of restraint or isolation orders were given because of actual or "potential" violence towards others. Psychotic patients were restrained more frequently than non-psychotics. If, however, one looked more

closely at the reasons for restraint one found that psychotics and non-psychotics had the same amount of "violence related" incidents. There was also no statistical difference between people admitted voluntarily and those committed involuntarily in terms of predisposition to violence. The reason for the violent behavior of patients didn't seem to be related to their mental problems.

So what could be the reason? One reason is quite simple and obvious. It is lower class people who tend to end up in asylums. People in the lower classes accept physical aggression much more readily than do the mainly middle class staff at mental institutions. People in mental institutions are penalized for behavior that is often quite acceptable amongst their peers on the street. What violence there is is more related to class differences than to alleged mental disorders. This is the major explanation that Phillips and Nasr give for their failure to find any evidence that more severe mental problems predispose to greater violence.

There is another reason. What if the degree of violence is related, not to some inner fault of the patient but to a fault of his or her environment? What if the mental hospital atmosphere itself predisposes people to violence? This is one hypothesis that the authors of this paper advance to explain the time of day distribution of incidents leading to restraint or isolation. Violent (and other "bizarre behavior") incidents occur most frequently at those times of day when patients have the most interaction with the hospital social system. In common sense terms, the pressure of staff and other patients will almost inevitably predispose people to be irritable and prone to violence.

The authors of this study have provided some pretty powerful ammunition for those who feel that mental hospitals are not the solution. They have debunked some powerful myths about the mentally ill, and their hypotheses of explanation cast a long shadow on the whole rationale of incarceration as prevention of violence. Much could be added to what they have looked into. This study, however, provides some good background for those who are looking for alternatives to the "mental unhealth" system.





Rights and Wrongs

Lawyers Over Lithium at Queen Street

By Mike Stein

The common law has long held that every individual has the right to be protected from the unwanted touching of their bodies by other persons. Inviolability of the body and the mind may, in fact, be the oldest of all legal rights. With the development of medicine, though, a process had to be created that would allow treatment without endangering the physician to legal action. Thus, the concept of consent was developed. The common law rules of consent have been altered by statute, but the main element still remains: an individual can not be touched against his or her will unless they agree to do so voluntarily with full knowledge of the circumstances, or he or she is not competent to give consent. In a situation where the individual is not competent to give consent, substituted consent may be given by relatives, next of kin or a Regional Mental Health Review Board. The corollary of consent is, quite naturally, the right to refuse treatment. Often times this principle is honoured more in the breach than in its observance.

A case in point is that of a client of mine named, for the sake of anonymity, Jane Doe. My first exposure to Jane's case was over the telephone. One of the Patient Advocates had called me concerning Jane's situation at the Queen Street Mental Health Centre facility. It seems that Jane had contacted the Patient Advocates concerning the treatment she was receiving and specifically the drug that was being administered to her—lithium. Lithium adversely affected Jane by making her nauseous and giving her stomach aches. The Patient Advocates prepared a withdrawal of consent to treatment form for Jane and witnessed her signature to it. They then arranged for this withdrawal of consent form to be placed upon her file and sent a memorandum to the physician in charge of Jane's case setting out her refusal to treatment with lithium.

Since the forms were filled out late Friday afternoon, the Patient

Advocates did not have contact with Jane again until Monday morning. At that time, Jane told them that she was treated with lithium approximately 45 minutes after she had withdrawn her consent to such treatment. What was even more distressing was the fact that Jane had informed the hospital staff of her refusal to receive lithium and of the consent form on her file! Instead of acquiescing to Jane's obvious desire to not be treated with lithium, the staff threatened Jane with physical restraint and injections of lithium if she did not take the drug orally. Facing this situation, Jane complied.

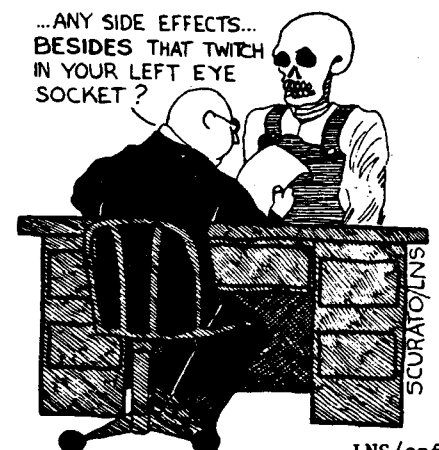
Upon discovering that Jane's wishes had been so nonchalantly ignored by the hospital staff, the Patient Advocates decided that this particular situation called for more than negotiation but legal action. Because of their role at Queen Street, they (advocates) were unable to take the necessary legal steps. However, they could and did obtain Jane's instructions to contact ARCH or another community legal aid clinic to represent her interests.

I was contacted on a Tuesday and made arrangements to meet with Jane the next day. Though the Patient Advocates could not disclose the contents of Jane's file to me, I did make two assumptions about the case: 1. that Jane's status was that of an involuntary patient, and 2. that Jane had not yet been found incompetent. I based my assumptions on the fact that she was unable to leave the hospital, and that the Patient Advocates had accepted her instructions. Since the Patient Advocates are allowed access to a patient's file, their willingness to take instructions from her indicated that there was no finding of incompetency, as of yet, on her file.

On Wednesday morning, accompanied by the Patient Advocates, I went to visit my client. As an individual who had been to visit clients in prison before, but never to a psychiatric facility, I was amazed at the similarities between the two

institutions. The presence of a lawyer seemed to act as an alarm to the hospital staff. Both the Patient Advocates and myself were left to wait for 3 or 4 minutes in a little cell-created by the two locked security doors. One of the Patient Advocates confided to me that they were usually whisked right through the signing-in procedures, but the mention of a "lawyer" seemed to especially unnerve the staff. Eventually the second security door was opened and we were led into the ward to meet our client. As we seated ourselves, Jane was led into the interview room.

Even at first glance it was obvious that Jane was being drugged heavily. She had difficulty in focussing on us and our questions and occasionally had the slack-jawed, bleary-eyed look of a person who was desperately in need of sleep. Jane informed us that she had just received some lithium and that this was the result of her treatment. With the Patient Advocates as witnesses, I had Jane sign another withdrawal of consent to treatment form, a retainer and a disclosure of record authorization. Both Patient Advocates then left, and I discussed Jane's case with her. While Jane did have some difficulty with answering my questions, she was able to indicate through her answers to me that she was quite competent. Her instructions were quite clear: stop further treatment with



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lithium and arrange for her to leave Queen Street. I advised Jane that if the staff came to treat her with lithium again, she was to tell them that she refused treatment. If they threatened her with restraints and injections, she was to acquiesce but state to them that they were forcing her to take such drugs against her will. Since up to this moment, Jane had not been a control problem, this approach was adopted to prevent the hospital from using her refusal as a weapon against her.

At the close of my interview with Jane, I approached the nurse's station and politely requested that the withdrawal of consent form I had just had Jane sign be placed on her file. The upshot was immediate. Nurses on the phone, nurses asking me to wait in the interview room, nurses looking for the file. I was quickly informed that Dr. Q. (not his real name) would be coming downstairs to meet me and discuss Jane's case. After a short wait of 5 minutes, I was escorted to another interview room in the ward to talk to the doctor.

The doctor introduced himself and one of the nurses who was sitting in the corner of the room. To this date, I am unsure of her function, though I assume it was to be as a witness to the doctor's conversation with me.

There were very few preliminary matters to be dealt with and we got down to the meat of the matter very quickly. Our conversation went something like this (I'm paraphrasing here):

Dr. Q.: "What can we do for you?"

M.: "I would like this withdrawal of consent placed on Jane's file."

(*Dr. Q. reads withdrawal of consent form.*)

Dr. Q.: "You know that it's (treatment with lithium) in her best interests?"

M.: "A! I know is that she is competent to instruct me, unless you can show me a finding of incompetency, and she is also, therefore, competent to refuse treatment."

Dr. Q.: "She has consented, you know that."

M.: "I think she has also vitiated her consent in writing on two occasions. I think any physical acquiescence given these refusals would be considered under duress or coercion and that is how I'll advise Dave Baker who will be handling the case."

The interview then ended and I returned to ARCH to discuss the case with both our staff and other lawyers on the Case Review Committee.

The next morning all three lawyers from ARCH appeared at the door to Jane's ward—David Baker and Elaine Newman had accompanied me to see Jane. If one lawyer had caused an uproar the day before, three lawyers

almost brought the hospital or that particular section of it to a standstill. After a wait of a few minutes, a staff person came out of the ward and told us that Jane was being let out of Queen Street. We demanded to speak to our client and after a considerable amount of aggravation were eventually allowed to see her. To me, the difference in her bearing was extraordinary! She was much brighter and alert and did not seem likely to doze off as she had the day before. It seems that after my visit to Dr. Q. the day before, treatment had stopped and proceedings were taken to have Jane released from Queen Street. My last remembrance of Jane was her assuring me that she had my name and phone number at ARCH and would give a call if she had any further problems.

There are a number of points I would like to bring to your attention with respect to Jane's case. The first is that steps can be taken to prevent an individual from receiving treatment they don't want. Oftentimes, litigation may be required but this is not always so. It is important to contact a lawyer or community legal aid clinic to help get your point across. As can be seen from Jane's case, doctors do respect lawyers when it comes to legal matters and a lawyer on your side can make the difference.

Secondly, I have come to greatly respect the Patient Advocates at Queen Street. They took a lot of pressure from the hospital staff, but they refused to

back down an inch in acting for their client. (It helps that both Patient Advocates at Queen Street are lawyers and have an ethical code that is quite rigid with respect to acting in their client's interest.) It should be remembered that the Patient Advocates are not lawyers because they are not allowed to take legal action on behalf of their clients. As negotiators, though, they represented her interests to the limit and were quick to advise her to take legal action through retaining ARCH. Perhaps if they had been given more power, the unauthorized treatment would have ended earlier.

Thirdly and most importantly, the system worked without the need for court action or any type of legal battle. This is indicative, to me at least, that we were right concerning Jane's rights as a patient—to consent to or refuse treatment—and her competency (steps were taken to have her declared incompetent). To me this made this victory all the sweeter.

Editorial Note: This article shows that when patients' rights are at stake patient advocates can not act directly. Instead they resort to referral to lawyers. We still have serious doubts about the effectiveness of patient advocates in psychiatric institutions because they lack the necessary independence to advocate on behalf of their inmate clients.



Mike North



phoenix pharmacy

Drug Withdrawal: How to Come Down

This article is a chapter from a forthcoming booklet titled *Dr. Caligari's Psychiatric Drugs*. Dr. Caligari is the pen name for David L. Richman, a physician practicing in California. The booklet is published by Network Against Psychiatric Assault (NAPA) and costs \$3.50 (US) plus \$1 for postage and handling. It will be available in January 1984. To order copies of this important booklet please write to: Network Against Psychiatric Assault, 2154 University Avenue, San Francisco, CA 94704.

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General Information

Just as psychiatrists usually supply little information about psychiatric-drug effects to those being drugged, they supply even less information about the effects of drug withdrawal and how to minimize them. Frequently, problems occurring during drug withdrawal or afterwards are seen as signs of "relapse," a resurgence of "symptoms" previously held in check by the drugs. These explanations are used to justify the resumption of drugging, usually on a long-term basis.

Often, because of the unpleasant effects of the drugs, people suddenly stop taking them the first chance they have. This can cause even more serious drug-withdrawal problems. Sudden discontinuation of psychiatric drugs is *NOT* the best way to come down from them.

Because almost all psychiatric drugs are depressants of the brain and nervous system and act like a brake on body energies, drug stoppage, particularly when it is sudden, can lead to anxiety, restlessness, insomnia, irritability, gastrointestinal problems, muscular reactions, and hallucinations or "agitated states."¹ On the other hand, one might not experience uncomfortable or distressing withdrawal reactions and might, in fact, merely feel better, more alive, sensitive and energetic as the drug's depressant effects slowly wear off.

People of all ages, even newborns whose mothers took psychiatric drugs during pregnancy, can have withdrawal symptoms. After drugs are stopped, the time period before withdrawal symptoms occur is variable. Some people experience these symptoms within 8-24 hours after starting withdrawal, while for others withdrawal symptoms do not start for several days or a week or two. In part, this depends upon how long the drugs have been taken and in what amounts, for most of these drugs accumulate in body tissues, in the form of drug reservoirs. When drugs are no longer being taken or intake has been reduced and the blood's level falls, these stored drugs will start being released into the bloodstream. Tests have shown that neuroleptics can be detected in the body and urine for up to even 6 months after they have been discontinued.

Another factor to be considered is that drug effects are experienced most intensely when drug levels in the blood are either rising or falling: the more rapid these changes, the more intense the effects. Thus, when large and rapid increases in the drug blood levels occur, one is more likely to experience distressing *drug effects*. On the other hand, when drug blood levels fall rapidly, one is more likely to experience distressing *drug-withdrawal effects*.

Drugs are broken down, inactivated, and eliminated from the body at different rates. This factor, called the drug half-life, is very important. Drugs with short half-lives, that are eliminated quickly, lead to more rapid drops in

blood drug levels and more intense withdrawal effects that start and end sooner. Drugs that have longer half-lives are eliminated more slowly by the body and cause withdrawal reactions that start later, but last longer. Neuroleptics, anti-depressants and the older anti-anxiety drugs (like Valium and Librium) have longer half-lives. Lithium and the newer anti-anxiety drugs (like Restoril, Halcion, and Serax) have shorter half-lives.

There are a number of factors that bear on the difficulty of drug withdrawal:

1. Type of drug taken.
2. Dosage level and length of time drug has been taken.
3. The person's general health and attitude about drug withdrawal.
4. The quality of support received during the withdrawal period.
5. The person's understanding of the withdrawal process, knowledge of the possible symptoms and problems to be encountered, and the concrete measures taken to alleviate such problems.

Scheduling

The most crucial factor in minimizing drug-withdrawal problems is to gradually reduce drug-intake. This is especially important if the drug has been taken for more than 1 or 2 months. If you have been taking small doses of psychiatric drugs, or have been taking such drugs for a brief time only (i.e., a few days or weeks), then you may wish to try discontinuing "cold turkey,"

that is, just stop taking the drug. With neuroleptics, anti-depressants, and lithium it is possible, although not advisable, to stop taking these drugs all at once regardless of how much and for how long you have been taking them. There are no life-threatening consequences to sudden withdrawal from these drugs, although there may be severe discomfort and distress. However, with sedative-hypnotic and anti-anxiety drugs, if high enough doses have been taken for long enough periods, there can be life-threatening withdrawal problems. Under no circumstances should these drugs be stopped suddenly.

Gradual, Stepped Drug Withdrawal: The 10% Formula

Using this formula, drug withdrawal is accomplished by slowly reducing the drug dose in sequential steps, taking as long as necessary at each step. If you have been taking psychiatric drugs for years, it may take many weeks, or even longer, to withdraw from them completely. Following this plan, the drug dose is lowered by 10% of the current dose in 10 successive steps over time. Here is the way this would work if at the time of starting withdrawal you were taking 500mg of Thorazine a day: at each step, drug-intake would be reduced by 50mg (10% of 500mg = 50mg).

Step 1. Go from 500mg a day to 450mg a day. Wait several days or a week until you are free of distressing drug-withdrawal symptoms.

Step 2. Then go from 450mg to 400mg, again waiting several days or a week until you feel o.k.

Step 3. Then go from 400mg to 350mg, and so on until you have completely withdrawn from the drug.

If you are taking divided doses, i.e., some of the drug in the morning, some in the afternoon, some in the evening (a common practice), then there are several ways to put this plan into action. You could first reduce and eliminate the morning dose, then the afternoon dose, and finally the evening dose. Another way would be to reduce the morning dose by 50mg (using the Thorazine example from above) as Step 1, then reduce the afternoon dose by 50mg as Step 2, then reduce the evening dose by 50mg as Step 3, then reduce the morning dose by another 50mg as Step 4, and so on until complete withdrawal.

If after reducing the dose you experience what may be withdrawal symptoms, then stay at that level of dosage until the symptoms diminish or disappear before going on to the next step. As an alternative, go up to the previous step (at the higher dose level) where you felt comfortable and stay there for more time before going on to the next step.

Sometimes the first part of this reduction plan will not cause any problems. But then, as much lower doses are reached, problems will occur. For instance, going from 50mg to no drug (again using the Thorazine example) can cause difficulties, in which case you could decrease the rate of dosage reduction at that time, going from 50mg to 40mg to 30mg, and so on.

In order to use this step-by-step approach, it may be necessary for you to obtain different pill strengths or "cut" the tablets or capsules that you have. Pills that have a hard coating are difficult to break evenly. Tablets are usually "scored," meaning they have a groove down the middle which makes it easy for you to break them in half, or ultimately into quarters, with your fingers. Capsules are harder to cut. If they are cut in half with a razor or knife, the contents spill out, and you must keep the unused half-capsule in a plastic or paper container.

Here is an example of a drug-withdrawal schedule involving dosage reductions where cutting is necessary. If you are taking 60mg of Valium a day (six 10mg tablets) and want to use the 10% Formula, reduce the dose in increments of 5mg, instead of 6mg (10% of 60mg = 6mg). Thus at Step 1, take 55mg (five-and-a-half 10mg tablets) a day (by breaking one 10mg tablet in half). Then at Step 2, take 50mg (five 10mg tablets), and then 45mg (four-and-a-half 10mg tablets) at Step 3, and so on until you are off the drug entirely. If you experience some withdrawal symptoms when going from 5mg (one-half of a 10mg tablet) to none, try going from 5mg to 4mg (two 2mg tablets), then to 3mg (one 2mg tablet and one-half of another 2mg tablet) and so on. These dosages could be cut even finer, e.g., if you wanted to set the dosage level at 2-1/2mg of Valium, you could take one 2mg tablet and with a knife cut another 2mg tablet in quarters and take one of the quarters (one-quarter of a 2mg tablet = 1/2mg).

Again, the 10% Formula is not an inflexible system for drug withdrawal. It can and should be adjusted to your individual needs.

Practical Suggestions

1. Diet

The purpose of withdrawing from psychiatric drugs is to cleanse the body, to rid it of accumulated poisons. Nausea, vomiting, and other stomach problems can be anticipated. What you eat during this period will influence your experience of the withdrawal and its outcome. Therefore, it is important to eat well, regularly, but not to excess. Some people report good results by *concentrating on* grains, beans, fresh vegetables, fresh or dried fruit, and uncooked, unsalted nuts, and *avoiding* junk food, sugar (candy, cakes, ice cream, and soft drinks), processed foods (canned and frozen), fried foods, animal products (meat and dairy), caffeine (coffee, most commercial teas, and some soft drinks), alcohol, and drugs ("grass," cocaine, and "speed").

2. Sleep and Relaxation

Insomnia (difficulty in getting to sleep or staying asleep) is a common withdrawal problem. But you need to get adequate sleep and rest during the withdrawal period. If sleep does not come easily, it is better to rest in bed than to pursue some activity. Some people have found it helpful to drink an herbal tea (valerian tea is one of the better ones) before going to bed. Others have benefited from yoga and breathing exercises, warm baths, and massages before sleep.

3. Physical Exercise

As your body becomes free of drugs, you are likely to have more energy than you had while taking the drugs. This energy can be used to further the withdrawal process or, if misused, can hinder it. A regular activity program can prove helpful. It might include walking, jogging, dancing, exercise (yoga, aerobics, etc.), or sports. Moderation is a key principle: if you increase your activities, do so gradually.

4. Mental Exercise

Your mind is also likely to become more active during withdrawal. For some people this has proved to be a good time for learning new survival and social skills, as well as for study, reflection, and meditation.

5. Mental Attitude

Withdrawal from psychiatric drugs can be a very trying experience. Maintaining a positive attitude—believing you can do it—is crucial to your success. You should know that withdrawal can cause moderate to severe discomfort and outright misery at times. Being mentally prepared for this decreases the chances that you will become scared or discouraged. Patience and determination are needed.

6. Environmental Factors

Having a good, stable life situation among people who understand the nature of drug withdrawal and support your efforts to go through it is extremely important. Their mental attitude is almost as important as your own. As you come down from the drugs, you are likely to feel better physically and have more energy for improving your relationships and developing new ones, getting politically involved, and tying in with a local support system.

WITHDRAWAL EFFECTS BY DRUG CATEGORY

1. Neuroleptics

Drugs like Thorazine, Stelazine, Haldol and Prolixin³ are associated with 3 basic types of withdrawal reactions, usually starting a few days after the drugs are stopped or reduced, peaking during the first week and generally diminishing by the second or third week:

A. Nonmuscular Reactions: flu-like symptoms, such as nausea and vomiting (at times severe), sweating, runny nose, insomnia, diarrhea, restlessness, headaches, and aches and pains. With the exception of severe vomiting, all of these reactions can be suffered through without special attention.

B. Muscular Reactions: neuroleptic-induced parkinsonism, such as muscular rigidity, tremors, and stiffness, can persist for several months, or longer, after the drugs are stopped. Other abnormal, uncontrollable, rhythmic movements, particularly around the mouth, can last for many months, or even indefinitely, if tardive dyskinesia has developed.

C. Withdrawal "Psychosis": as people withdraw from the neuroleptics, they sometimes feel like they are "freaking out" or "going crazy." Often this is not recognized for what it is—a condition brought on by the withdrawal process itself. This development can then result in a return to more intensive drugging. A far better course would be to slow down, not reverse, the withdrawal process.

D. Combinations: If you have been taking a neuroleptic and an anti-parkinsonian drug, then come down from the neuroleptic first, as explained above, while taking the same dose of the anti-parkinsonian. After you have completely withdrawn from the neuroleptic, gradually withdraw from the anti-parkinsonian over the following 2-4 weeks. This may be the most difficult and uncomfortable part of the withdrawal.

D. Prolixin : Long-acting Injections: Prolixin injections pose a unique withdrawal problem. These injections last from 2-6 weeks. Once you decide to withdraw, just stop getting the injections. You will gradually come down as the last shot wears off. If an anti-parkinsonian drug is also being taken, continue it for 6 weeks after the last Prolixin shot. After this period, taper off the anti-parkinsonian over a 2-week period. This is the safest way. You can also stop the anti-parkinsonian sooner and see what happens, then restart it if there is a problem.

2. Anti-depressants

What has been said of withdrawal from the neuroleptics applies to the anti-depressants, such as Elavil, Tofranil, Norpramin and Vivactil, although muscular symptoms are usually less severe. Stopping these drugs abruptly is not recommended.

3. Lithium

Lithium, because it is a mineral salt and not an organic chemical like all other psychiatric drugs, presents a different type of withdrawal situation. Sudden discontinuation of lithium appears to be safe. The body will eliminate the lithium through the urine over the next 3 days to a week. Although there are no reports in the psychiatric literature documenting serious withdrawal reactions from lithium, personal reports indicate that there have been withdrawal difficulties, including "freak-outs", insomnia, anxiousness and irritability. The best approach is to withdraw slowly from lithium over at least a 2-week period.

4. Anti-anxiety Drugs

With the anti-anxiety drugs ("minor tranquilizers"), like Valium and Librium, it is crucial that withdrawal be gradual. Dosage levels should be reduced to nothing over at least a 1-week period. Abruptly stopping these drugs can produce dangerous withdrawal reactions, including life-threatening seizures. Even with gradual withdrawal, reactions can include: flu-type aches and pains, nausea, diarrhea, sweating, shaking, insomnia, anxiety, restlessness,

dizziness, fevers, muscle tics, and feelings of freaking out. Withdrawal symptoms can occur immediately or shortly after the drugs are reduced or stopped and can build in intensity for a week to 10 days. It is during this early stage that seizures are most likely to occur. Withdrawal reactions of a milder nature can linger on for several weeks or even a month or 2 after the drugs are stopped.

5. Sedative Hypnotics

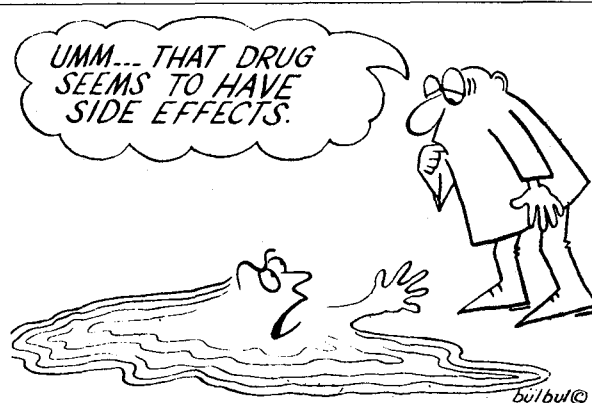
Sudden withdrawal from barbiturates and pseudo-barbiturates, such as Qualude, Tuinal and Placidyl, can be hazardous, with life-threatening seizures a possibility. If you have been taking these drugs continuously for longer than 2 months, it is necessary to reduce doses over a period of several weeks. Withdrawal symptoms with the sedative-hypnotics are similar to those of the anti-anxiety drugs.

6. Psychostimulants

Amphetamine and quasi-amphetamines, like Ritalin, are addicting drugs, and withdrawing from them can cause problems. Unlike the sedative-hypnotics, there is no danger of life-threatening withdrawal seizures. But suddenly stopping the psychostimulants can induce severe despair (at times of suicidal proportions), extreme fear, and feelings of freaking out. Therefore, gradual withdrawal is recommended. Other less serious withdrawal reactions include: apathy, fatigue, nervousness, irritability, and gastrointestinal symptoms. There is little documentation concerning psychostimulant-withdrawal problems for "hyperactive" children. But there are many published reports of such problems with adults, and it is reasonable to assume that children withdrawing from Ritalin-type drugs sometimes experience difficulties.

7. Geriatric Drugs

There is almost no information about withdrawal problems with geriatric drugs. In the absence of reliable information, slow withdrawal over a 2-week period, or longer, is advised.



Having a good, stable life situation during the drug withdrawal period is very important. Count yourself lucky if you are among people who understand the nature of drug withdrawal and support your efforts to go through it. If you must be among people who disapprove of your decision to go off drugs, you should insist upon their at least respecting your right to do so. Of course, during withdrawal you are better off being by yourself than with unsympathetic or hostile people. Many individuals have withdrawn from drugs *on their own*. As you come down from the drugs, you are likely to feel better physically and have more energy for improving your relationships and developing new ones, getting involved in the community, and tying in with a support system or creating your own.

1. Alcohol consumption presents a similar problem: after alcohol binges or long-term heavy alcohol use, one can experience withdrawal reactions, including hallucinations and a serious, sometimes life-threatening condition called delirium tremens, or the DT's.
2. A note on smoking. It is not wise to stop smoking at the same time you are withdrawing from psychiatric drugs. Each process can lead to an increase in tension. When both are undertaken together, these tensions can be overwhelming. It is far better to get off psychiatric drugs first and then deal with the smoking problem.
3. Modicate or Moditen in Canada.

TRANQUILIZER MAY IMPAIR MEMORY

Diazepam, a common tranquilizer taken orally or intravenously, may impair the memory and the ability to learn, a University of Iowa anaesthetist warns. In Dr. M.M. Ghoneim's tests on 150 volunteers who were asked to recall lists of words and numbers, the memory was impaired for at least five and a half hours after patients received 0.3 milligrams of diazepam per kilogram of weight, which would be 16.2 milligrams for a woman weighing about 120 pounds. Therapeutic doses prescribed for adults by their doctors generally range between five and 40 milligrams a day.

People who have been using the tranquilizer for years may have trouble remembering the past. Two or three years of their life may be a blank to them. While the drug may be beneficial in certain situations, Dr. Ghoneim says, patients should be aware of the drug's possible side effects.

—Sidney Katz

Reprinted from Chatelaine.

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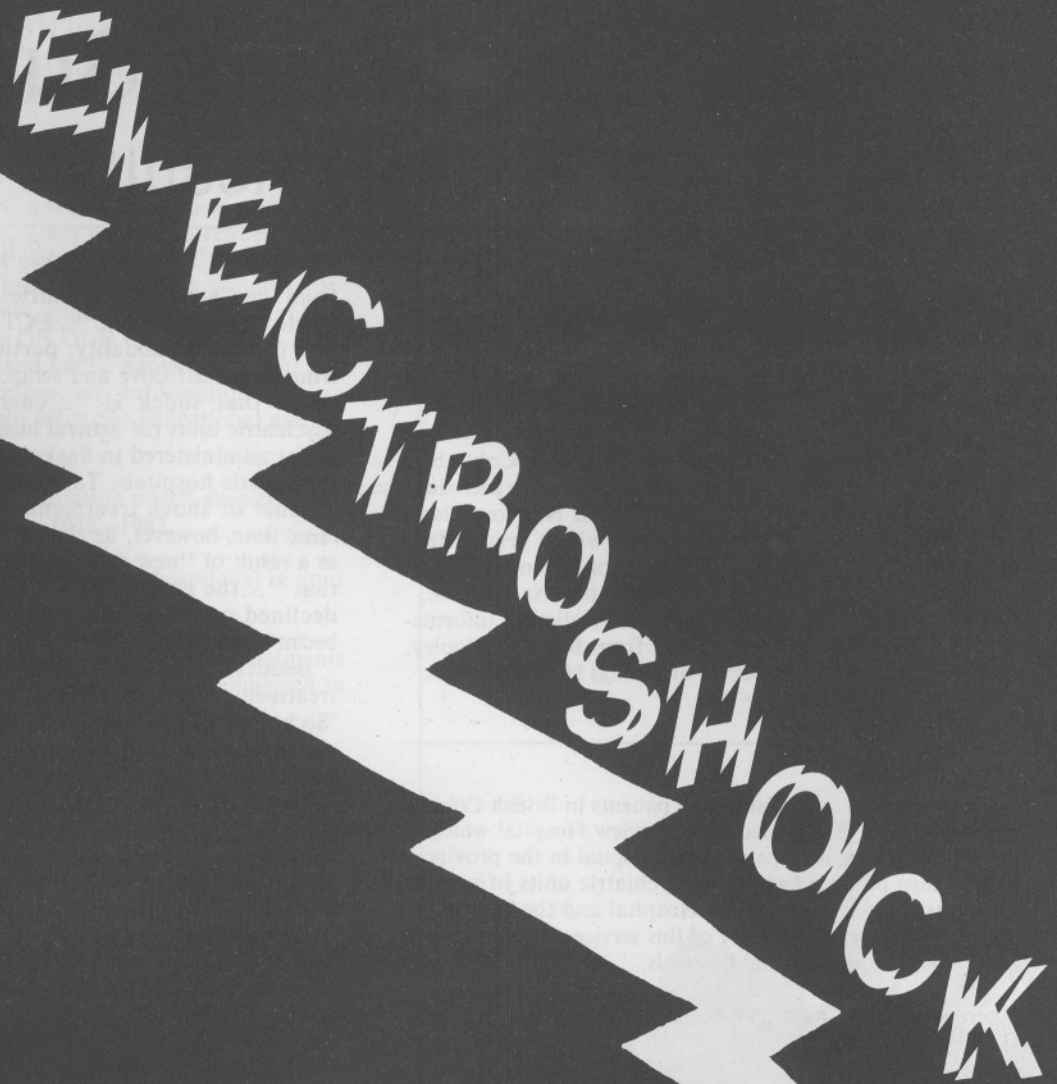


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ELECTROSHOCK

“Electroshock is violence.” RAMSEY CLARK (former US Attorney-General) in a statement during the Annual Meeting of the American Psychiatric Association in New York City on May 2, 1983.

“When I saw the patient’s reaction, I thought to myself: This ought to be abolished! Ever since I have looked forward to the time when another treatment would replace electroshock.” UGO CERLETTI, M.D. (inventor of electroshock) in F.J. Ayd Jr., M.D., Psychosomatics (Nov.-Dec. 1983).

Canadian Shock Survey

Preliminary Results

On August 15, ON OUR OWN Co-ordinator Susan Horley and Don Weitz mailed a letter to the Ministries of Health and Social Services in Canada's ten provinces. In the letter, they asked seven major questions concerning electroshock. The letter appears below: (see attached letter)

As we're going to press in mid-October, only five provinces have responded to this letter: British Columbia, Saskatchewan, Manitoba, Ontario and New Brunswick. Alberta, P.E.I., Quebec, Nova Scotia and Newfoundland haven't yet replied. All the provinces which responded, except for New Brunswick which sent a non-committal letter, admitted that electroshock is administered in their province.

However, only B.C. provided detailed, statistical information. We reprinted most of this letter from Brian D. Copley, B.C.'s Acting Executive Director of Mental Health Services:

1. "ECT is presently administered to patients in British Columbia. Most ECT is provided by Riverview Hospital which is the major government psychiatric hospital in the province. ECT is also provided at a few psychiatric units of general hospitals. Vancouver General Hospital and the Trail Hospital account for the majority of this service. Very little ECT is provided at other general hospitals.
2. There were 4,798 treatments of ECT during the fiscal year 1982-1983.
3. The total number of patients who received ECT treatment is estimated at 600.
4. The average number of ECT treatments administered to a patient during the course of treatment is 8.
5. The fee schedule for ECT treatment is \$22 per treatment. Total cost is $22 \times 4,798 = \$105,556$.
6. ECT treatment is covered under the Medical Services Plan of British Columbia.
7. There have been no reported cases of death or injury as a result of ECT treatments in British Columbia..."

Re Copley's letter, we must challenge his figure of \$22 for one shock treatment. This is the fee which the B.C. government pays to the shock doctor only. It does not include other medical costs such as the anaesthetist's fee. So the actual *total* cost per shock treatment in B.C. is probably closer to \$50, if not higher, and over \$200,000 per year for all shock treatments.

The letter from Saskatchewan (Graham Taylor, Minister of Health) was a mix of psychiatric propaganda and a few bits of hard information. Taylor starts his letter by quoting

from the Canadian Psychiatric Association's position paper on electroshock (1980). "...ECT continues to offer an important treatment modality, particularly for people suffering from major affective and schizophrenic disorders." He then states that shock is "...currently administered in the psychiatric units (of general hospitals)..." Apparently, shock is not administered in Saskatchewan's public or provincial psychiatric hospitals. Taylor also says he doesn't know the number of shock treatments or patients shocked. At the same time, however, he claims that "ECT has diminished..." as a result of "new and more effective antidepressants", and that "...the number of patients treated has significantly declined over the past twenty years as other treatments became available."

Besides the antidepressants, we wonder what these "other treatments" are. Psychosurgery? Behaviour modification? 'Seclusion'? Taylor also doesn't know the average number of shock treatments administered but estimates a course of ECT as "...four to six treatments." In addition, from Taylor's letter we learn that electroshock is covered by the Medical Care Insurance Commission, and the "fee paid...to specialist psychiatrists is \$20.00 per treatment. The same amount is paid to specialists in anesthesia . . . in connection with ECT." Like B.C.'s Minister of Health, Taylor claims he doesn't know of any shock-related deaths. At the end of his letter, Taylor suggests we can write to Dr. Colin Smith, Chairman of a committee of the Canadian Mental Health Association which is holding public hearings on B.C.'s *Mental Health Act*, if we wish to make any recommendations re electroshock. Our recommendation is simple: **ABOLISH ELECTROSHOCK IN SASKATCHEWAN AND MAKE IT A CRIMINAL OFFENSE PUNISHABLE BY A FINE OF \$500 AND/OR IMPRISONMENT UP TO A MAXIMUM OF SIX (6) MONTHS FOR EACH OFFENSE.**

Manitoba sent a short and defensive letter from Dr. H.K. Sigmundson, Director of Psychiatric Services. In Dr. Sigmundson's letter, we learn that shock is "used when it is deemed appropriate, the decision being made by a psychiatrist well versed in the procedure and knowledgeable of the possible side effects." Like permanent memory loss or brain damage? This letter also mentions that shock is administered in both the provincial psychiatric hospitals and psychiatric units of general hospitals. However, no figures on number of shock treatments or patients shocked are provided, and no shock-related deaths are reported. Apparently, Manitoba keeps no separate costs for shock: "The cost of giving ECT is not isolated from the other costs of operating a psychiatric facility...I believe it would be quite small." How small?

As for Ontario, we still haven't received any shock information or statistics from the Ministry of Health. In his letter dated September 1, David Corder (Executive Director, Mental Health Division) states that his Ministry needs more time to compile the information. Although we're still waiting for the official shock statistics and other information from the Ministry, we're publishing the unofficial shock statistics given us over the phone from a reliable Ministry source.

We'll publish more shock information, including responses from other provinces, in future issues.

Written by Don Weitz for the Ontario Coalition to Stop Shock.

Letter to the Ministries of Health & Social Services in Canada

Dear

On behalf of ON OUR OWN, a self-help group of psychiatric inmates and former inmates, I am writing to request some information about the use of electroshock ('ECT' or electroconvulsive therapy) in your province. (As background information about ON OUR OWN, please see attached copy of our information sheet.) Many ON OUR OWN members, their families, friends and the general public know little about this psychiatric procedure. Therefore, any information you can provide about 'ECT' will help serve our educational and research purposes.

Specifically, we would like information which answers these questions for the last five years, 1978 - 1982.

1. Is 'ECT' presently administered in any hospital(s) in your province?
2. (If YES) What was the total number of 'ECT' treatments administered? How many treatments were administered in these types of hospitals?

Public Psychiatric Hospitals
Private Psychiatric Hospitals
General Hospitals
Other hospitals/clinics

3. What was the total number of people who received 'ECT'?
4. What was the average number of 'ECT' treatments administered to a patient during a course of treatment?
5. What was the average cost per treatment and the total cost for all treatments?
6. Is 'ECT' covered by your health insurance system?
7. Have any deaths resulted (directly or indirectly) from the use of 'ECT'. (If YES, please provide details such as number of deaths, age group and sex of deceased and official causes of death.)

If 'ECT' has *not* been administered in your province during the last five years, would you please provide the information requested for the last year during which it was administered? Also, if 'ECT' is no longer administered in your province, would you please briefly state the major reason(s) for its discontinuance?

As I previously mentioned, this information will serve our educational and research purposes. We would appreciate receiving your answers to our questions by *September 15* or as soon as possible. Thank you in advance for whatever assistance you may give us. I hope to hear from you shortly.

Sincerely,

Susan Horley, Co-ordinator
ON OUR OWN

Don Weitz, Co-founder
ON OUR OWN

encl: ON OUR OWN information sheet.



"Ten volts of electricity to the genitals is regarded as torture, while 10 times that amount to the brain is called a treatment." Statement from Network Against Psychiatric Assault (San Francisco, CA) quoted in *The Toronto Star* (April 17, 1976).

THE CLARKE INSTITUTE OF PSYCHIATRY: A SHOCKING RECORD

*"It (ECT) very quickly became an accepted treatment without formal clinical trials as the untreated patients languishing in mental hospitals serving as 'controls' attested to the effectiveness of convulsive therapy."**

Electroshock is a very common psychiatric procedure used at the 'Clarke'. During the last 17 years slightly over 11% of patients admitted have been subjected to this brain-damaging procedure (See Electroshock Fact Sheet). At the 'Clarke,' people diagnosed as suffering from an "affective" or "manic-depressive" psychosis and from "schizophrenia" are shocked. During a 17-year period (1966-82), approximately 22,000 shock treatments were administered to roughly 2500 psychiatric inmates. 37% of these shock victims were diagnosed as "schizophrenic." Inmates diagnosed as having an "affective" or "manic-depressive" disorder received

an average of 8 shock treatments; inmates diagnosed as "schizophrenic" got an average of 10. Accordingly, and contrary to psychiatrists' usual claim that shock is the "treatment of choice" primarily for "manic-depression,"** it would seem that—at least at the 'Clarke'—almost as many shock treatments have been ordered for inmates considered "schizophrenic."

Also from 1966 to 1981 a total of 203 inmates were subjected to 15 or more shock treatments.

These facts and the shock statistics below appear in an unpublished paper titled "The Clarke Institute Experience With Electroconvulsive Therapy: Treat-

ment Evaluation and Standards of Practice" by B.A. Martin, P.M. Kramer, D. Day and H.B. Kedward—all professional staff at the 'Clarke.' (This paper was delivered at the Annual Meeting of the Canadian Psychiatric Association in Montreal in September 1982.)

*Quoted from "The Clarke Institute Experience With Electroconvulsive Therapy: Treatment Evaluation and Standards of Practice."

**... ECT... is the treatment of choice for patients suffering from very severe depression... — Ibid.

CLARKE INSTITUTE OF PSYCHIATRY TOTAL NUMBER OF TREATMENTS PER YEAR¹

YEAR	NUMBER OF TREATMENTS	SCHIZOPHRENIA	AFFECTIVE DISORDERS	OTHER DISORDERS
1966	30	—	30	—
1967	279	43	212	24
1968	1059	470	461	128
1969	1634	659	772	203
1970	2497	1246	941	310
1971	2010	705	1010	295
1972	1577	610	817	150
1973	1468	668	612	188
1974	1537	528	850	159
1975	1485	725	531	229
1976	1471	521	643	307
1977	1062	395	505	162
1978	1307	498	749	60
1979	1339	603	573	163
1980	1213	444	742	27
1981	968	348	515	105
TOTAL:	20,936			

¹B.A. Martin, P.M. Kramer, D. Day, H.B. Kedward. The Clarke Institute Experience With Electroconvulsive Therapy: Treatment Evaluation And Standards Of Practice. September 1982.

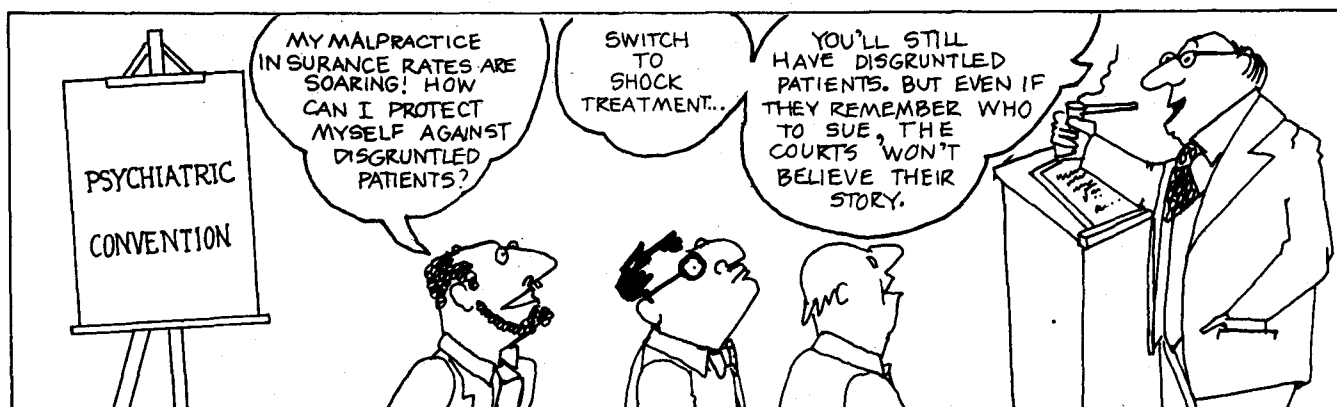
Electroshock Facts

Prepared and published by Ontario Coalition To Stop Electroshock

- **Electroshock** ("ECT) or "electroconvulsive therapy") is a major psychiatric procedure which is still widely used in many countries including Canada, Great Britain and the United States.
- **Electroshock** was first introduced as a treatment in 1938 by two Italian psychiatrists, Cerletti and Bini, after Cerletti observed how pigs were effectively stunned by electric cattle prods to their head on their way to the slaughterhouse. The shocks made the pigs docile. The first human being to be shocked was a "schizophrenic" man—he vainly protested against the procedure.
- The shock procedure involves passing 70-175 volts of electricity through the prefrontal and/or temporal lobes of the brain for about a half-second. An anaesthetic and paralyzing muscle relaxant are administered; artificial respiration (oxygen) is given to sustain breathing.
- The immediate effects of electroshock are a convulsion or seizure and coma. The person then sleeps for a half hour to two hours.
- Upon awakening from a shock treatment, the person experiences many of these reactions: memory loss; disorientation; dizziness; confusion; severe headache; muscle ache; breathing difficulties; heart irregularities; delirium; weakness; nausea or vomiting; wild excitement and terror.
- Memory loss after shock is extensive and often permanent. Shock advocates, including many psychiatrists, claim the memory function will return within 2 or 3 months. However, many shock critics, particularly shock victims, assert that the memory loss is permanent. Months or years of their experiences and knowledge have been totally wiped out.
- Electroshock has also caused permanent impairments in people's learning ability, intellectual functioning, creativity, energy and enthusiasm.
- The death rate for electroshock is roughly 1 death per 1000 people shocked. Since 1941, approximately 400 shock-related deaths have been reported in English language books and journals.
- Electroshock is usually administered in a series for "depression", Manic-depressive psychosis" and "schizophrenia." For "depression", the average series is 6-12 treatments; for "schizophrenia", 15-35.
- In North America, twice as many women as men are subjected to electroshock. Women and the elderly are the prime candidates for this procedure.
- In 1982 across Ontario, at least 16,000 shock treatments were administered to 2000 people in community and general hospitals and outpatient clinics. Many more were administered in the province's 10 public psychiatric institutions. The Ministry of Health has never published its shock statistics. Electroshock is covered by most health insurance plans including OHIP, one reason for its continued existence.
- In 1982, the people of Berkeley, California voted by a 61% majority to ban electroshock in their city. Shock critics, including victims, assert that electroshock is a brain-damaging, violent and unethical procedure, a brutal form of mind control which should be immediately abolished. Public criticism of and protest against shock is growing rapidly across North America.

"Then something bent down, and took hold of me and shook me like the end of the world. Whee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant. I wondered what terrible thing it was that I had done." SYLVIA PLATH (poet-writer) in *The Bell Jar* (1971).

"What these shock doctors don't know is about writers . . . What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure, but we lost the patient." ERNEST HEMINGWAY (Nobel Prize winning writer) to A.E. Hotchner in *Papa Hemingway* (1966). Two months after a second series of shock treatments in July 1961, Hemingway committed suicide.



Dorothy Nissen Sibley

Berkeley's Electroshock Ban

History of the Ban

Berkeley community groups have been holding demonstrations against the practice of electroshock (sometimes called ECT) since 1974. In January of 1982, city council member Florence McDonald made a motion that the Council hold hearings on ECT, which was voted down. The Coalition to Stop Electroshock next appealed to the Berkeley Human Relations and Welfare Commission, which held hearings on the subject in April of '82. Dozens of people, including many shock recipients, nurses, doctors, psychiatrists, and community activists, testified against the procedure, which they claimed was not a medical treatment, but an instrument of social control. Only three people testified in favor of ECT, all psychiatrists. As a result of the energy generated at those hearings, the Coalition decided to put the issue before Berkeley voters, and began collecting signatures to put a shock ban on the ballot. In November of '82, 61% of Berkeley voters passed Measure T.

Psychiatric Associations Sue The City of Berkeley

The Northern California Psychiatric Society, the American Psychiatric Association, and other psychiatric organizations brought suit against the city to have the ban overturned. In January of '83 they were granted a preliminary injunction which permitted the continued use of ECT at Herrick Hospital (the only hospital in Berkeley which uses ECT), until a ruling could be made on the legality of the ordinance. Knowing that a full hearing on the subject would be detrimental to their suit, in June the psychiatric associations moved for a summary judgment, which claims that there is no dispute as to issues of fact, and that the case should be decided in their favor without a full hearing. In a preliminary decision, Alameda Superior Court Judge McKibben ruled against the summary judgment, based on the written briefs submitted by the parties. On July 14 there was a short hearing where each side presented oral arguments, and the judge said he would take the matter under submission.

Court Overturns Berkeley's Shock Ban

On Sept. 14, Judge Winton McKibben granted a motion for a summary judgment made by the psychiatric associations. If unchallenged, this would permanently invalidate the ban and eliminate the possibility of a full hearing on the legality of the ordinance. Manuela Scott, the Assistant City Attorney who has been defending Measure T, stated that she will have to consult with City Attorney Natalie West and the City Council before deciding whether to appeal the decision. Members of the Coalition to Stop Electroshock, the organization which put the shock ban on the ballot, appalled by Judge McKibben's apparent indifference to the democratic process, and demanded that the city appeal.

The Berkeley City Council voted to appeal the summary judgement which overturned Measure T on Thursday, Sept. 22 in a closed session. (See article entitled "Shock Ban Ruling Angers Voters" for background.) A week later Assistant City Attorney Manuela Scott filed a motion for reconsideration of the summary judgement, which is scheduled to be heard in Alameda Superior Court on Oct. 19.

Meanwhile, The Coalition To Stop Electroshock Filed A Motion For Intervention

in the suit against Berkeley's shock ban on Sept. 27. The motion was originally filed ex parte, which is an informal hearing held before a research attorney who makes a recommendation to the judge. The value of this kind of hearing was it gave the lawyers for the psychiatric associations very little time to develop a response. The motion was argued by Sam Trosow, the Berkeley attorney who is representing the Coalition, and Mark Kenney, representing the shrinks. Judge McKibben, after hearing the report of the research attorney, indicated that the motion would require a full hearing, and denied the ex parte motion. The new hearing on the motion for intervention will be held on Nov. 7. The motion will be argued by David Ferleger, an attorney who specializes in the rights of institutional people.

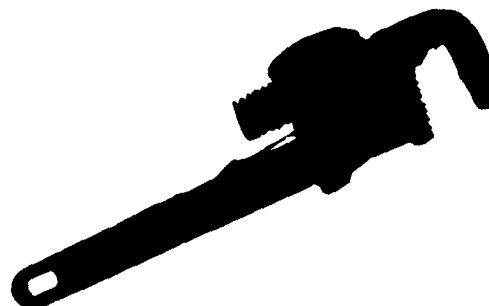
Reprinted with permission from *NAPA Newsletter*.



Kate Thompson, *Women's Press*, July/August 1976

"I see no beneficial effects for...this so-called treatment...ECT enforces child-like behavior and enforces traditional female dependence at a time when...all women in this society are trying to break out of constricting societal roles. Instead of finding their identities, ECT blots out much of what they already have. ECT is used to keep women in a subservient and inferior position."

CATHIE MEYER, R.N. (psychiatric nurse) in personal testimony at the "Public Hearing on Electroconvulsive Therapy" in Berkeley, California on April 24, 1983; Madness Network News (spring 1983).



Shock: The Gentleman's Way to Beat Up a Woman

PSYCHIATRIST GETS A SHOCK

Reprinted with permission from *NAPA Newsletter*.

A prominent Berkeley psychiatrist whose lawsuit overturned the city's electroshock ban has been charged with Medi-Cal fraud.

Ronald Bortman, 42-year-old president of the East Bay chapter of the Northern California Psychiatric Society, faces 25 counts for filing false claims and grand theft.

Bortman, former chairman of the society's Medi-Cal Committee, is charged with overbilling the state during 1981 and '82.

During those two years, according to court records, Bortman generated \$975,000 in Medi-Cal claims. The complaint filed against Bortman does not indicate how much of that is alleged to be fraudulent.

Contacted Monday at his Berkeley office, Bortman declined to discuss the matter. He is expected to surrender to authorities soon. His bail is set at \$72,000.

According to documents filed in Municipal Court, Bortman had been under investigation since May of last year when state investigators were tipped off about his billing practices.

The investigation centered on treatment Bortman administered at Oakland nursing homes.

The owners of Essie's Board & Care told state agents that Bortman only saw the home's eight patients for a few minutes at a time and never stayed more than an hour.

And at the Adeline Board & Care home, Bortman allegedly took Medi-Cal stickers for patients he never saw, according to court records.

The Bortman investigation included surveillance of his Kensington home, state agents tailing the doctor as he drove around Berkeley and Oakland and the use of an undercover operative who Bortman treated.

Under Medi-Cal rules, doctors cannot bill the state for time not spent treating patients.

Dr. Bortman, who filed lawsuit overturning electroshock ban, charged with Medi-Cal fraud.

Bortman was the only named individual plaintiff in the electroshock suit filed by the Psychiatric Society and other psychiatric organizations.

The electroshock ban, approved overwhelmingly by Berkeley voters last year, was killed by a Superior Court Judge, who ruled it unconstitutional.

The city of Berkeley has since decided to appeal the matter to a higher court.

Bortman is currently chairman of the society's Government Affairs Committee.

Last October, another Berkeley psychiatrist was charged in connection with a Medi-Cal fraud conspiracy.

Robert Picker, a self-proclaimed holistic doctor, and four others were charged with defrauding Medi-Cal out of about \$50,000.

Picker pleaded guilty to felony charges of grand theft and filing false claims. He was placed on probation and ordered to do community service work. The state pressed unsuccessfully for a jail term.

Bortman's wife, Patricia, is currently appealing a \$500,000 judgement against her and three other defendants.

Mrs. Bortman was named in January 1978 lawsuit brought by a teacher at the Fred Finch Youth Center which provides psychiatric care to disturbed adolescents.

The instructor, Martin Carls, was scalded in January 1977 by one of the students who dumped a pot of boiling water on him.

Carls sued the center and others, including Mrs. Bortman, then the center's child care social worker.

After a three-week trial in early 1981, a Superior Court jury returned a verdict against the defendants for \$500,000, finding that their negligence caused Carl's injuries.

Electroshock Tribunal

On Friday evening, October 21st, a meeting was held in the Council Chambers of City Hall (Toronto), to present facts and opinions about electroshock treatment (ECT). The meeting was chaired by David Reville (Alderman for Ward 6), with a panel of six members, including Don Weitz of On Our Own, and two representatives of self-help group, SPRED, Hamilton. About sixty to seventy people attended, and following the initial presentation made by the panel, members of the audience were invited to speak. Everyone who spoke that evening spoke against shock treatment, as one horror story after another was revealed.

Teenagers (15, 16, 17) told of being given as many as fifteen shock treatments to deal with their alienation and rebellion, of being threatened by psychiatrists for anti-social and non-conformist attitudes. The picture portrayed of these psychiatric institutions by the ex-inmates was a world where a privilege awarded might mean being able to wear your own prescription glasses; where punishment usually meant more druggings, confinement, or ECT—a world more suited to creating depression and alienation than treating it.

One woman from the audience, wearing a blue T-shirt labelled "lunatic" on the front and back, spoke up from time to time from her seat, in a loud Scottish accent.

"At sixty bucks a shot (ECT) you bet they (psychiatrists) are making money!" "People don't need ECT or Stelazine, they need Tender Loving Care!" "Fire the psychiatrist!" Her spirit and energy was appreciated.

Another woman who spoke in a shaky, almost faltering voice, explained articulately and intelligently how she was treated for depression for ECT. Her depression was the result of boredom and frustration with her family and job. Now, after ECT, she has difficulty remembering things, her speech and movements are impaired, and she remains unemployed.

A remark made by Carla McKague, a lawyer on the panel, summed up the attitude and purpose of the meeting: "ECT has nothing to offer, except brain damage. We don't need it, let's get rid of it!"

North American Day of Protest Against Electroshock

Public criticism and protest against electroshock is growing rapidly—particularly in the United States and Canada. On October 22, various antipsychiatry groups and coalitions of ex-psychiatric inmates and supporters held protest demonstrations and other educational events against shock in San Francisco, Denver, Philadelphia, Boston and Toronto. In the US, the Women's Psychiatric Inmates Liberation Front in Denver and the Coalition To Stop Electroshock in Berkeley, California led the anti-shock organizing.

In Canada, the only anti-shock demonstration occurred in Toronto. The Ontario Coalition To Stop Electroshock, a new, grass-roots organization of ex-psychiatric inmates from ON OUR OWN in Toronto and S.P.R.E.D. in Hamilton, worked hard to organize the very successful protest. The protest actually consisted of two parts: a 3-hour public forum of shock survivors giving personal testimony on October 21 in City Hall, and a public demonstration against shock and the Clarke Institute of Psychiatry on October 22. The public forum was moderated by Alderman David Reville, an ex-inmate and ON OUR OWN member. About 50 people participated in both events; despite the small turnout media coverage was quite good.

In our next issue, we'll publish more detailed accounts of the shock protests in Toronto and other cities in the USA. In Canada, the Toronto protest was the first public demonstration against electroshock or any other psychiatric procedure. It won't be the last!

For more information on electroshock please write to: Ontario Coalition to Stop Electroshock, c/o P.O. Box 7251, Station "A", Toronto, Ont. M5W 1X9, or call: (416) 699-3192 or 596-1079 in Toronto, or 1-522-8525 in Hamilton.

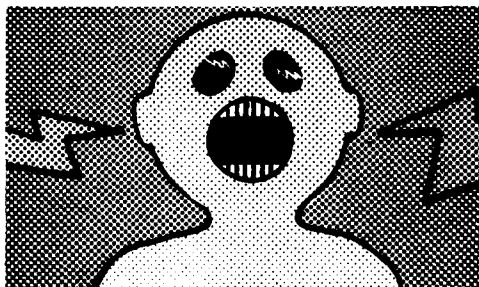
Shock Case Needs Your Support Now

An historic case involving the individual's right to refuse electroshock ("ECT") is now unfolding in Ontario. Last month, a psychiatric inmate (an involuntary woman patient) refused to consent to electroshock—her husband also refused. Despite the woman's and husband's refusals, her psychiatrist appealed to the review board which then ordered that electroshock be administered to her. However, because of legal pressure from her lawyer, the hospital and Ministry of Health agreed not to administer electroshock to her—at least temporarily.

The woman's lawyer is now arguing her case in court on the grounds that electroshock falls within the definition of psychosurgery ("Lobotomy") in Ontario's *Mental Health Act*. The Act outlaws psychosurgery for any involuntary patient. Under section 35 (1) of the Act, psychosurgery is defined in part as: "... any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue..." (our italics.)

Electroshock, it will be argued, destroys normal brain tissue or causes brain damage. If the judge decides that electroshock meets the Act's definition of psychosurgery, then electroshock may not be administered to any involuntary patient in Ontario. This ruling could protect thousands of people who otherwise would be subjected to this brain-damaging psychiatric procedure. The ruling would also be a great victory in our continuing struggle for psychiatric inmates' rights in Canada.

The legal costs in fighting this crucial case will impose a financial burden upon the woman and her husband. We therefore are asking you, our readers, to contribute whatever you can to help meet these costs. A cheque or money order should be made payable to: Brodey, Waclawski & Smolkin, together with a note stating your donation is for the shock case. The address is: Brodey, Waclawski & Smolkin, 78 Charles St. West, Toronto, Ontario M5S 1K8. We thank you and deeply appreciate whatever financial support you can offer.





frame By frame

Sophie's "Choice"?!

BY MARLENE CHARYN

Sophie's Choice seduced me. The acting is superb, the settings and photography magnificent. When it ended, my companion announced that it was a shoo-in for an Oscar. Very likely.

But as I walked out of the theatre feeling depressed, I said, "Wait a minute. What is *Sophie's Choice* saying? And who is saying it?"

The message is perfectly clear. Two of the three main characters—Sophie, tormented victim of a viciously sexist and anti-Semitic father and later of the Nazis as well, and her Jewish lover Nathan, the brilliant and compassionate doctor-without-a-license who brings her back to health but unfortunately "was diagnosed paranoid schizophrenic at the age of ten"—commit suicide in each other's arms. The third character, Stingo (a thinly disguised version of William Styron, who wrote the book), the young Southern white male writer who supposedly loved both of them and who had tried only two days earlier to persuade Sophie to marry him, walks off into the sunset toward his bright future saying something like "Too bad for them, a gloomy lot; tomorrow is another day."

Stingo's ego has apparently been so thoroughly armor-plated by Sophie's farewell note—which repeats twice, in case the audience misses the first time, "You're a great lover"—that the death of his two dearest friends barely touches him. He got what he really wanted—he got to fuck Sophie, a classic Oedipal triumph. He got her "Approved By Parents" seal on his technique, and now he's ready for Real Life. He wrote his first novel during the months spent with Sophie and Nathan and serendipitously found intriguing characters for a second one. Yes. The young Southern white male walks away with all the marbles.

For the other two the message is just as clear. There is no redemption. No way out. The dazzlingly attractive mad

genius doesn't have a chance because of his fateful diagnosis. The beautiful, sensuous victim of fascism and gross sexism doesn't have a chance because she is tortured by guilt. Their problems, of course, are purely personal, not social. They can't help themselves, nor can anyone help them. It is all so glamorous and tragic.

And wouldn't the Southern white boys, and the Northern white boys—all the Good Ol' Boys who are upset by uppity women, Jews, Blacks, Central Americans, Asians, mental patients, disabled people, gays, senior citizens—wouldn't they like it to be true that our diagnoses, our femaleness, our dark skin, our age, our accents, our sexual preferences, our disabilities, our guilt, render us powerless. Why are we getting this message of despair so seductively packaged at this time? Why isn't Styron—and Hollywood—showing us an immigrant woman and a Jewish mental patient triumphing over their circumstances and a Southern white boy taking cyanide?

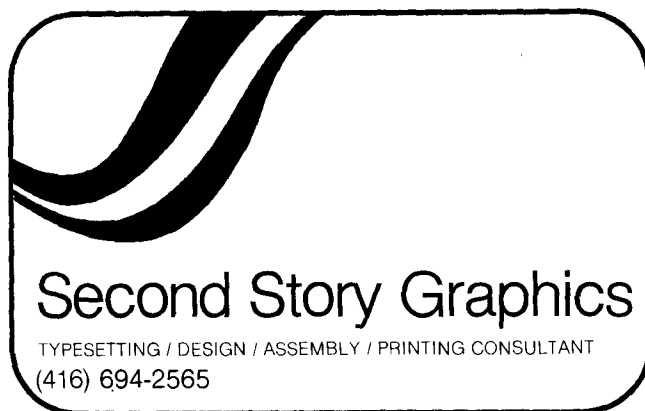
Because Styron is a die-hard. He is the cultural equivalent of Reagan's

politics and economics. Even in the midst of a society in the throes of transformation, he insists on trying to turn the clock back, reverse the engine of social progress. If he can sell us despair, we won't challenge his WASP male world view. He won't have to move over and share his loot with the disenfranchised, nor his fame and position with writers who choose (and it is a choice) to teach (and novels and movies invariably teach *some* values and attitudes) hope, understanding, and forgiveness.

I'm waiting for a Hollywood version of Marge Piercy's *Woman On the Edge of Time*. For the Technicolour shots of a truly equal society where meeting the physical, spiritual, and emotional needs of all people is the goal of common endeavour. For the vision of reward for years of struggle, vindication for millenia of humiliation and abuse. For the movie that gives mental patients hope for change as well as a sobering view of present reality.

The day is coming. We will see it. Styron is a dinosaur.

Reprinted from *Inmates' Voice*.





movement news

Bill C-157 Update

On May 18th Federal Solicitor General Robert Kaplan, introduced bill C-157 calling for the creation of a "civilian" security intelligence service (CSIS).

Bill C-157 if passed would legally allow the CSIS to wiretap phones, plant electronic listening devices, open mail, break into homes and offices and examine confidential files in public institutions. According to the bill, the CSIS would use the following criteria to decide which groups or individuals would come under its investigative powers:

1) "Subversive attempts to undermine the government". This statement leaves it to the discretion of individuals in the CSIS to decide what is subversive. This is vague enough to include virtually anyone who disagrees with any government policy. For example, unemployed workers, sole support mothers and union activists.

2) "Foreign attempts to undermine Canada's interests". This initially was intended to cover foreign spies and agents but also includes people doing support work for El Salvador, working against Apartheid in South Africa, and many other Canadians working to stop human rights violations throughout the world.

John Starnes, former head of RCMP (1970-73) estimates warrants for surveillance will be issued for approximately 200 people a year. Because the CSIS will be autonomous and is not accountable to elected representatives, the general public has no way of knowing who is the object of surveillance or why. They do not have to justify their actions and therefore have no limits to the numbers of people inves-

tigated. Section 21 of the bill says that a security agent is "Justified in taking such reasonable actions as are reasonably necessary" to enable them to perform their duties. Anyone who identifies or infers the identity of a member of the CSIS, or their informers is liable to up to 5 years in prison. (This includes media, politicians, and police). The CSIS will exchange information and work with the CIA and other foreign intelligence services.

The widespread opposition has forced Kaplan to withdraw the bill and establish a committee to hold public hearings and recommend amendments to the bill. However, the purpose of the committee is not to diminish the powers of the CSIS but to tighten up procedures and re-word the bill enough to make it acceptable to the public. The original intentions of the bill will remain. The bill will probably be re-introduced in its new form, and under a new name, within the next 6 to 12 months.

The spy agency issue may temporarily seem to be a dead question but it will rise again, whether as a separate agency or within the RCMP. (As the Conservatives want). If such an agency were to exist in Canada, it would severely strip away at our rights.

We must use this time and the upcoming elections to keep up public awareness and education, and to prepare now for what is ahead. The concept of a domestic spy agency must be stopped no matter what amendments are added.

Reprinted from Guardian magazine.

Canadian Human Rights Commission Ensures Protection For Disabled

Canadians who believe they are victims of discrimination because of disabilities can now ask the Canadian Human Rights Commission to investigate.

With the July 1 amendments to the Canadian Human Rights Act, people with physical and mental disabilities have access to federal employment, goods, services and accommodations.

The amendments also spell out that differential treatment of women because they are pregnant or have given birth, is sex discrimination. Another new ground prohibits discrimination because of family status.

The federal human rights act applies to federal government departments and crown corporations, and such industries as transportation, broadcasting and banking. Although about one in 10 Canadians work for a federal organization, almost all Canadians are served by the chartered banks, the post office, the CBC, interprovincial bus, train and airline companies, and many receive family allowances or old age pensions.

LABOUR - ECONOMY - ENVIRONMENT - EDUCATION - COMMUNITY - HUMAN RIGHTS

IMMIGRATION - FOOD - NUCLEAR

CONNEXIONS

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EMPLOYMENT - AGRICULTURE

Clauses in the amendments ensure that employers will not have to hire individuals who cannot perform the essential tasks of a job, and organizations will not be required to make major structural changes to their premises, for example, which would cause "undue hardship."

Although independent human rights tribunals will not be able to order an organization to make structural changes until April 17, 1985, nothing prevents the Commission from accepting, investigating and attempting to settle complaints from disabled individuals who believe they have been denied their rights.

For further information please contact: Sally Jackson (613) 996-2558; or Dorothy Richardson (613) 995-1277.

New Anti-Psychiatry Groups

B.A.S.H. (Bytown Association of Self Help),
c/o J.A. Yvon Bisson,
1119 Merivale Rd.,
Apt. 1,
OTTAWA, Ont.
K1Z 6B1

Movement for the Right of Mental Patients,
Charalambi-6A
ATHENS, Greece

GROW,
209A Edgeware Rd.,
Marrickville, N.S.W.
2204
AUSTRALIA

Portland Coalition for the Psychiatrically Labeled,
c/o Amity Center,
277 Cumberland Ave.,
PORTLAND, Maine
04101

Contact: Sally Clay (207) 774-4366

Women Psychiatric Inmates Liberation Front
c/o Herizons
3242 East Colfax Avenue
Denver, Colorado 80206

Abolition of Legal Psychiatry Society
c/o Norman A. Plotkin,
26 W. 39th Street,
NEW YORK, N.Y.
10018

Corrections In Group Addresses

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Barugotu 11,
101 Reykjavik
ICELAND

AUTO-PSY
332 St. Luc,
Quebec City, QUEBEC
J1S 2N8
(418) 529-1978

S.P.R.E.D. (Society for the Promotion of the Rights of the Emotionally Distraught),
c/o Shirley Johnson/Fred Serafino,
195 Wellington St. So.
Apt. 242
Hamilton, ONTARIO
L8N 2R7

S.E.T.I. (Self-Esteem Through Independence),
c/o CMHA,
355 Princess Ave.
London, ONTARIO
Contact: Robert Whiteman

Women Psychiatric Inmates Liberation Front

A new group has been formed in Denver. WOMEN PSYCHIATRIC INMATES LIBERATION FRONT is the core organizing group for the fall shock demonstration. We are also coming together to support each other as inmates, and talk about how to continue to build that support after the demonstration is over.

We encourage male inmates/ex-inmates and all non-inmate supporters to form groups to work on the demonstration and to form coalitions with us on this issue.

WOMEN PSYCHIATRIC INMATES LIBERATION FRONT meetings are at 10:30 A.M. Sundays. Contact us at:
WOMEN PSYCHIATRIC INMATES LIBERATION FRONT
c/o Herizons
3242 East Colfax Avenue
Denver, Colorado 80206

Portland Coalition for the Psychiatrically Labeled

We are an independent group of mental health clients who seek to help ourselves and other clients through peer support, advocacy, and public education. Our purpose is to explore alternatives for social change. Recent projects have included production of the slide show "Stigma", presentations by members before consumer and public groups throughout the state, advocacy for client issues at public hearings and elsewhere, participation in the Task Force on Rights of Recipients of Mental Health Services, and coordination of a statewide conference for mental health clients. We meet every week at 7:15 p.m. at Amity Center, 277 Cumberland Ave., Portland Maine 04101 (207) 772-1248. Anyone who has received psychiatric treatment of any kind is eligible to join. Our meetings include both mutual support and discussion of issues.

PORTLAND COALITION FOR THE PSYCHIATRICALY LABELED
Sally Clay
296 Woodfrod Street
Portland, Maine 04103
(207) 774-4366

Conference News

THE 12th ANNUAL INTERNATIONAL CONFERENCE FOR HUMAN RIGHTS AND AGAINST PSYCHIATRIC OPPRESSION will be held in the spring or summer of 1984 in Denver, Colorado. To be kept informed, contact the *Women Psychiatric Inmates Liberation Front*, c/o Herizons, 3242 E. Colfax Ave., Denver, Colo., 80206. The Conference is open to former psychiatric inmates (women and men) and non-ex-inmates who are activists in the Movement and have been approved by an ex-inmate group. (from *NAPA Newsletter*, fall 1983.)

Not Patients — Human Beings

By **BONNIE BURSTOW**

What follows is an interview between myself—Bonnie Burstow—and a woman who has worked in Ontario “mental health centres” for over 15 years. The interviewee—“Susan Jackson”—agreed to speak out on the problems she sees in the Ontario “mental hospital” system and to respond to my probes on the proviso that I took the measures necessary to ensure her anonymity. To ensure anonymity, we conducted the interview in private; Susan chose a pseudonym early on and we stuck with it; I transcribed and erased the tape immediately after the interview, so nothing with her voice on it would remain; and I edited out all references which either of us felt might enable her colleagues to identify her. Unfortunately, this meant editing out explicit references to people and places for Susan felt such references could place her in jeopardy.* The procedure is a standard one I have used and will continue to use with hospital workers who are willing to speak out.

The interview means something to me, partly because it is nice to hear people right inside the system raise some of the same complaints the rest of us are raising, and partly because some of the subjects examined are ones not generally discussed. What particularly stands out for me in this regard are the damages done to immigrants and the issue of sexual harassment and sexual insensitivity within the hospitals. Though we often coincided, I did not agree with everything Susan had to say. And there were times when I wanted to push her to question herself more—her own handling, her own certainties, her own absolutes. There were times as well when I felt issues got scrambled, though this, of course, is something I bear equal responsibility for as interviewer. Overall, though, I had the sense of somebody who genuinely cared, and who saw through a lot of the crap in the system, who had visions of what might be, and who struggled with real issues. My thanks to Susan for her time and her trust.

Burstow: For the purposes of this interview, what name should I call you? Pick something nice and innocuous.

Jackson: Susan Jackson.

Burstow: Our apologies to all the Susan Jacksons in Ontario. Okay, Susan, just to keep the records straight, it's true, is it not, that you've been working in Ontario “mental hospitals” for over 15 years now?

Jackson: Oh yes, that's correct.

Burstow: God, that's a long time! How about beginning by telling me what's your sense of the system. You've been in these hospitals for over 15 years now, so have had a good chance to observe them. How would you assess the care that people get in them?

Jackson: I don't agree with a lot of the treatment. In most places where I've worked what I have observed is that people's power is taken away from them. You have doctors or you have therapists dictating rather than helping. They are not concerned with understanding what the person is going through. They are concerned with what is expected. The important thing should be what is happening within the inner person. It's not looking at the person as a thing or putting the person into a category like, say, schizophrenia. This is one of the basic things. When people don't understand what is happening with the patient, they're primarily diagnosed as schizophrenic. Something else that disturbs me is what happens to people from different cultures. People from different cultures react in different ways and in many, many cases psychiatrists are not trained to understand the cultural differences. You have to deal with people on their own cultural level. The people who came to this country from countries like Poland and Hungary where there were revolutions—those people came here about 40 years ago—did not understand English. They did not know how to cope. They ended up in hospital and many of them are still in hospital. I've looked at their charts. In most cases the workers could not understand what was going on inside the person. They did not even speak the person's language. Now the psychiatrists would say, “Oh well, we can judge by the nonverbal communication.” To me, that's hogwash. Nonverbal communication—it's different in different cultures. You take someone, say, from the African countries—people in Africa will behave different nonverbally. Blacks in America to a certain extent will react different nonverbally than blacks in the Caribbean countries. Here, in this country, psychiatrists are not trained to appreciate these differences. What happens to women, that also bothers me. Women were the ones that were prescribed Valium years and years ago. They just gave them Valium. Those psychiatrists weren't looking at what was happening to women.

Burstow: They didn't understand the plight of the women they were dealing with?

Jackson: No. They did not understand. Basically, it was a question of the patriarchal system. Most psychiatrists, you know, they're males, and they look at everything in terms of the Freudian concepts. Well, you know how crazy that is. Those are the kinds of things that really disturb me.

Burstow: Let me clarify something. You are saying, are you, that you think people are treated badly in mental hospitals generally and that there are two groups that are treated particularly badly—people from other cultures and women?

Jackson: Yes. I'm also worried about what they do when they think someone's depressed. Giving people things like Haldol—I think it's ridiculous because I don't think you can get rid of the problem that way.

Burstow: The hospitals are trying to drug people out of their problems and it doesn't work.

Jackson: Right. You're drugging away the person's being as far as I'm concerned. And there's other things. There's the system and there's oppression. People in the hospital are

* Ed. note: All employees of psychiatric hospitals in Ontario are required to take an oath of confidentiality before commencing employment. If she were identified, then, not only might Susan Jackson's job and career be put in jeopardy—she could also be sued. Obviously, the oath helps to close an already very closed system—one in which very, very few employees dare take the risks of speaking out. We are very grateful that Susan Jackson has.

people oppressed by the system. Look at the layers of oppression. How can medication get rid of those layers? If somebody doesn't look at those people and love them—you're not helping them simply by giving them medication.

Burstow: The medication, in fact, is another layer of oppression.

Jackson: I'm not saying that people don't sometimes need medication, if a person is violent, say, but—

Burstow: You feel the medication has been overused, abused.

Jackson: That's it. Being overused and abused. In many cases it would be better to help people get rid of the anger instead of repressing it. I believe in padded rooms with one-way mirrors. People can get rid of things in that confined, watched environment. And not to give them medication to wreck their system. Can you believe it? Take the Asians. I've seen some of those patients. Number one, as you know, they're not drug-oriented people. Third World people are not drug-oriented. You put medication in their system, it's a shock to their system.

Burstow: They're being violated by it.

Jackson: Yes. And you know, I've seen many of them. With one dose they are confused and do not understand what is happening to them.

Burstow: Do you think it fair to say that the medication creates the situation which keeps them in the hospital? They continue to look confused because of the medication and so they continue to be locked up.

Jackson: Yes, yes. Unless you've got a sensitive doctor who can see what is happening. I've seen such doctors.

Burstow: What percentage of the doctors are sensitive?

Jackson: Very, very...

Burstow: Very, very what?

Jackson: Low. Very, very low. And most of those doctors are ones who have studied in England, as you know. I think they take psychiatry on a more community level there. Things are really good there.

Burstow: Well, I've seen some "horrors" there. But, yes, I appreciate their community psychiatry model. Here in Canada, we're stuck with the custodial model. People who don't want to be locked away, people who want to walk about like you and me, are taken and locked away. Do you think these people could be free and a more community approach taken?

Jackson: I'm not sure what you mean.

Burstow: How do you feel about the custodial approach to problems in living? Do you agree that these people should be involuntarily confined to a hospital or should another approach be taken?

Jackson: I do believe that you basically have to be voluntary to get real treatment. I'm looking at it in a very philosophical way. You take a person from a home, a person that we consider is not dealing with reality, and you commit that person. The person is not entering a mental health hospital on a voluntary level. How can you help that person when the person is being forced into treatment, into mental health? I hate that word—"mental health".

Burstow: I'm glad. So do I and so do most of the people connected with this journal.

Jackson: 'Mental health.' What does it mean? It's a very terrible word to use, 'mental health', because basically, what you're saying is that the person is "mental". I would only use that word with people with brain damage. When you look at emotional problems, there's a big difference.

Burstow: Would you say that most of the people locked up are simply human beings going through emotional problems, problems in living?

Jackson: Yes, as far as I'm concerned it's emotional. It's not mental. People with brain damage—that's mental. It's them that should be involuntarily locked away. That's what Szasz says, isn't it?

Burstow: Why should people with brain damage be locked away?



Jackson: Maybe not all. Anyway, what I'm saying is that with most people locked away, it's emotional, it's not mental. And it's personal. Yet the person is not taken into consideration. Only the staff is taken into consideration. You know what I mean. The staff is busy.

Burstow: The primary factors determining how a person is treated is the staff's needs not the person's needs, is that what you're saying?

Jackson: That's right. Also, when they think about things for the person, they do not think about growth. They just make the person dependent on them.

Burstow: Let me ask you something. You obviously have a very different perspective than many of your colleagues, and you are obviously unhappy with a number of things you have seen. What's happened when you've suggested trying more human approaches?

Jackson: Well, there are two psychiatrists I've worked with who respected my opinion and I really learned a lot from them. They were really sensitive and you can learn a lot.

Burstow: Only 2?

Jackson: Well, let's say 3.

Burstow: And how many psychiatrists have you interacted with in your professional career?

Jackson: Well, I would say, probably something like 40.

Burstow: 3 out of 40 were sensitive?

Jackson: Yes, I know, it's a low percentage. I liked those 3 because they considered the individual; they were not just getting off on the fact that they were psychiatrist. Those psychiatrists were real human beings. There's people who are just people and there's human beings.

Burstow: And how many of the other staff—the nonpsychiatrists, were “human beings”?

Jackson: A very small percentage. What most of those people don't realize is that any of them could become sick any day. We don't have control over our lives. We don't know what will happen. I've worked with nurses who thought that they would never, never become ill.

Burstow: They think of the people in their care almost as if they were a different species than themselves; so they can't imagine becoming disturbed like that themselves.

Jackson: Yes, yes. Aliens. But those nurses who thought that, I've seen some of them end up ill and doing exactly the same things they looked down on the patients for. Twisting their arms and pacing, you know. I don't make that mistake. When I work with patients, for me, these people are human beings and I'm going to try to give them everything possible I can.

Burstow: Do you find yourself ever thwarted by other staff members when you attempt to give these people “everything you can”?

Jackson: Of course. Of course. You get called a trouble maker. You're being antagonistic, you're being...it's very hard. Though, you know, in some small way I know that they respect me for my values. Also, sometimes, there's jealousy. They see I have a different perspective and they wish that they could. Now, I'm a professional. But under that professional, I'm human being; and I think what I try to do is let the human being evolve rather than being THE PROFESSIONAL. Though I have to be a professional, and I have to worry about the guidelines, you know, legalities. Also, I've got to know my rights. What really gives a person power is knowing their rights as a professional.

Burstow: Wouldn't you say the same holds true for people locked away? If they knew their rights, wouldn't they also have some sense of power?

Jackson: I think so. Anyway, to get back to what you were saying about communities, now we have more community projects, and to me they appeared like they were different, but I think they're still functioning on the medical model.

Burstow: They're still authoritarian?

Jackson: Yes. Except for a few. I know a few that are okay. For the most part, though, it's all the same reactionary stuff. The 60's and 70's were an exciting time. They did sensitivity training with us. It's very dull now. I don't see any changes happening.

Burstow: The new projects the government is involved in, you see them primarily as tokenism?

Jackson: I think they mean well. But yes, it's tokenism. To me, it's just a way of making the hospital look good.

Burstow: So maybe they don't mean well. Anyway, to get back to a previous issue, you talked earlier about women and the inappropriateness of the treatment they get. I've heard other people talk about this in Canada. But there's something they talk about in the States that I haven't heard anyone mentioning here. They talk about female patients being sexually abused by male staff members. Do you think that happens here?

Jackson: Sexually abused? Oh, well, could you be a little clearer?

Burstow: Do you think that we have any problem with staff making unwanted sexual advances on female psychiatric patients?

Jackson: I don't know. I cannot speak on that. You can't generalize from a few cases. I really couldn't say. Although, I have heard of it. I've heard of a young patient in the hospital being sexually abused by a staff member and that staff member was transferred out.

Burstow: Transferred out to where? Out of the system?

Jackson: No. Out of our mental hospital into another.

Burstow: So the person was not fired.

Jackson: No, the person was not fired but was transferred. And even though that person was transferred, that person made several attempts to get back to visit that person.

Burstow: To visit the female patient he had sexually molested?

Jackson: Right. So what they did was control the patient. They didn't let her out of certain areas. And she was only allowed family visitors.

Burstow: And this was never reported to the police?

Jackson: No. I mean we couldn't get any evidence. He was so crafty. And you can't go doing that anyway.

Burstow: Why not?

Jackson: Well, you have to report things to your superiors first.

Burstow: And did you report it to your superiors?

Jackson: Yes.

Burstow: And did they report it to the police?

Jackson: No.

Burstow: Let me ask you about an area I see as related. I know that many years ago when patients or inmates were thought of as going out of control, a bell rang. When the bell rang, all the male staff nearby would come and tackle the person. Whether the person was male or female, it was always the male staff that did the tackling. Is that still the case?

Jackson: Well, yes. It's not a bell anymore. Now it's a human voice. It calls for men to come and tackle the patient. But yes, that happens. And basically, it's still men that do the tackling. That bothers me too. I think if women in institutions are paid equally as men, women should also have to do their share of the tackling. They're getting the same pay for it. They should have to do the same work. Equal pay for equal work.

Burstow: I understand the point you're getting at. It's a different aspect of the problem I'm asking you about, though. There's another reason why I'm bothered that it's men. To be clear on this, I'm not crazy about the idea of anyone being tackled but I particularly object to men tackling women. Women who have been tackled in this way by a group of male staff members have told me that it felt

like being raped. That was their experience of it. Have you heard the same thing?

Jackson: Of course, of course, I've heard the same thing. And in many cases when I look at it, too, I see it as rape. But you see, most of the staff members in the institutions are not that conscious.

Burstow: They are not really aware of what they are doing?

Jackson: No. They don't know anything. They don't read anything.

Burstow: So regardless of their degrees, when it comes to what's really meaningful, they're essentially uneducated?

Jackson: That's it. They don't look at the psychological implications, or the psychological impact on those women. Knowing that women in this society are raped in so many ways—physical and verbal rape are happening. But they do not take that into consideration.

Burstow: The staff members don't look at the fact that they're extending it.

Jackson: No. I tell you, in some of those situations I just cringe, because I think, "Oh my God! What is going on in that woman's mind? Is she experiencing it as rape? How is she experiencing it?" Because in a way, you know, when you look at it, it is rape. You are raping that person physically and mentally. I mean that act isn't exactly happening. But the mental damage is being done.

Burstow: On the symbolic level, it's rape.

Jackson: Yes.

Burstow: What is significant is the meaning it holds for the human being.

Jackson: Yes, still, I would have to say that in some of the cases, where people are violent, people have to be gotten to and held.

Burstow: But do they have to be gotten to and held in that way?

Jackson: I don't know. I've seen cases when people smash things and so forth. But then again, as I always say, if they're smashing things but not hurting anyone, let them do it. Let them get rid of the anger.

Burstow: So not only is restraining them the way they do symbolic rape, restraining in general is often just thwarting their need to vent their feelings.

Jackson: Yes. I think it's a matter of reaching that person. Trying to figure out what is happening with that person. Sometimes, though, you know, you don't have the time to do that.

Burstow: The problem of understaffing?

Jackson: Understaffing. And things happen so quickly.

Burstow: I follow you. Let me introduce a new element into the conversation. In the last 20 years the anti-and critical psychiatry movement and the patient's self-help movement have appeared on the scene. What's your sense of their potential? Do you see them as a possible alternative to the system that has been set up by psychiatry?

Jackson: Oh. I'm not sure what you're saying.

Burstow: Do you feel that patient's self-help groups and others like them could be a viable alternative to the psychiatric system that we now have?

Jackson: Yes. It's one of the best ways of helping people. People helping themselves.

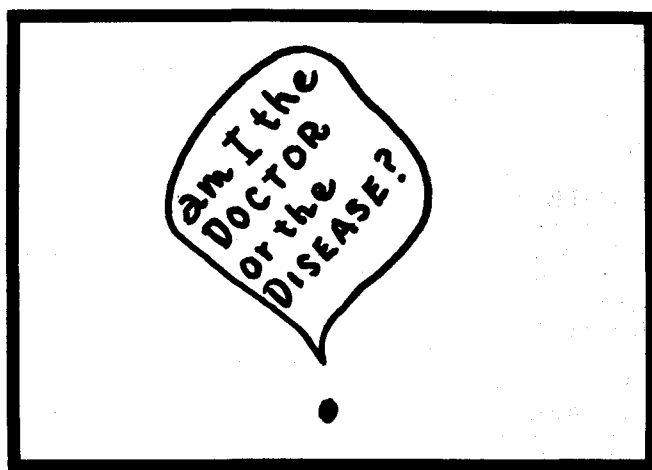
Burstow: So if you were advising the government where to channel their money to get something good for the future, would you tell them to direct a lot of it toward self-help groups?

Jackson: Yes, with a consultant.

Burstow: A consultant?

Jackson: A facilitator who is knowledgeable in the field but a very sensitive person.

Burstow: When you say 'consultant', are you intending someone by this who will be making decisions or really someone just there in a consulting capacity?



Jackson: Just there in a consulting capacity. One psychiatrist that I worked with dealt with things in that manner in a hospital setting. He had what I call a therapeutic community.

Burstow: Laing's model?

Jackson: That's right. The patients made decisions about treatment, about environment. And when there was a problem within the system, the community decides. When a patient acted out, a community emergency meeting was called. To me, that was a very good model. It wasn't a very popular program within the institution, though.

Burstow: Why not?

Jackson: Most of the officials there thought that it was...There's a word for it...What do they call it?—Oddball. Some of the staff did not like it. There were staff who needed power. They become very, very threatened by that way of operating. So it didn't end up working. But it could have worked well had the staff...

Burstow: Been less power hungry?

Jackson: Right.

Burstow: And not been afraid of the patients' power?

Jackson: Right. And had the staff been picked. You need to select special staff to work on a unit like that. You need to select people who are not afraid to be just a part. They can't be power hungry.

Burstow: Do you think that's a problem with conventional psychiatry? They get their sense of safety from taking control over other people's lives, and they've equipped themselves with paradigms which justify their acting in this way.

Jackson: Yes. I think so. I worked in countries where things are great. In some of the European countries, patients were encouraged to lead a normal life. They were dressed in their own clothes. Not these awful hospital clothes. Can you imagine giving people these kinds of clothes? It's terrible. It's dehumanizing. It may take a long time for us to make it better. I don't know. I'm not very optimistic. Where I do have optimism, it's when I think of nurses asserting themselves and not letting the psychiatrists dictate what is going to happen.

Burstow: The psychiatrist's power has to be eroded.

Jackson: Yes.

Burstow: By patients and nurses, I think you've been saying

Jackson: Yes.

Burstow: Would you also like to see more things like radical therapists?

Jackson: I'm not very well versed in the radical therapist movement. Feminist therapist, is that what you are talking about?

Burstow: That's one type.

Jackson: I've been reading a little about radical therapy and I've been talking to women who are working in that area. To me, it's very exciting. I think that may be one way to go. They don't devalue people's feelings.

Burstow: In the system now, you feel people's feelings *are* being devalued?

Jackson: In many, many cases.

Burstow: And people are often humiliated?

Jackson: Yes. We wonder sometimes why people don't get well. But if you give people all these drugs and people don't feel like a human being and respected for being a human being, they're not going to get well.

Burstow: Because they're not being respected?

Jackson: Because they're not being respected as a human being. I mean, you have to show some love, humanity, and dignity to that person.

Burstow: Love, caring, esteem, respect—these are things that you feel are lacking, and these are what help and human relating are really all about, aren't they?

Jackson: Yes. They're basic human needs. That's what it is. Just basic human need. And rights. I think if we can protect that, then I think there is hope for the future. If I had control over staff, I'd take them all out and teach them how to deal with human beings. *HUMAN BEINGS*—remember that word.

Burstow: Human beings. Not things, not objects, would you mind if I also added, *NOT PATIENTS*?

Jackson: Human beings.

Homelessness

The following resolution was made at the workshop on the "Myth of Mental Illness" held during the Eleventh Annual International Conference on Human Rights & Psychiatric Oppression.

Homelessness is not an individual or psychiatric problem, despite the fact that psychiatrists have claimed that 80-90% of all homeless people are "mentally ill." This is an example of how psychiatry uses psychiatric labelling to scapegoat defenseless people, rather than doing anything to help solve a serious human problem.

Homelessness is increasing because of powerful social forces over which individuals have little control: Reaganomics and other disastrous economic policies, gentrification (throwing low-income people out of inner-city housing that is then remodeled for the middle and upper classes), the lack of affordable housing because of the for-profit nature of the market, inflation, and unemployment.

A lot of people end up in psychiatric institutions only because they lack homes or jobs. A lot of homeless people have become disabled by the so-called "help" of the psychiatric sys-

tem. Some people become homeless because of the guardianship system that prevents them from spending their own money (a guardian can refuse to pay the rent, for example, because the guardian decides that the ward is "too disabled" to live unsupervised). And homelessness itself produces legitimate feelings of anxiety and helplessness that can then be conveniently viewed as psychiatric "symptoms."

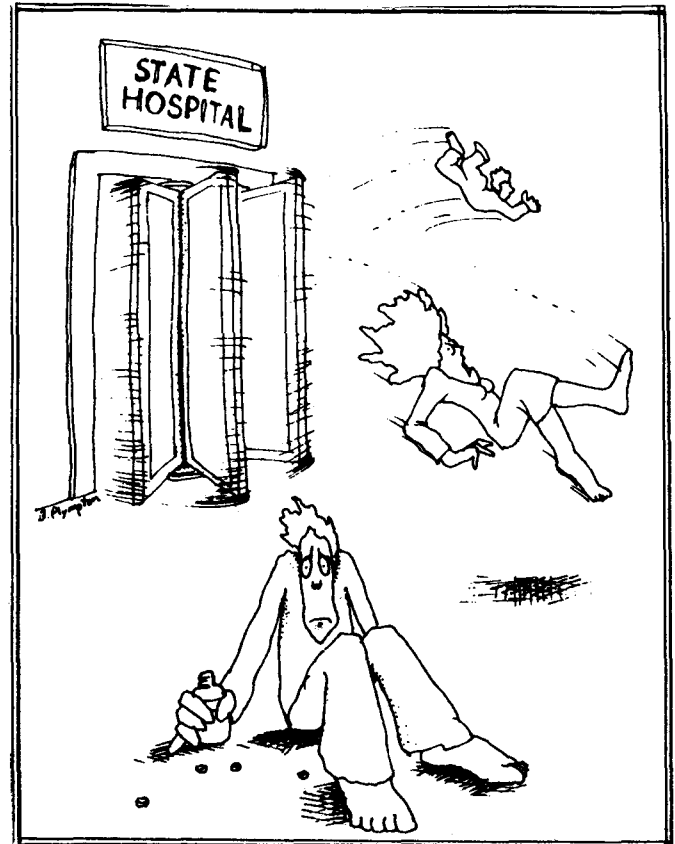
Homeless people need housing—in shelters on an emergency basis only; but, in the long run, in decent, affordable, permanent housing, with supportive services available for those who want them. We also support the right of any homeless person to remain on the street, if that is his or her choice. Homeless people need to know that their homelessness is not their fault—the present welfare system and psychiatric blame-the-victim techniques increase people's feelings of powerlessness, Welfare, Social Security, and SSI

and other public benefits need to be increased so that people can actually afford to live in dignity on them. Above all, the psychiatric industry must be prevented from claiming to "solve" the homelessness problem by attributing it to "mental illness," and by offering "therapy," re-institutionalization, and other such psychiatric non-solutions as the answer.

The media coverage that has been given to homelessness shows that most journalists have bought the psychiatric line. We particularly deplore and condemn the *Philadelphia Inquirer's* description of homeless people as "the litter of humanity."

We believe that homeless people by themselves, or aided by others of their choosing, can best solve their problems through organizing, self-help, and political action.

*Adopted by Acclamation
Second Plenary Session, May 21, 1983*



Healthpac/cpf

The International News Magazine on Prison Abolition



is inviting subscriptions and submissions. This newly established magazine is intended to disseminate information and analyses on issues directly or indirectly related to prison abolition and to keep people informed of abolition events throughout the world. It will be coming out four times annually.

subscription rate \$6.00 for 1 year

Communications, submissions, and subscriptions should be sent to:

**Ruth Morris
198 Grandravine Drive
Downsview, Ontario, M3J 1B7**

ULYSSES LOST IN THOUGHT

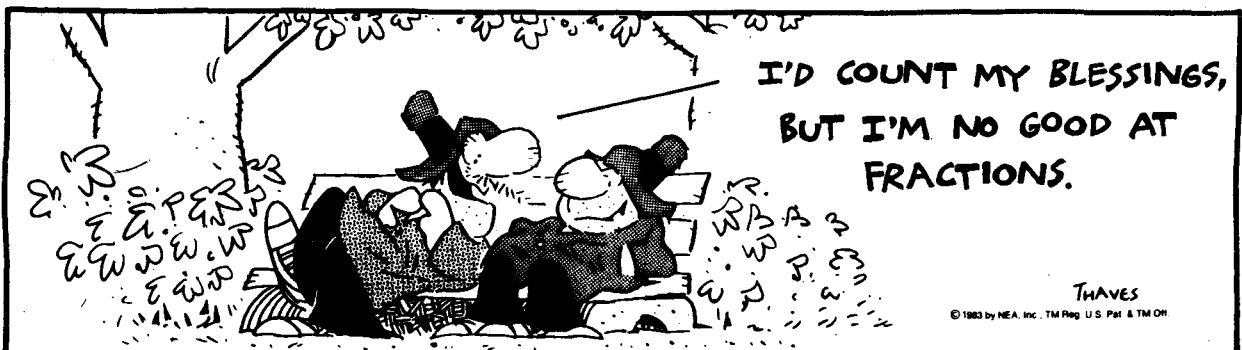
Ten lost years, ten years
365 dying days time ten
Twenty four hours a day
Losing one's mind
Travelling . . . travelling,
A mind-warp of one's reality

The furnace in the sky
Sweating the summer heat.
Drifting, shuffling, wandering
down the street

Now, if I just keep going
without losing my balance.
I might get home for
my supper in time
Climbing the stairs of the boarding house
The faces of the tired and down-trodden appear.
Victims of habit, they are in the same place
they were yesterday
White haired, they are symbols of despair
The smell of sweat, stale tobacco and
two day old soup are prevalent.

The menu doesn't differ from the day before
An occasional complaint falls on the staff's
deaf ears.
Sleepless nights, shaking convulsive by the pills
and the northern winds.
The howling
and the creaking of rafters, sound
and the death of human soul.
Then end of joy, the death of hope. The halls' lights dim
Once society has pronounced sentence, very few escape.

by John Calder

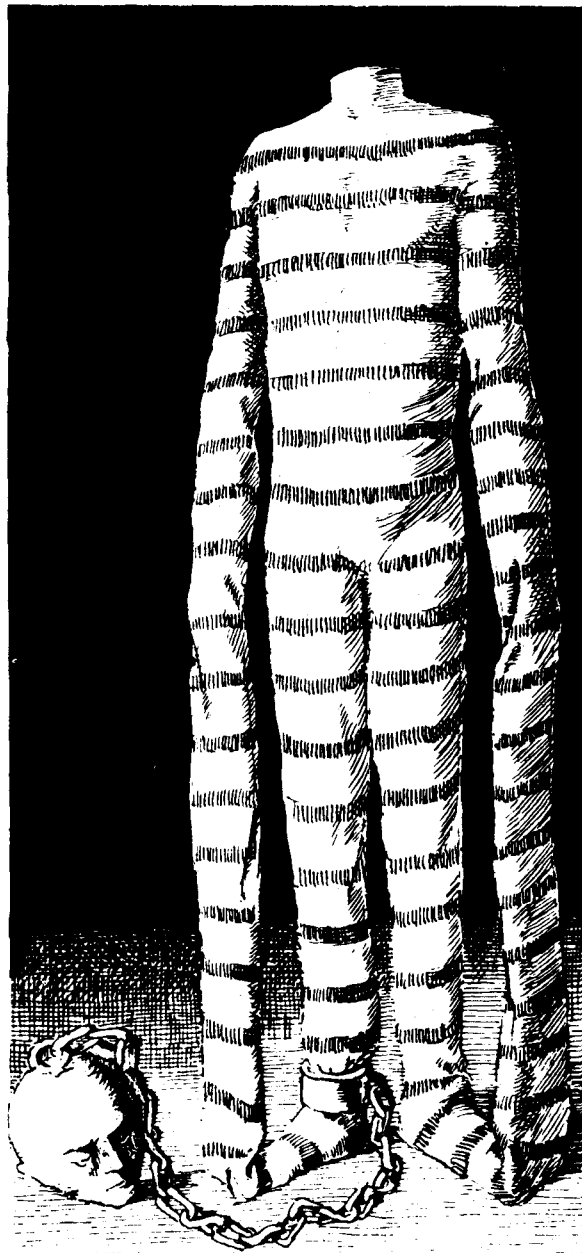


Let's Abolish Prisons

An historic event happened in Toronto last spring. The first International Conference On Prison Abolition (ICOPA) was held May 26-28 at the University of Toronto. About 400 abolitionists including prison workers, ex-prisoners and volunteers from Canada, the United States and Europe attended the conference. Some of the organizations which endorsed the conference were: Quaker Committee on Jails and Justice (Toronto), Prison Research Education Action Project (Syracuse, N.Y.), Prison Rights Groups (B.C.), University of Toronto-School of Theology (Toronto), Youth Corps (Toronto), La Ligue des Droits et Libertés (Québec), Alternative to Incarceration (Kingston, Ont.), Toronto Justice Council, Native Sons (Guelph, Ont.), and the Ontario Federation of Labour.

Many workshops were held during the 2-day conference and included these issues: "Analyzing the System" (law & crime, economics and prison abolition, racism and ethnic aspects of prison, women and prison); "How to Get to Abolition From Here" (alternative models toward abolition, working toward abolition inside and outside the system, role of the prisoner in abolition); "What To Do With the Tough Cases: True Alternatives to Prison" (sanctuaries, healing communities, response of radical activists). An exciting workshop on civil disobedience was also held and videotaped. Claire Culhane, a leading prisoners' rights advocate, author of *Barred From Prison* and active in the B.C. Prison Rights Group, was the resource person for this workshop.

Although many people helped make this landmark conference a success, special thanks are due Dr. Ruth Morris and Anthony Lorraine. Ruth chaired the final plenary session which drafted the ICOPA preamble and resolutions which include abolition of warrant of the Lieutenant-Governor. She's the former director of the Toronto/York Bail Program, a founder of the Toronto Justice Council and member of the Committee for the Rights of Psychiatric Inmates. Anthony is also a member of the Toronto Justice Council and the Committee for the Rights of Psychiatric Inmates. He knocked himself out videotaping many workshops and the final plenary session.



RESOLUTIONS OF THE INTERNATIONAL CONFERENCE ON PRISON ABOLITION (Passed May 28, 1983 in Toronto)

Preamble:

WHEREAS, we are all agreed that:

- 1) Prisons are brutalizing and dehumanizing institutions which have grave consequences not only for the prisoners and their families, but also for those who must administer the system and work in the prisons, and for the community itself;
- 2) The disadvantaged are overrepresented in penal institutions;
- 3) These institutions are not even effective in terms of the aims of those who advocate their continued use and to protest society and deter crime;
- 4) The criminal law system reflects the worst values of society, and this is not only seen in the inequities of the criminal trial, but also in the lack of concern for victims of crime:

We Resolve That All Practical Steps Must Be Taken Toward Abolition of Prisons.

We recognize that everyone working toward this goal will need to find the ways in which s/he can work most effectively and appropriately given their values and life situation. Nevertheless, we have found great value in the *Attrition Model* as a realistic and practical method of achieving our goals in a non-coercive manner. This would include:

- a) *Moratorium* on Prison Construction
- b) *Decarceration*—keeping people out of prison by pre-trial and post-trial diversion systems
- c) *Excarceration*—diminishing the sentences by providing alternatives to institutional confinement
- d) *Restraint for the few demonstrably dangerous cases* to enable them to be treated in humane environments.

All these options must be pursued with humane respect for the value of the persons participating in them.

Action Proposals

1. That an International Prison Abolition Newsletter be established, with a representative from each country collecting submissions and forwarding them to a newsletter chairperson (*Ruth Morris, 198 Grandravine Dr., Downsview, Ont., Canada*), for publication on a regular basis. One of the major aims of this newsletter will be to diminish wasted efforts of unco-ordinated interest and action groups.
2. That a press release outlining the outcomes of the ICOPA be drafted for international distribution (ICOPA Planning Committee to new International Planning Committee).
3. That efforts be directed towards facilitating immediate access to information from prisoners for media purposes during prison crises.
4. That we condemn especially the highly discriminatory use of prisons in every country toward racial, cultural, and ethnic power-minority groups. We specifically condemn the discriminatory use of prisons for American blacks and the discriminatory use of prisons for aboriginal people throughout the world. Such behaviour is contrary to human rights and the UN Charter of Freedoms.
5. That psychiatric confinement without due process should be abolished. Specifically, in Canada the Lieutenant-Governor's Warrant should be immediately abolished in all provinces and territories of Canada. Attorneys General in all provinces and the Minister of Justice should be petitioned to this effect.
6. That Special Handling Units should be abolished immediately as contrary to the UN Charter of Freedoms. These are cruel and unusual punishments. Solitary confinement and other forms of administrative segregation should also be abolished immediately for the same reasons.
7. That a Second International Conference On Prison Abolition be called for 1985. A Steering Committee is being formed immediately to plan and conduct the 1985 conference. This Steering Committee is empowered to incorporate a non-profit organization, to seek and receive funds, to solicit academic papers, and to take any and all other actions appropriate to the planning and conduct of the 1985 conference.

The Steering Committee is also empowered to take any and all actions appropriate to the formation of an international association or union of people opposed to oppressive legal systems. The Steering Committee is also empowered to expand its membership and to substitute members as needed.

It is suggested that the 1985 Conference be held in Europe, but the location should be determined by the Steering Committee wherever it can be most effectively organized.

The following persons agreed to serve on the Steering Committee:

Australia: George Zdenkowski
Canada: Renée Millette, Ruth Morris
England: Janet Arthur
Germany: Kirsten Horn
Netherlands: Jack van Wirken
Norway: Thomas Mathieson
Scotland: Daphne Brooke
USA: Frank Dunbaugh,
Russ Immarigeon, Bonnie Page,
Marc Mauer, Dante Germanotta





personal stories

One Winter Evening

By FRANK FARKAS

My shadow and I, on a mission of slight importance, walked through the front entrance to the hospital, commonly called Queen Street. We groped our way through the main corridor leading to the heart of the Establishment. The lights had gone dead for some reason. In the shopping bag, swinging at my side, were several pairs of shoes destined for two patients, who were barefooting on the cold floors of their unit. The spokes-person for the two explained the previous week how to obtain them free of charge. She also added, with impish humour, that her fury would be intense to an extreme if I showed up empty-handed. The shadow was in hot pursuit of a secret grandiose aim in life.

Reaching the Mall, the meeting place for patients and visitors, our first stop . . . the vending machine, feeding nickles and dimes into a robot coffee monster. As programmed, it coughed up cups of hot "essence" of a cheap Columbian coffee bean. Deciding to check a few new furnishings for creature comfort but quickly abandoned our first choice—the chairs, in groups of four, were bolted together, permanently. Instead we joined a couple of lovebirds lounging around a conventional table and mobile chairs.

The conversation got around to music: Elvis Presley; his singing style, movies, fame and the tragic end. Taxing our memory bank, we tried to name all the tunes made famous by the star. Out of the blue "Heartbreak Hotel" screamed, rattled our ears, bringing a momentary hush over all. The soul, after the shrill outburst, slumped in a trance, staring at the plastic encasing the tropical plant. The people in here with their shattered dreams and the obvious parallel to "Heartbreak Hotel"

was on our minds for a spell. Changing the mood, the girl began a neat rendition of "Good-Luck Charm" . . . but started mixing it with lines from another tune. She gave up and laughed with us, explaining: as long as the feeling's there, the words are secondary.

A familiar figure passed us by, making himself comfortable in a nearby chair with the City's phone book in his lap. This character collected empty match books, magazines, bits of paper, anything that contained a written word. Studied closely every item that came into his possession. Now the Toronto directory: a serious undertaking. This once, I mused, it was tangible info he was digging for . . . legal aid or phone number of a friend . . . as his fingers leafed very slowly from the last page to the second last page . . .

The restless shadow went over to the temporary counter set up in the gym, and climbed in. Acting up, kid-wise, the make-believe pilot put his fighter jet through its paces with simulated sound effects of a fierce air battle in progress. The security showed up quickly, stopping the war and grounding the shadow. In true pilot style, he sailed over the waist-high counter top, landing smartly on both feet. Muttering a few choice words about hospital policy, the Hawk rejoined the group.

Shortly I had to go, for the main purpose of dropping in was not accomplished. At the time, the mission seemed easy enough. High voltage floodlights glared over the fenced-in area (dubbed 'the cage'), and into the hallway that ran by the Metfors building. The authorities must have been worried sick that the "cage" would be demolished by activists, working through the night with chainsaws.

Reaching the right floor, the recipients of the shopping bag contents could not be located. At the nurses' office they would not "accept the responsibility" of giving shoes to patients. Thrown off balance by the refusal . . . was she joking? . . . No . . . her stern look emphasized the stance. After all the group therapy sessions on responsibility! Pointing out the time of year, freezing temperature, they had pyjamas

on, the security . . . they bent a little . . . if I wanted to take the risk. With indifferent gestures they said, "O.K." I accepted! After a short wait, one girl showed up and found a pair of brown sandals that fit. The staff co-operated by looking the other way.

The search for the blonde in purple nightgown began; stop at each floor, the TV room, downstairs, lunchrooms, other units, basements, the Mall, asking questions, checking with guards, friends, nurses. No luck. Back to the floor where I started. "Yes, she has returned." How did I miss her? Probably sleeping. "Let's check." A gentle tap and we were in the room, the city lights and a bright half moon illuminating our criminal activities. The shoes were to her liking and comfortable enough. Then came the request for blue jeans . . . NO way would I go that far, unless the doctor had granted that privilege. Already the scene of a double escape flashed by in my mind. The staff giving a detailed description of the accomplice with the "We warned him not to," in the police statement. Time was flying, and a recently admitted friend in Crisis I wished to visit. With a few parting words, made myself scarce, taking the elevator to the ground floor.

Soon as the elevator door opened, a person needed a cigarette; as it was lit, asked "How do you treat a Martian?" Replying in a low voice (in case an alien was near), "Like a foreigner." That upset the apple cart and biting accusations, all false, bombarded me. The verbal duel, mostly one-sided, got so heated the guard dropped the book he was reading, gearing up to intervene. Retreating, pointing a finger, yelled, "You know every hit-man in Parkdale!" and stormed out. Counted my blessings; there was no violin or guitar case in sight that might appear to conceal a lethal weapon. The bag that was at my side had been checked earlier. The evening was far from dull but things were getting a bit out of hand.

Pulling myself together, determined to make it to Crisis, rang the buzzer by the locked door. After a few inquiries was shown to a waiting area. Within seconds, out-of-smokes clients ap-

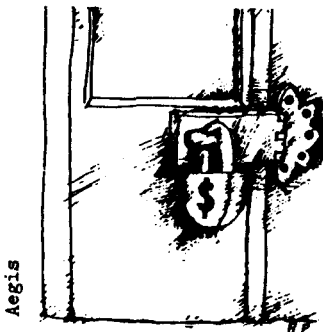
proached, asking for aid. The heavy set guy, with boots resting on the sofa arm rest, craned his neck to the side and in macho lingo . . . "Use The Ashtray." The toughy returned to watching the hockey game on the tube, rocking in a chair. Loved to have seen the power tripping bouncer attendant fall on his ass. For the sake of freedom my boiling anger was forcibly stifled. The sleepy-eyed friend came over with an escort who made the situation worse, again, "Use the ashtrays please!". Three smokers in unison, tinged with aggravation, retorted "WE HEARD!" The stay in that unit was as short as possible. There was doubt: would I leave in peace or covered in bandages?

With the lights back on, my shadow and I, with two guards on our heels, made for the front lobby. It was the bullying time of the closing hour. A welfare-blues singer accosted us. Another smoke. This person started divulging the unusual circumstances leading to where we stood. The boarding house owner did not fancy this tenant borrowing a dress from another, without permission, just to look pretty for tea-time. The guards listened closely, staring at the small pink handbag swinging on an arm. One of the guards directed the "man" to admittance to see if there was a vacancy for the night.

We made our getaway, into the first true snowfall of the season. Fluffy, white blanket covered the grime of the big city. The shadow continued his melancholy journey as I turned west, towards home. Snowflakes swirled and danced; the wind, with gutsy bursts of energy, gave a push from behind; the walk was to be fun. Her farewell lingered warm in memory. The package slipped under the pillow will be a welcome surprise.

Homeward bound. Feeling fine.

Reprinted from "The Cuckoo's Nest II," May '83.



The Medical Director

ANONYMOUS

He was sent to Whitby because he lived east of Yonge Street, which is like sending someone to the North Pole because he lives north of Barrie.

The Reception Ward wasn't bad except it was locked all the time except for intervals when the staff herded the patients outside for a baseball or soccer game.

There was nothing to do in the ward except play cards with the student nurses in the morning.

The doctor made his rounds once a day spending about 5 minutes with him. He couldn't communicate with the doctor in that short space of time.

One day when he was singing the Battle Hymn of the Republic the doctor asked him if he talked to God. That snapped the tenuous bond that existed between himself and the doctor.

Finally, one day, he was told that he was being transferred to a cottage and that from there he would be allowed outside whenever he wanted to go.

The "cottage" turned out to be a two storey brick building. Upstairs was the dormitory where everyone slept. On the first floor were two rooms bare of anything but a couple of chairs and both a TV and a radio going simultaneously. The dormitory was locked all day and when he felt ill he could only lie on the floor.

Permanent and transient patients were mixed up together in the cottage and at times it was impossible to tell the difference between the two. There were no nurses, only orderlies, and it was obvious their job was to patrol the place to make certain everyone was quiet and pacified. Doctors made very irregular visits to the cottage.

The most incredible events of the day were the meals. First, it was impossible to tell what it was that he was supposed to eat. It looked like nothing on earth and it had no taste to it whatsoever. No wonder the permanent patients were thin and scrawny.

One day he was told he could work on the grounds, transplanting flowers

from one bed to another. The simple tools for this job were kept in a small greenhouse. In this greenhouse there was a very large wheelbarrow. He discovered he could lie down quite comfortably in the wheelbarrow so each day he slept for several hours when he was supposed to be transplanting flowers. No one bothered him; no one questioned him. He just slept happily every day in the cool greenhouse and began slowly to feel better.

One day he awoke with all the symptoms of the flu. When the orderly came up the stairs to roust everyone out of bed he refused to get up. He told the orderly he was sick and would stay in bed all day. After an inconclusive argument the orderly left with the other patients and he went back to sleep.

He was awake when the other patients came back upstairs to go to bed that night. One of them was a smallish, bird-like looking man who wore the clothes of the 1900s. The small man came over to the bed where he was lying and examined him carefully.

"You have influenza," he said and walked away to carefully undress. Then just as carefully he folded his old-fashioned clothes and put them on the floor beside his bed.

The next day he felt better so he got up and went down to what he now laughingly called breakfast. The small man was sitting some distance away from him at the long table.

When an orderly walked by he asked him who the small man in the old-fashioned clothes was and why did he think he was a doctor.

"He is a doctor," the orderly replied. "He was the first medical director of this hospital after it was built. Slowly he became a patient in his own hospital."

He last saw the old doctor, and former medical director of the hospital, carefully collecting all the silverware from the table. He took it to the kitchen to be washed then he disappeared into the cottage.

Penetang

By
JOHN H. REIJNEN

Reprinted from "The Cuckoo's Nest
11," May '83.

What is life like in Penetang? Well, here is my own story. I spent two years in Penetang, from 1976-78. Penetang is divided into 2 sections. A, B, C, & D and E, F, G, and H wards. The first 4 wards are for people who are really "crazy" and beyond "help". The other four wards are for people who are not *that* crazy and require treatment. You see, on A, B, C, and D wards there is not treatment except the medication you are on. All you do, day after day, is odd little jobs like: washing windows and floors, putting laundry away, etc., to earn points. The more points you earn, the more privileges you receive. Even the way you keep your room clean and the way you keep yourself clean everyday can earn you points. I spent 2 months on these wards before being transferred to the other side.

Wards E, F, G, and H is where all the therapy takes place. From 8AM-4PM, Monday thru Friday, one's time is spent in these therapy groups where other patients try and help you. You see, it is patient that treats patient, not doctor treating patient. Doctors usually just sit back and supervise to make sure everything is going well and to give advice. Some of the treatment groups they offer you here are: Alcohol Treatment, Capsule Groups, Dyads, Working Groups, and MAP.

An alcohol treatment is a treatment where they keep giving you alcohol hoping to break down any defenses you have so you will be able to talk more freely about yourself. These sessions usually last 1 day and are video taped so you can view it the next day and learn something about yourself.

A capsule group is a group where you are locked in a room with 3 other people. You stay in this room for 2 weeks with next to nothing to eat, just enough to keep you going during the day. During this time the other members of the group constantly confront you, trying to break down your defenses and get you to talk about yourself. While this group is going on everything is put on video so that when you leave the capsule, you can look at it yourself and learn things from it about yourself and the other people in the group.

Dyads is a group consisting of two people who try and help each other with their problems. Usually the two people who are together have a lot in common like their family life, their crime, etc. The dyads usually last one hour each day and at the end of each session each person writes up a report on what transpired during the group; these reports are then handed to the doctors for their own personal use.

Working groups consist of 6 people who try and help each other. One person in the group is the secretary of the group and writes down everything that has transpired so that at the end of the day it can be read back to the rest of the ward so they can comment on it.

MAP (Motivation, Attitude & Participation) is a program devised for the rebellious people. In this program you sit in a very intense therapy, 12 hours a day, seven days a week. In these groups you wear a gown made of heavy material and sit on hard concrete floors, like statues not moving. If you do move more than just an inch you are immediately reprimanded by the other members of the group. These groups are usually in session two weeks, depending on how well you participate and obey the rules. While the groups are in session everything is monitored by staff on T.V.

I found that the programs I have mentioned did not help me at all. All through my stay, I was very rebellious because I felt I was never crazy and that I should be released from Penetang and be put back on the street. The way I got out of Penetang was through the back door. Back in 1976 a new law had just been passed and because of this law, I was set free.

People, not experimental programs, helped put me together again.

René Desjardine Commits Suicide

By RAYMOND T. RENAUD

I met René when I was transferred to Brockville from Penetang five years ago. He had all his faculties and for a man of sixty-five he had a zest for living. He was in Brockville to await a trial. Dr. Bradford had given him the option of going to an old age home or returning to Brockville and being let out by the Review Board. I tried to point out the benefits of the home, but he was so young at heart and in such good health that I didn't persist. It saddened me that he didn't know what he was letting himself in for. He figured since it had been a temporary illness brought on by valium that in a year of stability he would be out on his own with no strings attached.

He went to his trial, got what he wanted—a Lieutenant Governor's

Warrant—not knowing that this would eventually corner him into committing suicide.

René tried his best to get out, obeying all the rules, working in the greenhouse, and being friendly with everyone. He had the services of a lawyer. I know last year Dr. John Bradford recommended he be transferred to Ottawa & live in the community under supervision. But all to no avail. The Review Board insisted that he remain in Brockville.

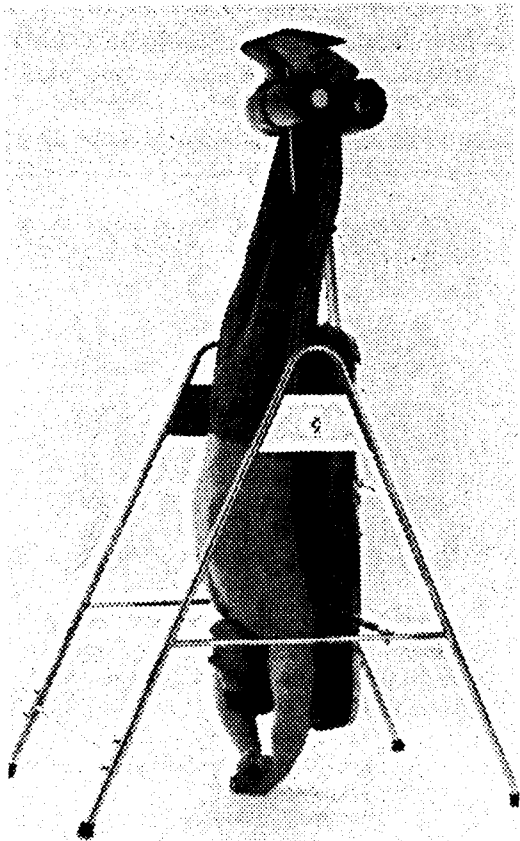
This year being turned down again was too much for the old man. He knew he didn't have many years to live and he wasn't going to live them on a string. He ended his misery at the end of a rope. I know the Review Board can wash their hands of it. But with my personal know-

ledge of René and his situation I know he should have been a candidate for a release for quite some time. It seems like the Board kicked the bucket out from under him.



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“Are there no workhouses? Are there no prisons?”

from Charles Dickens' "A Christmas Carol"

I recently had a conversation with a psychiatrist. It went something like this:

Psych: You must find employment. Everyone must work you know.

Myself: Do you enjoy your work?

Psych: Yes, very much so.

Myself: I have little education. No skills and no trade. I am seeing you because I am legitimately disabled.

Psych: You are able bodied and seem lucid enough to work. Besides, don't you feel it is morally wrong to live off the state?

Myself: You enjoy your job and you should. In three sessions lasting an hour apiece you "earn" more money than I receive in a month. You are paid this outrageous sum to sit and listen to someone who tries desperately to make his life sound interesting because he is too polite to bore you. Your value to society is extremely questionable in view of the fact that your profession has the highest suicide rate of any. How can psychiatrists be taken seriously when they presume to help people to live?

Your only value to me is that you push a pen once a month which enable me to procure needed medication.

As a psychiatrist you should be aware that afflictions of the heart and mind are very disabling. Whether a person is able bodied or not is of little significance.

As to the morality of living off the state I can say that society should be grateful that I accept their pitiful sum of money and thereby relieve their guilt at bargain prices while I make the dubious sacrifice of remaining law-abiding in a system which starves its sick.

Do you not feel it would be morally wrong for society to deny the handicapped food and shelter when people who mass murder children eat better than I and are given special cells complete with colour T.V. and stereo? — at a cost per year of almost your rate of theft?

Yes, I call your income theft because I have been seeing psychiatrists for 12 years and have not benefited at all. The drugs you prescribe help but your words and advice are a waste of time. I do nothing and live 60% below the poverty line. You do nothing and "earn" over 100,000 dollars a year.

In these times of high unemployment let's suppose that after competing with healthy people I was hired. I know what it is to work in factories and at manual labour. This is the only kind of work I would be likely to get and it would almost certainly pay the minimum wage.

Financially I would hardly benefit at all. Emotionally a job of such drudgery would probably culminate in a suicide attempt. This is in fact what happened to me three times in the past as you well know.

The results of such a venture might be that your income would decrease until you found a replacement for me (not a hard thing to do in this society) and the generous state would be spared a few thousand dollars a year.

Finally doctor, I think it is affliction enough to be poor without the added burden of guilt the rich seem only too eager to load on our backs.

By Roger Griffiths



the Book worm turns

Organizing: A Guide for Grassroots Leaders

By Si Kahn
McGraw-Hill Book Company
New York, 1982.
387 pp.

REVIEWED BY DON WEITZ

Si Kahn is a down-to-earth, seasoned organizer in the United States. He's been active in the Southern Civil Rights Movement, farm co-ops, political campaigns and neighbourhood and state-wide organizations. Kahn is also a political songwriter, and his book sings. It sings of people, about us, about our ability to get together and fight for our rights, to live in dignity and to control our own lives. Thanks to Kahn's commitment to direct communication, the book's language is crystal clear and so simple to read that almost anyone can understand and enjoy it.

Organizing covers many basic topics of vital interest to any people's group or organization: organizing, leadership, strategy and tactics, issues, dealing with the media, meetings, research, money, unions and coalitions. In talking about the benefits of organizing, Kahn writes, "Through organizing people learn something new about themselves. They find dignity in place of mistreatment. They find self-respect instead of a lack of self-confidence. They begin to use more fully the skills and abilities they possess: to work with other people, to influence, to speak up, to fight back . . . They rediscover their own history of struggle and resistance."

In the first chapter on *Organizing*, Kahn calls our attention to why some people resist organizing or being organized—fear of being fired, fear of threats or unpredictable consequences. At the same time, Kahn reminds us that individual actions or solutions change nothing—only collective or mass action will. And Kahn rightly urges us as victims of an oppressive society to *stop blaming ourselves* for problems or crises created by the capitalistic system—a system which systematically exploits and dehumanizes people and always puts profits before people. The system,

he adds, encourages people or "minority groups" to blame themselves for their misfortunes: women, gay people, Black and Native people, and other people of colour, children, the elderly, the poor and unemployed, psychiatric inmates, and prisoners.

The chapter on leadership is very important. Kahn effectively exposes the old myth that leaders are born, not made. He asserts that virtually any person can become a leader through training, experience and development. According to Kahn, some of the personal qualities which a leader should have include: listening to people, building trust, letting others take the credit for successes or victories; working hard; being open to new ideas; flexibility; honesty; self-discipline; courage; having a vision and also a sense of humour. In Kahn's checklist of 20 leadership skills, I feel one of the most essential is power—"learning how power works, who has it, how they got it, how they keep it, and how to take it away from them."

If we want to challenge the power of psychiatry or the "mental health system," we must analyze and understand psychiatry's use (abuse) of power over people's lives—not only in psychiatric institutions or wards but in "community mental health centres" and private doctors' offices.

In starting a grassroots or self-help group, mobilizing—in contrast to advocacy or being passive recipients of professional services—is more human and effective, because it encourages lots of people to get directly involved and working together on issues. Issues to mobilize around can include almost anything which people feel is vital in their lives, e.g., poor or inaccessible health care; high rent; poor working conditions; low wages; lack of human or civil rights, to name a few. A good

issue, says Kahn, is one that is: a) winnable, b) helps build the organization, c) involves and affects many people, d) is strongly felt and is e) simple. In general, it's best to focus on a single, specific issue, which can expand to include other related ones after the first victory.

Kahn's discussion of strategy and tactics is equally clear and helpful. He says a strategy is "like a road map. It's a plan for getting from where we are to where we want to go." For example, one basic strategy of the Psychiatric Inmates Liberation Movement is the abolition of forced treatment such as drugging, electroshock and involuntary commitment. The tactics to achieve this may include: public hearings, protest demonstrations, marches or civil disobedience. In the chapter on "Tactics," Kahn lists many types of action which groups can use to "create pressure necessary to win a particular issue": strikes; boycotts; picket lines; sit-ins; public hearings; confrontations; press conferences; paid ads; visits to public officials; mass demonstrations; marches; petitions; letters; exposés; silent vigils; civil disobedience; rallies and legal action (sue the bastards). Both strategies and tactics, Kahn reminds us, must be carefully thought out and planned, flexible and educational for everyone.

Another important point concerning tactics is that they must fit in and support the members' experiences and values—not be strange, uncomfortable or threatening. For example, not everyone is into civil disobedience, mainly because of fear of possible arrest, harassment or violence, and nobody should be pressured to participate in any tactic. However, non-violent civil disobedience has been successfully used in the Peace Movement, Women's

Movement, Civil Rights Movement and the Psychiatric Inmates Liberation Movement. For example, this year civil disobedience was effectively carried out to protest electroshock by several ex-psychiatric inmates in front of hospitals in California and New York. Timing is also essential for any successful tactic. The civil disobedience against electroshock at Gracie Square Hospital in New York City last May, for example, was carried out during the Annual Meeting of the American Psychiatric Association, immediately after some of us learned that live shock demonstrations would be held at that hospital. We were outraged and angry, so we acted. A lot of New Yorkers and the shrinks soon became aware of our existence and protest against shock, thanks to good organizing and media coverage.

Broad-based coalitions are also necessary in people's continuing struggles

for radical change. Kahn wisely cautions organizations to make sure of their own issues or priorities before forming alliances with other organizations. While organizations should feel free to work on their own specific issues, they can find common ground in discovering they share an issue and commitment to democratic principles or power-sharing. This recognition can bring many different organizations into a common front or coalition—the Peace Movement and Civil Rights Movement are good examples. For member groups of the Psychiatric Inmates Liberation Movement, this can mean reaching out to and forming alliances with various citizen or consumer-controlled groups and advocacy groups to fight against psychiatric abuses which affect millions of people. One self-help group acting alone has no political clout—a coalition does.

Organizing is essential reading for

any organization or self-help group of people who want to start controlling their own lives and fight back. I urge all members of self-help groups to read and discuss Kahn's book. It's not only a guide for organizing but a recognition and celebration of the power of the people. As Martha West shouted once during the Tenth Annual International Conference for Human Rights and Against Psychiatric Oppression last year in Toronto: "Don't mourn. ORGANIZE!"

My only criticisms are that Kahn provides very few examples of some of his successes, particularly organizing tactics. Civil disobedience is becoming a major tactic in the International Psychiatric Inmates Liberation Movement—especially in protests against electroshock and other psychiatric crimes. Some detailed information on the planning, carrying out and risks of civil disobedience would have helped.

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ALIENATION, NOT 'MENTAL ILLNESS'

By STEVE HOLOCHUCK

Reprinted from Guardian, May 18, 1983.

In the past several months two pieces regarding the phenomenon of "mental illness" have appeared in these pages. Lenny Lapon's Opinion and Analysis (Guardian, Dec. 22, 1982) succinctly presented ideas generally accepted by those in the psychiatric inmates' liberation movement. The article Richard Morrock wrote in response (Feb. 16) discounted Lapon's ideas as a regurgitation of what Morrock regarded as the blanketly "conservative" ideas of Thomas Szasz. I would like to continue the discussion, not by debating Morrock's ideas point by point, but by refuting the general thrust of his position.

It is important for us as radicals, as people who go "to the root" in our effort to understand things, to use Marxist thought and methods when looking at the phenomenon of "mental illness." We need to use these tools and take a hard look at the facts.

What is "mental illness?" Can we approach it from a perspective that is dialectical, historical, and materialist? If we do, we see people who have experienced a lot of negativity in their interpersonal relationships, in their work situation, and with the world in general. And they have reacted by suffering emotionally, and this has left its mark. Disproportionately, they are members of socially and/or economically oppressed groups: third world people, working class and poor people, women, lesbians and gay men. Their emotional states and their socioeconomic position form an inter-related whole.

Unemployment, poor working conditions, inadequate housing, interpersonal conflicts, and a myriad of other problems are intimately connected with the emotional state of people labeled "mentally ill." Perhaps the term "mental illness" is not a very helpful one for Marxists. Perhaps this medicalization of the process of human suffering is a self-serving ruling class mystification. Not that people aren't really suffering, aren't confused, aren't out of touch with the common experience of reality. Just that in spite of all this, the fact of the matter is that they're not sick.

Is there a better theoretical explanation for what is going on than this re-

ification of their experience into a disease entity contained within? Yes, there is one from our own tradition, one which ties up the personal and the political. These people are not experiencing "mental illness" but they are experiencing alienation, very intense alienation, alienation experienced as separation from other people, work, other activities, self, emotions, thoughts, the body, and the world in general.

Intensely alienated people do and say things that are seemingly meaningless. For example, a psychiatric inmate may say, "Someone is trying to poison me!" Obviously crazy! Paranoid! Quick, add some other labels. But don't go to the heart of the matter and try to understand. Such messages can be understood with the use of a sensitivity to poetry and symbol and by analyzing the person's social situation from a perspective that is both historical and materialist.

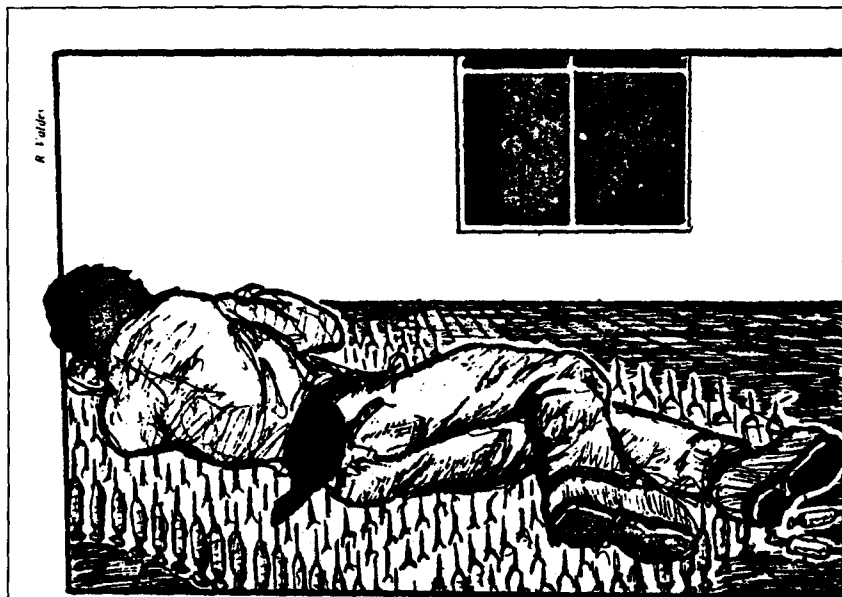
Although probably not literally true, the statement, "Someone is trying to poison me" speaks a truth about the person's past and present social experience. We all need emotional "nourishment" and this person in his/her social experience has probably been "poisoned" with lies, hate, and rejection too many times to mention. When we add

to this concerns about unhealthy working conditions, food additives, toxic waste, nuclear energy, and the general poisoning of our environment, we have a better sense of the root source of this "out of contact" statement. Distorted ideas don't just blossom ex nihilo in the mind. That's bourgeois idealism. These ideas are rooted in the social context and are a social product. These ideas and other seemingly bizarre behaviours are communications, perhaps symbolic and poetic, yet communications nonetheless.

In addition to its social aspect, alienation has a physical and a biochemical dimension. The effects of psychiatric drugs on intense alienation no more make it an illness than the positive effects of a few beers after a difficult shift at the factory make the alienation related to work a disease.

Opting for viewing "mad" behaviour as alienation rather than "mental illness" is not just an esoteric theoretical stance. It has practical implications for an area in which Marxists are particularly interested: what action to take in addressing this problem? Should we opt for medical treatment alone or an approach which focuses on macro- and micropolitical analysis and struggle?

This intense alienation commonly called "mental illness" evolves in a soc-



ial context, is maintained in a social context, and will be overcome in a social context. The struggle of those who are intensely alienated is one with the struggle of workers and all oppressed peoples of the world. Psychiatric inmates and others experiencing intense psychological suffering need their own autonomous movement within the greater movement to address their special concerns and to allow them to struggle around these issues. Alienation, intense or otherwise, is overcome through achieving understanding and taking action with other people.

The experience of consciousness raising and other group activities in the women's movement and in other parts of the people's struggle clearly shows that the personal is political and that problems such as anxiety and chronic depression can be dealt with on a political basis.

The psychiatric inmates' liberation movement is one front where people are struggling to overcome their alienation and change social structures. And although indebted to the pioneering work of Szasz, Laing, Cooper, and others, it has used the experience of real, live psychiatric inmates to go beyond the ideas of these original thinkers to arrive at a higher theoretical synthesis.

Our movement is not the only front on which to struggle to ease the emotional pain of intense alienation. People labeled "mentally ill" can struggle in our movement against the oppression inflicted by bourgeois psychiatry. Other dimensions of their oppression must be confronted through unions, political parties, women's groups, third world organizations, etc.

Psychiatric inmates' liberation has over a decade of experience as an autonomous movement. We have united the psychiatrically oppressed and formed a front of collective resistance. Like other oppressed groups, we feel that we are the ones best able to theorize about our particular oppression and to formulate the specific strategies for our liberation struggle. Many of us see ourselves as part of a wider movement for the total liberation of workers and all oppressed people, the struggle for world socialism. We earnestly desire to join in common struggle with those in the wider movement. We extend our hand, seeking solidarity, not diagnoses.

Steve Holochuck is a former "mental patient" and a Massachusetts-based activist in the psychiatric inmates' liberation movement.



Youth Alternatives/cpf

help unlimited

i work day labour, minimum wage, leashed to the front of an assembly-line, while 2 other bums work the end, all of us moving like treadmill gerbils, veins rushing with amphetamine,

& in between us

50 unionless immigrant blueskirted women slump over machines doing other eviscerating labour.

i sometimes dream if only we were canning food full of protein & vitamins, to send to people in worldwide ghettos, camps, & other places of extermination, i could feel my work had meaning, joined to a global positive purpose, instead of

hating what im doing just to survive, sending a powder full of refined sugar & dyes, a cancerdust & bloodstream demon, into the stores for corporate profit fiends.

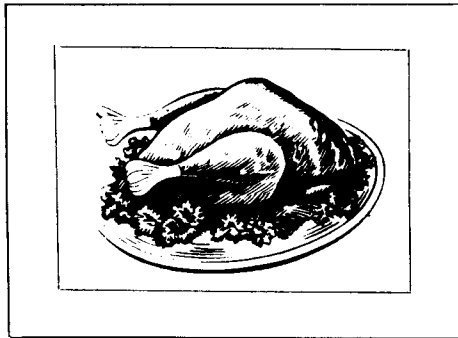
& the cans i handle gleam at me like expressionless human beings, filled with designated-product-lives, unless theyre the least bit individually dented or creased, then i must discard them into the psychwards & jails of the garbage bins.

what to do? the trap is shut & penalties are great, but can we somehow make bridges of the wounds our lives are, in order to see each other safely through the dangerous ecliptic midnight of our time—guided by what is truly felt & longed for & needed: a global healing,

beneath the deafening engines & blinding fluorescence inside the thick & corroded gloves we have learned to wear into the world . . . ?

by bud osborn

GIVING THEM THE BIRD



Chai Tikvah—a Jewish home for ex-psychiatric patients which is committed to helping people return to 'mental health', has a number of bizarre, one might even say 'crazy' rules. The 'craziest' of these is a prohibition against sex. Although the governing board allegedly wishes residents to 'make this place their home', and live there for 'many years', they have slapped a 'no sex' prohibition on the house. Presumably, they think that long term lack of intimacy is conducive to 'mental health.' Along the same lines, they are giving residents no 'say' in who will be moving in and very little say on the actual running of the house. Presumably, they think that depriving people of responsibility and control over their environment is conducive to 'mental health.' There are many other such rules. To end, however, by mentioning just one more, they absolutely require people to 'take their drugs', and have empowered the coordinator to oversee the taking of these drugs. The coordinator is to ensure residents continue to take 'their proper dosage.' Presumably, they think that keeping people in a doped-up state is conducive to 'mental health'. For their 'crazy' rules and total insensitivity to what human life is all about, we award Chai Tikvah the PHOENIX Turkey Tail.



Our Phoenix Pheather this time is jointly awarded to a former psychiatric inmate (a 30-year old man, name unknown) and Judge Kenneth MacDonald. Last month, this inmate freed himself from a psychiatric ward of Queen Elizabeth Hospital in Charlottetown, Prince Edward Island. In early September he was involuntarily committed, because of his alleged dangerousness. This man was referred to a psychiatrist by another doctor after consulting the doctor about surgery, "which would turn him into a eunuch" (according to the article in the *Globe and Mail*, September 17). After talking with this man for only 3-5 minutes, psychiatrist Ben Spears committed him. However, neither the man nor his mother or sister considered him dangerous. The man applied for a writ of *habeus corpus*, represented himself in court, presented evidence and called witnesses. Judge Kenneth MacDonald issued the writ which forced the hospital to produce the man in court and explain the reasons for his incarceration. Judge MacDonald decided there was "reasonable doubt" that the man was dangerous, challenged the committal form filled out by psychiatrist Spears, and forced the hospital to release him. It was the first time that such a writ has been issued against a hospital in P.E.I. The hospital is now asking the P.E.I. Supreme Court to clarify grounds for committal.

We hope thousands of other inmates in Canada, who are not dangerous or "mentally ill" and who have been involuntarily committed, appeal their commitment in court (*not* before stacked, useless review boards). It's time psychiatric judgements of dangerousness, incompetence and "mental illness," which are notoriously inaccurate and stigmatizing, were directly challenged in court—and everywhere. Our congratulations to this ex-inmate and to Judge MacDonald.

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**SOCK
 IT TO
 'EM!**

How come you're picking on our kid?

Be quiet, dear, these men are from the Community Mental Health Team!

Psychiatric intervention can never occur too early!

Sociological studies have shown that children born in mangers blah blah blah blah blah oink blah

Not Licensed By Community Care Facilities Licensing Board

One, four times a day!

RITALIN

Schizophrenogenic mother?!

As an under-three I'll never get into day-care!



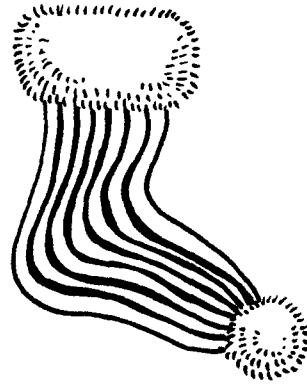
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**SOCK
IT TO
'EM!**

Shock doctors up to date

Here is *Phoenix Rising's* revised and updated list of Canadian psychiatrists who administer or authorize shock treatments. Listed psychiatrists who no longer use ECT, or who have been mistakenly included in the list, may ask *Phoenix Rising* to remove their names.

If you, a member of your family, or

a friend, have been shocked by a Canadian doctor and want his/her name added to our list, please send us the doctor's name and hospital affiliation. We will of course withhold the informant's name, but doctors' names submitted anonymously will *not* be included.

Allodi, Federico. Toronto Western Hospital, Toronto, Ont.

Ananth, Jambur. McGill University School of Medicine, Montreal, P.Q.

Arndt, Hans. Northwestern Hospital, Toronto, Ont.

Boyd, Barry. Penetanguishene Mental Health Centre, Penetanguishene, Ont.

Conn, Bert. Belleville General Hospital, Belleville, Ont.

Cornish, David. Alberta Hospital, Edmonton, Alta.

Denew, Paul. Hamilton Psychiatric Hospital, Hamilton, Ont.

Eades, B. Riverview Hospital, Port Coquitlam, B.C.

Eastwood, M.R. Clarke Institute of Psychiatry, Toronto, Ont.

Giles, Charles. Alberta College of Physicians & Surgeons, Edmonton, Alta.

Gulens, Vlademars, Jr. Chodoke-McMaster Hospital and St. Joseph's Hospital, Hamilton, Ont.

Harvey, Michael. Misericordia Hospital, Winnipeg, Manitoba.

Heath, David S. Kitchener-Waterloo Hospital, Kitchener, Ont.

Hoffman, Brian. Clarke Institute of Psychiatry, Toronto, Ont.

Jeffries, Joel. Clarke Institute of Psychiatry, Toronto, Ont.

Jeney, Leslie. St. Joseph's Health Centre, Toronto, Ont.

Karlinsky, Harry. University of Toronto, Toronto, Ont.

Kedward, H.B. Clarke Institute of Psychiatry, Toronto, Ont.

Kolivakis, Thomas. McGill University School of Medicine, Montreal, P.Q.

Littman, S.K. Foothills Hospital, Calgary, Alta.

Martin, B.A. Clarke Institute of Psychiatry, Toronto, Ont.

McFarlane, W.J.G. Riverview Hospital, Port Coquitlam, B.C.

Mitchell, Wallace. Greater Niagara General Hospital, Niagara Falls, Ont.

Pankratz, Werner John. Lions Gate Hospital, North Vancouver, B.C.

Peacocke, J.E. Clarke Institute of Psychiatry, Toronto, Ont.

Plumb, Lois. Women's College Hospital, Toronto, Ont.

Rapp, Morton S. Sunnybrook Medical Centre, Toronto, Ont.

Rodenberg, Martin. Kingston Psychiatric Hospital, Kingston, Ont.

Roper, Peter. Douglas Hospital, Montreal, P.Q.

Sauks, A.A. North Bay Psychiatric Hospital, North Bay, Ont.

Shoichet, Roy P. Toronto Western Hospital, Toronto, Ont.

Shugar, Gerald. Clarke Institute of Psychiatry, Toronto, Ont.

Shulman, Kenneth. Sunnybrook Medical Center, Toronto, Ont.

Sim, David G. Hamilton General Hospital, Hamilton, Ont.

Solursh, Lionel. Toronto East General Hospital, Toronto, Ont.

Stevenson, Cameron M. Kingston Psychiatric Hospital, Kingston, Ont.

Zamora, Emil. St. Joseph's Hospital, Hamilton, Ont.

Zielonko, Walter. Guelph General & St. Joseph's Hospital, Guelph, Ont.

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“And what is a genuine lunatic? He is a man who prefers to go mad, in the sense of the word, rather than forfeit a certain higher idea of human honour. That’s how society strangled all those it wanted to get rid of, or wanted to protect itself from, and put them in asylums, because they refused to be accomplices to a kind of lofty swill. For a lunatic is a man that society does not wish to hear, but wants to prevent from uttering certain unbearable truths.”

—Antonin Artaud

Van Gogh: the man suicided by society (1947).