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Through the fire



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APRIL ISSUE

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Open Letter to Phoenix Readers:

We have been thinking ahead and we'd like to share a few projections with you, to see where *your* interests lie and to solicit your ideas, contributions and support.

The theme we've planned for our next — Summer 1984 — issue is "Women and Psychiatry." We believe that *some* things have changed since our last (1981) 'women's issue' and we want to interview people in relevant community positions to see what they think has changed — or hasn't changed — and what they've been learning. We plan to publish a feature article about the long-term sexual abuse of two women in Quebec — and their subsequent inability to secure compensation or even professional acknowledgement of this gross malpractice. We hope, too, to offer poems, prose — diary excerpts from women expressing their feelings and experience with psychiatry.

We have further ideas for future issues or articles: An issue on "suicide": one of the most focal and sensitive areas of concern in "mental health" from anyone's point of view.

An issue on "Lesbians and Gays in Psychiatry": a region where traditional 'therapeutic' methods and perceived human needs seem in particularly acute conflict now.

An issue, or articles, on psychiatry and the prison system — and some of psychiatry's more blatant forms of *social control*.

In addition, starting in this issue we will regularly feature a section devoted to 'creative' material: poems, prose, diaries, drawing, photographs, cartoons, lyrics — *anything* that can be printed from anyone who's experienced some sort of psychiatry.

Please send us, then, whatever you may have for this new section — it's your section. Send us, also, your ideas (or criticism of ours) for the topics we've suggested, as well as any other suggestions, articles or material you'd care to share. It's your magazine.

Finally, please send us, if and when you can (you recognize our theme song?): donations. We will certainly be very grateful for anything we receive, for while we are still seriously fundraising — meanwhile there is much to be done.

Many ideas to be pursued, many vital concerns to be raised — *from many inmate voices* as well as for them.

Thanks,
The Phoenix Collective

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This is just to put in writing what I was saying about the Food and Drug Administration, U.S., situation.

The basic fact is that shock machines have been in Class III ("high risk") since 1979 and they are still there. They have not been reclassified.

The significant events have been:
August 10, 1982—The American Psychiatric Association submitted its petition for reclassification to Class II ("low risk").

November 4, 1982—Public hearing was held. Panel of advisers advised reclassification.

April 5, 1983—FDA published a "notice of intent" to reclassify to Class II. Comments from the public were invited. Forty-two comments were received (31 against, 6 for, and 5 in-between).

At the present time FDA has not yet taken any further action. They expect their next step to be to publish a "proposal to reclassify" to Class II. That will again invite public comment.

In other words, the door remains open for concerted patient resistance.

One thing I did recently was to send Veale of FDA the press clipping about your "ECT = psychosurgery" case. I know they are at least somewhat nervous about granting the APA's petition, which would take the onus for lying to patients off psychiatrists and put it on the government. Anything that makes them more nervous works in the right direction.

Thanks for the final info on the ("Mrs. T.") case. I hated to hear it was defeated but I think such an emphasis on scientific fact will eventually pay off.

Marilyn Rice,
 Arlington, Virginia

I have read every word of the Fall 1983 Volume 4 No. 2 issue of *Phoenix Rising*. I would so much appreciate receiving the next publication. I am still a psychiatric inmate here in the U.S. I foresee one day I will be part of an organization like yours. It's quite obvious that these human warehouses don't help any human beings. In the U.S., we put billions of dollars into building institutions for the elderly, welfare children, prisoners, mentally ill and just about anybody who isn't middle class. Under Reagan we have a government of, by and for the wealthy and his administration's definition of middle class is an income of \$50,000 dollars a year or more. Our states may be united, but our people stand divided.

Cindy
 New Hampshire



I would like to thank you for sending me your Fall 1983 issue, with the article on drug withdrawal. I would like to see more printed about this in future issues.

I am considering drug withdrawal from the antidepressant Norpramin, which I have been on for two and a half years. I know of people who have been on these drugs for 15 to 20 years. If they try to withdraw, they are told their symptoms are returning, and they continue to take the drug, or usually they are more intensely drugged. This is terribly wrong to the people. The governments make such a big deal about illegal drugs, but it's alright for them to drug innocent people without them even knowing it.

In my opinion, psychiatric drugs are worse than street drugs.

Keep up the good work!
 Canaseraga, N.Y.



Dear Friends,

Thank you for your coverage of 'the historic event . . . the first International Conference on Prison Abolition . . .' on page 36 of the Fall 1983 issue.

However, would you please give credit to Rod Boisclair, former prisoner, who contributed greatly as the co-resource person with myself on the workshop on civil disobedience. He, after all, is the real expert in that field having managed to survive.

Thank you, too, for your fine magazine, which manages to improve with each issue — just when it seems it has become unsurpassable.

All the best,
 Claire Culhane
 PRISONER'S RIGHTS GROUP



Apology: To Jenny Miller, of *Madness Network News*, for failing to credit her for her article on "Berkeley's Electroshock Ban" published in *Phoenix Rising*, Vol. 4, No. 2.

Children of Darkness

An interview with Richard Kotuk

Allen Markman of WBAI, The Madness Network radio in New York, interviews filmmaker Richard Kotuk, producer of the film Children of Darkness.

Markman: How did you first get interested in the subject of juvenile psychiatry?

Kotuk: In 1976, I read about the Menninger Clinic in Topeka, and the idea came to me that it would be a good idea to make a film about the kind of care that kids get. Kids who were lost and really needed help. Actually, the idea was to make a film in my mind's eye, anyway, that would be kind of like David and Lisa. I had a picture of people going in and seeing psychiatrists on a one-to-one basis and analytically coming to grips with all of their problems, working things out, and everything would be kind of ideal.

Markman: Like a Hollywood version of mental health care.

Kotuk: In my mind, anyway. Until I started to do some research.

Markman: What did you find in your research? What kinds of things did you uncover, initially, before you made the film?

Kotuk: First off, we found that all of the fancy, private institutions wouldn't even let us in to talk with them. They closed the door in our faces. The places we ended up going to were basically though not entirely state institutions. And we found something, for the most part, that was very disturbing. In general, though not in all cases, we found that there was almost no one-to-one or almost any other form of psychotherapy for most children and teenagers. We found that many children were simply warehoused, that they were taken care of not by doctors or psychologists or social workers, but by child care workers, people who usually had, at most, a high school degree, and made anywhere from \$8,000 to \$12,000 a year, many of whom have problems of their own. We found that the basic form of therapy in many institutions was drugs, which didn't really help the kids, but that did control them. And we began to open the doors on a very disturbing and sad situation.

Markman: Maybe we can talk about what the film is like. I know nobody out there has seen it yet because it hasn't been shown, but I was fortunate enough to see a copy yesterday. I found that the film was broken up into a number of segments. You and Mr. Chekmayan visited — correct me if I'm not right here — four institutions.

Kotuk: That's right.

Markman: The first one was the Eastern State School and Hospital in Pennsylvania; the second one was called the Elan Treatment Center, which is a private institution in Maine; and then the Sagamore Children's Center, which — is that in upstate New York?

Kotuk: That's on Long Island.

Markman: And the fourth was South Beach Psychiatric Center here on Staten Island. My listeners will be very familiar with South Beach Psychiatric Center because we've done a number of shows on South Beach. We've had some people discuss some deaths that took place there. So that's really the last segment of the film. Maybe we might be able to start off with South Beach and what you found there.

Kotuk: Sure. Just before talking about that, one other thing that we did find . . . Usually when you're dealing with institutions you find that a lot of times the people who end up in institutions — and I'm not talking about mental hospitals now — are usually people who are poor or disadvantaged or minority persons.

Markman: That's very important.

Kotuk: Jails, for example. We found that, as far as the bottom line in terms of care is concerned, as far as state hospitals were concerned — public institutions — it wasn't just poor people, and it wasn't just minority people who ended up there. When you consider that it can cost as much as \$20,000 a year to send a child to a private psychiatric facility, medical insurance just doesn't come close to paying for it. And after your savings run out, most kids from middle-class families do end up in state hospitals if they have long-term problems.

Markman: Eventually.

Kotuk: Eventually. Eventually. So there's no bailout in terms of a nice place to go for a year because, at the kind of prices we're talking about, it's impossible. And so the disturbing things that we found, which I'll tell you a little bit about in just a moment, are very real for middle-class people, even upper-middle-class people. It's frightening because the things that we found, and the things that occur in the film, can truly happen to anybody, and to anybody's children.

Markman: I also noticed that the three institutions I mentioned, Eastern State, Elan Treatment Center, and Sagamore Children's Center, appeared to be pretty open about letting you and your film crew in. You were able to talk to people who worked there, to patients, family members, and administration. But when you got around to South Beach, you had a little bit more difficult time of it. Could you get into this a little?

Kotuk: Sure. First off, I just want you to know that Ara Chekmayan and I worked very hard at getting the trust of people at the different institutions, and that's why they even-

tually let us in. We also felt that mental patients in general have been stigmatized for so long and they had always appeared in films with black things over their faces or in shadows. We wanted people to get to know the children as children, as people, to know what they feel, to know what's going on inside their heads, to know what their parents are trying to do to help them. That was very important. I also just want to say that we did find some very positive examples of treatment in some institutions. But not to avoid your question ... you want to know about South Beach. Right?

Markman: I want to start off with South Beach because we are going to be joined soon, hopefully, by Mrs. Zamora, whom we're trying to get hold of. She's going to ask you some questions and make some comments. Mrs. Zamora is the mother of Andrew Zamora, who died in South Beach ... in 1981. (See *Phoenix Rising*, Vol. 4, No. 1). He is a prominent character in your film.

Kotuk: Right. OK. We didn't intend to put South Beach in our movie. We were not headed in that direction, per se, but as we continued to make the film, we found more and more examples of abuse and neglect and mistreatment including the overuse of drugs in some institutions. The fact that, basically, parents, when they gave up their children to the hospital, were losing control over their children's lives. We became concerned. Then Ara and I heard about Andrew's death in 1981. We said, Gee, it's happening right around the corner, right out here in Staten Island. Let's look into it. We talked with Andrew's mother. He seemed to have died under very unusual and unexpected circumstances, circumstances which made both Ara and I very concerned about what had happened to him. How did this happen? How did this 17-year-old boy die? It didn't end there. We found that within the two years prior to that two more young people had also died at South Beach. So we began digging into it. We determined that the circumstances of all three of these deaths were, at best, mysterious and as we went further and further they seemed to smack of neglect, mistreatment, and possibly even abuse on the part of the staff — some of the staff — at the institution. And we decided that, Hey, these are people's lives. This is going to be a part of our film because it's happening. And it can happen to anyone.

Markman: How did you go about getting the material you got in the film? I know there's a lot of material in the film which was — well, I don't know how to put this — they made it very difficult for you to get information on what was going on inside of South Beach. They really didn't permit you to film inside yet you managed to get some material out of there. How did you go about getting all this information? You used ... I just want to say that when the film gets to the South Beach segment it takes quite a turnaround. There's quite a change in the film's character. You mention mental patients being stigmatized and having black bands over their faces when they're interviewed. You interviewed some people in the film at South Beach and they were not identified. They didn't want to be identified to speak to you. Why was this?

Kotuk: First off, when we tried to get into South Beach, when we asked the New York State Office of Mental Health for access, they said No. No way. We will not talk to you about it, we will not give you an interview about it, we will not let you inside. We are shutting the door in your face. In fact, the Regional Director said, "We have nothing to say about South Beach, and we're not going to." So what are you supposed to do when you're making a film? Do you accept that? No, you don't. You have to find other ways of getting the material you need.

Markman: You didn't even say to them, well, I'm making a film about, part of it's going to be on deaths in South Beach. You just approached them very casually and said you wanted access to South Beach to film inside?

Kotuk: No, we were very direct with them. We said we know

about these deaths. We would like to know how they happened, why they happened, and they told us to forget it. So you can't accept that. First off, the people whose identities are concealed in the South Beach portion of the film have to be concealed. I'm getting into a sensitive area here. But let me put it to you this way ...

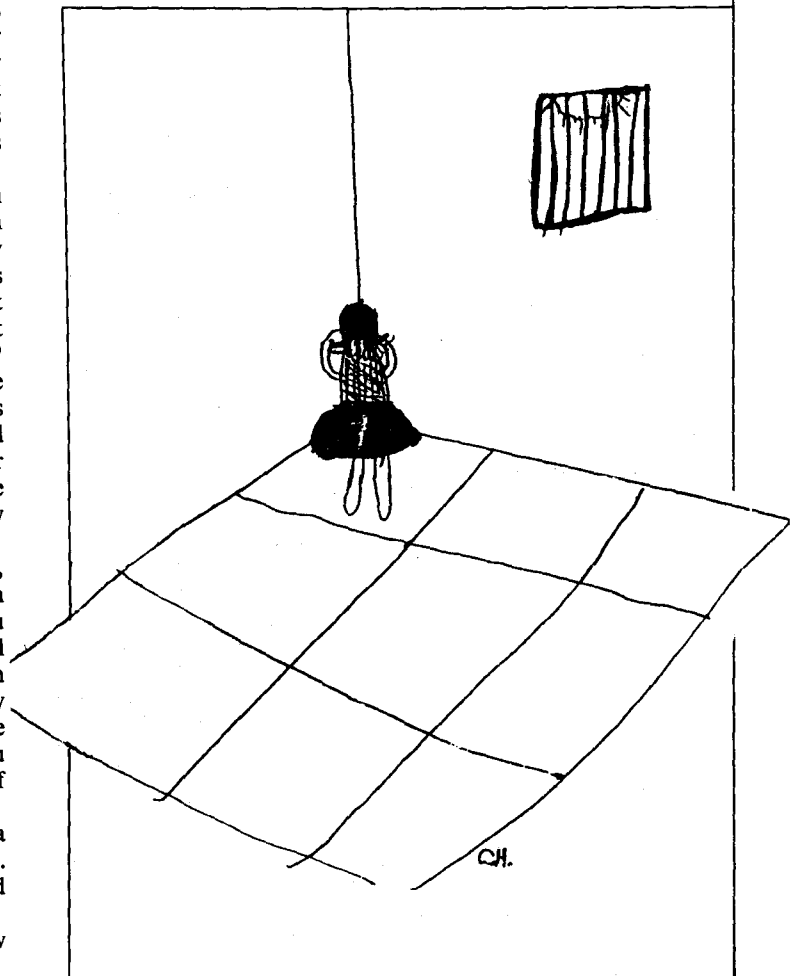
Markman: What is South Beach hiding?

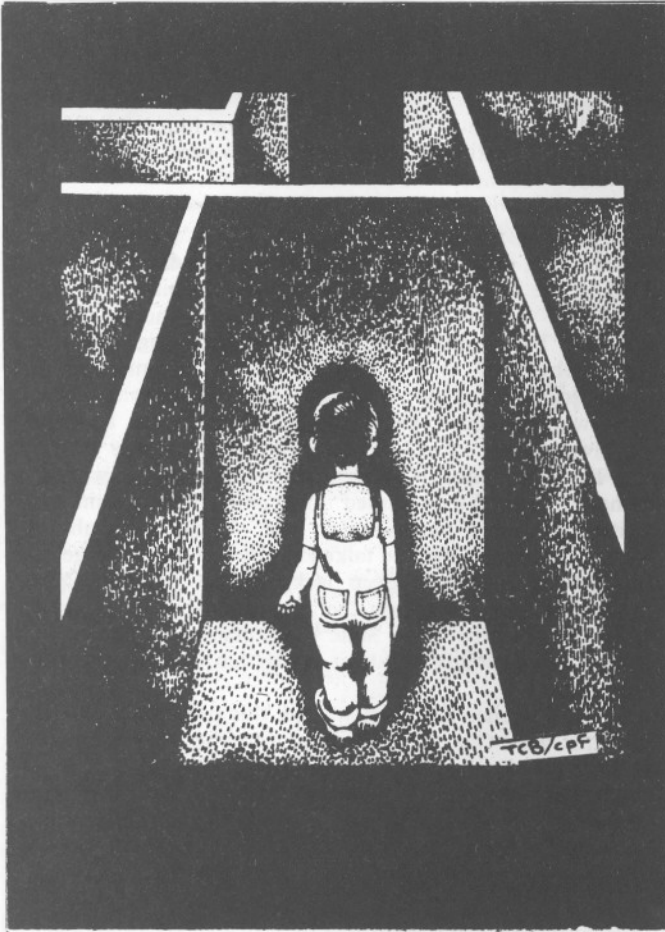
Kotuk: Let me put it to you this way. What's at stake are jobs. We have people in the program who are intimately involved in the day-to-day working of the hospital, and we have to protect their identity because their livelihoods are at stake. OK. That's very different from stigmatizing a mental patient. Obviously, it was easy to get the parents of the victims because in making a documentary that's always easy. People who are hurt, people whose children are abused. They always want to talk. For a producer, it's easy to get them. That's not enough because, obviously, right or wrong, they have a bias. We developed information from within the hospital from many sources and in both — I'm talking about staff and patients — and we talked to enough people to get a very solid idea to get very deep background as to what really happened and what went on there. In addition, we worked closely with the New York State Commission on Quality of Care for the Mentally Disabled which has investigated the three deaths.

Markman: Clarence Sundram was on this program a couple of months ago. Our listeners may remember having heard him. He's the chairman of the commission.

Kotuk: He's the chairman. Everything in our film has been very carefully documented by a task force of attorneys, every single word, every single word.

Markman: I've seen some of those attorneys. They look very serious.





Kotuk: They're very serious. And we are, too.

Markman: I wanted to get into some of the other places that you visited because, as frightening as South Beach is, the idea that people don't want to talk about what's going on there is because they're frightened ... but some of the other places you visited were not exactly country clubs either. I wanted especially to talk about the Elan Treatment Center in Maine, which is not a place for kids who could be called crazy, but it is really a place for kids who are disobedient, promiscuous, don't do what their parents tell them to do, have alcohol or drug problems. The kind of things you showed at this place seemed to me to be some of the most frightening stuff I've seen. Maybe you could go into some of your experiences filming at Elan. What kind of place is it? What is it set up for?

Kotuk: Elan in Maine is an extremely frightening place. When I first went there without cameras you are barraged by people screaming at each other incessantly. It's a kind of shrill blast from one moment to the next. And that's part of the "treatment" at Elan. Elan is a place where so-called "out-of-control" teenagers who have allegedly "acted out" so badly in terms of their parents, in terms of violence, in terms of crimes in their own neighbourhoods and around the country, that their parents have given up on them. Many of their parents feel that their kids either have to go to Elan or go to jail. They've lost control over these kids. Right or wrong — and we try to let the viewer decide whether it's right or wrong — they send them to Elan. Elan is a place where there is confrontation all the time. The idea there is to change the behaviour of the kids by constantly battering them emotionally with their own failures, with their own problems. There's "primal therapy." If you're a child at Elan, you MUST do what you're told to do there. You just have to become part of the system or you're severely punished.

Markman: What's a "haircut"?

Kotuk: A "haircut" is when an Elan resident is called into a room because he or she made a mistake. The mistake could have been something like not fitting the sheet properly over your bed. You come into the room, and five or six people scream into your face for three or four minutes. If you can imagine what this is like, this does not let up, this does not let up. The behaviour, the actions of every single adolescent there is monitored constantly. They're not even allowed to go into the bathroom without being observed.

Markman: What's the "ring"?

Kotuk: The "ring" is a situation ... If you break the rules at Elan, there are punishments. They're usually called "learning experiences" in the jargon of the place. "Learning experiences" can include being made to wear diapers over your clothes. It's all very psychotherapeutically oriented. That's supposed to mean you are "infantile" in your behaviour. Some residents are made to carry rattles. If residents won't participate, they can be made to sit in the corner facing a wall but not for a half an hour or an hour. We observed residents being made to sit facing a wall for WEEKS on end. and I just mean with a few hours' sleep at night. Can you imagine what it is to face a wall for weeks at a time, and someone standing guard over you? Another "learning experience" is the "ring." If you "act out" or become hostile, a resident is put in the "ring." The "ring" is just a piece of ground, but you're surrounded by other residents. In the "ring," you have to fight one Elan resident after another but there's no hope of winning because the number of residents just goes on and on.

Markman: This isn't an option you have. This is completely forced.



ZACHERY GRANT

Kotuk: It is forced. There are no options at Elan. Another "learning experience" which we documented in the film: We came across some residents who had been put in a garbage dumpster, you know, one of those big things filled with garbage, and they had been made to live in it for two weeks — in the garbage.

Markman: This is Maine. This is not in a warm climate.

Kotuk: No, it's in Maine, and there's no escape from Elan. They've all been brought back by what Elan terms "trackers." These are other residents and members of the staff who go out and physically bring the residents back. You have to remember, Elan is in a rural and isolated part of Maine. There's not much civilization around. Even if you get off the ground, you're not going to get away.

Markman: What happens to the people who are picked up by the "trackers"?

Kotuk: They're brought back and punished.

Markman: There was a young man you showed who had just escaped and had been brought back. What was his punishment?

Kotuk: His punishment was that he was put in a rabbit suit. He was made to wear a rabbit suit because he ran like a rabbit ... and also he was put in leg irons and made to live in the leg irons and the rabbit suit.

Markman: And this is all documented in the film?

Kotuk: This is documented in the film, yes. The "ring" is not in the film, but the last two examples are in the film.

Markman: The people who run this place didn't really have many reservations about talking with you and disclosing this information, did they?

Kotuk: At first, they were a little reluctant, but we told them that we wanted to present a realistic assessment of the place, and that's what we did. Allen, the truth of the matter is the people who run Elan are very proud of it. We also let viewers decide whether, in spite of the harsh treatment, it may not be helping some of these kids, which is an open question.

Markman: ...We've been contacted by Mrs. Zamora, and we're going to plug her into the board ... Mrs. Zamora?

Georgette Zamora: How are you?

Markman: Hi there. I don't know if you've been listening to the show, but we welcome you on the air. You're on the air now. Do you have any comments to make about South Beach, or any questions ... for Mr. Kotuk?

Georgette Zamora: I do want to make a statement that recently South Beach was accredited for an additional three years. This horrifies me because, after all these deaths, they're still getting their accreditation. It's inconceivable. I don't know what has to be done to stop them from having their accreditation. I'm glad to hear that the federal government still isn't convinced that everything is right there and they're still holding back their five and a half million dollars from the hospital.

Markman: We haven't mentioned it before on this show, but South Beach did lose their accreditation for awhile but, apparently, they have gotten it back. Did you hear anything about this, Mr. Kotuk? When you were working on the film, did the question of accreditation ever come up in the South Beach story?

Kotuk: No, it didn't come up in our story. We knew that it was going on. I don't know whether Mrs. Zamora knows ... that in the three years since her son died — and this is part of the film — there have been 62 more patient deaths at South Beach. I believe 14 of them are currently being investigated by New York State because they're considered unusual and unexplained. This is from the Commission on Quality of Care. I would just want to ask Mrs. Zamora this. I feel there's an important message, or lesson, that people listening maybe should hear from you, Georgette. I mean, what do you want to tell people? What's really important to you?

Georgette Zamora: It's important ... I'm a mother, and I feel the pain of losing my son. He was so gifted, and I can't understand. I mean, it happened to me so I'm involved. But after I found out all these things that are happening it seems inconceivable to me that they're still there. Nothing has changed that facility. They fixed it up to make it ... look like a model facility, but it's what happens behind closed doors that frightens me. And until the public speaks out and says they're outraged, this will continue to happen. I don't want anyone else to feel the pain of losing a child or a loved one. Even after Andrew died, I became very vocal. Then another boy died, they say, under mysterious circumstances. And now the hospital says they've done nothing wrong. I didn't even know about all these other deaths that are unpublished and the public doesn't know about.

Markman: There was a fourth death that wasn't mentioned in the film because it happened so recently. We had the parents' attorney on a few months ago, a Mr. Cooper from Brooklyn. They've brought suit against South Beach.

Kotuk: Georgette, what do you think parents should know and be careful of in terms of helping their own children who may one day have to go to a psychiatric hospital?

Georgette Zamora: I want them to be aware. I wasn't, unfortunately, and I had to pay the hard way. I was reaching out for help when I needed it, and I thought I was going to get the best help possible. I want them to ask questions, not to be turned away, not to let them say everything is fine and not let you see your child. You have a right. You should demand it, you should ask questions, you should be able to see that person you love every single day. Don't let them turn you away. Then it will be too late like it was in my case.

Kotuk: Let me just interject. We know that you were not allowed to see Andrew. Isn't that correct?

Georgette Zamora: That's correct. And, as in the other cases with Mrs. Ruggeri and Mrs. Singer, we were told that everything was fine. We had no indication that anything was wrong. Andrew was only there two and a half days. And the Ruggeri boy. They (his parents) were trying to contact him for ten days and were told everything was fine. It was all lies. Everything told to us were lies. I don't want anybody else there to be convinced what they're doing is fine and to believe. Ask questions. You have a right and you can demand to see that person you love. Don't let them con you.



Christine Hurle

That's all I want, and I want the best treatment for everyone.

Markman: Thank you very much, Mrs. Zamora.

Georgette Zamora: Thank you.

Markman: I also want to talk, aside from South Beach, about ... the other places you visited. You did visit some other psychiatric centers: a place called the Sagamore Children's Center where there are a lot of children who have a condition known as "autism." There's a patient there named Billy Calhoun whom you concentrated on. He was shown in full restraints. The narrator mentioned that Bill had been in restraints for two and a half years. The film showed that he was in terrible agony and suffering. He was out of restraints for just a few hours a day. They walked him around, and he really looked like a skeleton. When you interviewed either the head of the ward (or maybe the head of the children's center) he said he had been considering aversive shock conditioning, and possibly even a lobotomy for this individual. You also interviewed the mother, who wondered why he had ever been born, and what it meant. Actually, this story has one of the few positive endings in the film.

Kotuk: Right. Sagamore Children's Center stuck with Billy Calhoun and they worked with him very intensely. That story does have a very promising ending. I won't say what it is right now. I hope people will see it when they see the film. We found at Sagamore here was a public institution that, in spite of its problems, was trying to do a good job. We found some very positive work going on here. We found that within institutions very often there were individuals who, in spite of the institutions, were determined no matter what: They were going to help kids, they were going to try to make them better. They didn't have fancy titles. They might have been child care workers or school teachers. At Sagamore, for example, there's a teacher named Joe. He's worked with kids there for 12 years, and that's all he wants to do. He just wants to go to work and to help these autistic kids, and he'll be happy to do that, he says, for the rest of his life. And progress for the kids in Joe's class may be learning how to spell one's name or how to ask for a glass of water or how to say "I'm tired" or "I like you" or "I need this." But he's committed.



Annegret Lamure

Markman: He seemed very happy and very content with the work he was doing as opposed to some of the other people you interviewed in some other institutions. I have a quote here from Eastern State School and Hospital in Treviso, Pennsylvania. You asked a doctor, "Is that psychotherapy?" and the doctor said, "It's the best we've got." And he was giving somebody a shot. That was a little interchange.

Kotuk: Actually, that was a child care worker. Actually, he's a child care worker who does a good job. But the reality is in that place for the boy he was treating at the time — they had only two ways to deal with him. To hold him down physically, basically to sit on him and inject him with an anti-psychotic drug.

Markman: This is somebody named Brian. You showed him in the film outside the institution when he was visiting his father, when he was not screaming. He didn't have to be held down.

Kotuk: Right, and I think there's a message in there. In the institution, Brian is treated like he's crazy. He's restrained, he's given drugs, he's given no therapy. He doesn't get better. He just gets older. And he stays there. But when he goes home to be with his father, his father isn't a psychiatrist but his father cares about him. His father loves him. His father is 70. His father's had two strokes. His father has one leg, but his father is determined to give him the love that Brian needs. And it's amazing because outside of the hospital Brian's almost a different person. He's almost what you would call "Normal." This led Ara and I to talk about and think about many times, you know, maybe big hospitals with big wards with impersonal treatment with drugs, maybe that's really not the answer. Maybe we need something much closer to home in neighbourhoods all around the country.

Markman: I found the change in his behaviour, in his conduct, just startling. In the hospital, he was the stereotypical "schizophrenic," a raving lunatic who was sat upon by aides and forcibly drugged. I have a quote. He was screaming, "I want to get out of Eastern State. I want to get out of here." And when he did get out, when his father took him out for his weekly visit, he was well-behaved. More than well-behaved. He was polite, in fact. He has somebody he calls his girlfriend. She told you that she considers him perfectly normal.

Kotuk: See, Brian is a great kid and a great personality. He has some problems in his brain. He's sick, in a sense. Think of it this way. His father's an old man. Now, what's going to happen to Brian when his father passes away? Wouldn't it be a shame if Brian was put in an adult psychiatric hospital where the self-fulfilling prophecy of his craziness comes true? Maybe he wouldn't be noticed for the next 20, 30 years, or maybe even until he dies. Wouldn't it be better if there was another alternative for someone like Brian because he's a great person and he really ... as for the film crew, he added to our lives because he's so terrific. Wouldn't it be better if people could get to know people like him in a different way, and not just think of him as tied up in an institution somewhere and forgotten about. We feel strongly about this because these people are worth knowing as people.

Markman: Unfortunately, you made it pretty clear in the film that in all likelihood that's exactly what would happen to him. When he reaches the age of 18 or 19, he will be put in an adult psychiatric facility, and when his father dies he will most likely have no one. That story didn't really have a happy ending.

Kotuk: It's possible that can happen to Brian, and it probably will happen to many other kids like him, but maybe not.



CRUEL AND USUAL

Death at Queen Street

by HUGH TAPPING

Penny Rosenbaum's final admission to Queen Street Mental Health Centre occurred on June 16, 1983, her ninth in seven years. The psychiatrists diagnosed her as suffering from "schizophrenia" and "mild mental retardation." Six weeks later on July 30, Penny was dead. She was only 23.

Five months later on December 7, 8, 9 and 12, a four-day inquest was held; the Coroner was Dr. L.G. Dworatzek. According to the Coroner's Jury Verdict, the cause of death was "inhalation of stomach fluid due to fecal impaction." During the inquest, Dr. Edward Sellers, a psychopharmacologist at the Addiction Research Foundation, testified that Penny might have had no bowel movement during the six weeks she was in the hospital. The pathologist, Dr. Robert Ritchie, testified that dry fecal material had blocked her lower abdomen for weeks, "reversing the waste discharge process."

Mr. Alexander Rosenbaum was with his daughter at "Queen Street" on ward SW-5 when she died. He testified that Penny had complained of constipation, that he had asked a nurse for help, was turned down and then had asked that his daughter be transferred to a general hospital. He said he saw brown fluid coming out of Penny's mouth and heard choking noises. At 6:30 p.m., he told ward staff that she was dead. Penny was officially declared dead at 7:27 p.m. at Toronto Western Hospital.

Mr. Rosenbaum ended up screaming at the inquest, accusing a nurse of lying. Nurse Margaret Zawadski denied that he had asked Penny to be transferred and said she had taken Penny to the washroom "a few times" on the very day she died of constipation. Another nurse, Priscilla Todd, claimed

Penny had told her she had a bowel movement only two days before she died. Psychiatrist Eric Zarins said that on the day she died, he diagnosed Penny as suffering from the "flu."

Dr. Sellers said it was possible that two of the three drugs administered to Penny "might have been partly responsible for her condition." The drugs were Haldol (haloperidol) and Thorazine (chlorpromazine), common "antipsychotic" drugs, together with the anti-parkinsonian drug Benzotropine to prevent the other drugs' "side effects." In the *Compendium of Pharmaceuticals and Specialties*, the Canadian Pharmaceutical Association includes as "side effects" of Haldol: lethargy, confusion, constipation and many more serious "adverse reactions;" it is also used to "control nausea and vomiting." (See 'Phoenix Pharmacy', *Phoenix Rising*, Fall 1980, vol. 1, no. 3.) Like Haldol, Thorazine can cause constipation and suppress the gag reflex, thereby permitting the "aspiration of vomitus," i.e., the person chokes on his/her vomit. Both Haldol and Thorazine were found in Penny's autopsy blood samples. (See "Pheonothiazine-related deaths," *Phoenix Rising*, vol. 4, no. 2, 1982.)

Seven Verdict and Jury Recommendations came out of the inquest:

1. Abolish 12-hour shifts for the nursing staff.
2. A higher ratio of R.N.s to patients at all times, including weekends.
3. Doctors prescribing drugs should instruct staff in writing of specific side-effects to watch for.
4. "Physical examinations should be more thorough."
5. All requests for a physician and/or transfer to a strictly medical hos-

pital, from patients or families, should be recorded, and the duty doctor should read and sign the chart immediately.

6. Queen Street should conduct an official internal inquiry.

7. "A verification process be instituted to reveal accurate medical status of patients."

A great deal can be inferred from these recommendations as to the testimony given at the Inquest and the actual circumstances of Penny Rosenbaum's death:

No. 1 and 2: For whatever reasons (e.g., understaffing, overwork or simple negligence of nursing staff, etc.), the nursing staff was not fully responsible for their "patient."

No. 3: The patient was not properly monitored for common side effects of the drugs prescribed her.

No. 4 and 7: She did not receive a thorough medical examination.

No. 5: Both the patient's and her father's requests for her transfer to a regular hospital were neglected to the extent of not even being recorded in her chart; it should be noted that the recommendation here is only that such requests be recorded, not that they should be taken seriously or done anything about.

No. 6: Negligence is indicated.

During an 18-month period in 1980-1982, Aldo Alviani, Patricia Ellerton and Norman Davis all died of "drug-related" causes at Queen Street Mental Health Centre. This latest Inquest into the drug-related death of Penny Rosenbaum not only clearly confirms these indications of the negligent use of "drug therapy": it raises the far more fundamental issue of *just what treatment, medical or psychiatric, is being offered inmates of Ontario's largest mental health facility.*

OUT OF THE ASHES

... features poems, prose, graphics, photographs — writing or artistry of any kind by anyone who has been psychiatrized.

“Out of the Ashes” will be a regular section of Phoenix Rising.



finally, reparation

a veterans' administration clinic
in ohio
a guy sitting in the waiting area
a pop machine repairman working
the guy saying

that machine ripped me off
for 40 cents
I'm tired of getten ripped off

I was in world war two
got shot in the ankle
got malaria
& a nervous breakdown
lost 48 men
& I'm tired of getten ripped off

my son was sent to vietnam
& he's got agent orange
& a baby that's retarded
& I'm tired of getten ripped off
I'm tired of it

& the repairman

gave him back

his 40 cents

Bud Osborn

TREATMENT

You spend your days dying
on Queen Street wards
shuffling nowhere
waiting to be stoned
and shocked

Your eyes are open
but you can't see
your tongue hangs out
but you can't speak
your legs move in jerks
but you can't run
your hands shake
but you can't write
the EEG records your brainwaves
but you can't think or remember

Their drugs and shocks
have turned you into stone
a tombstone
over your rebellious soul

by Don Weitz

THE DESERT

The mother sits with her new baby,
a girl, with small, flat ears
and lovely skin.

The mother sits without speaking.
"How old is the baby?"...,
they pry.

The mother moves her hand over her baby,
softly, on her back.
But for others, nothing.

She is in another landscape,
a veil held over her face,
like an Arabian woman in a desert;

she walks through the flat landscape
where here and there
a plant blooms its prickly bloom,

and Scheherazade has forgotten
all her stories.

YESTERDAY, MOTHER WAS FOUND GIVING THE
CHILD A LIGHTER TO DISTRACT HER. A TRANSFER
TO ANOTHER PSYCHIATRIC HOSPITAL HAS BEEN
DISCUSSED. MUST CONTINUE OBSERVANCE.

An Abolitionist Prayer

by Bonnie Burstow

*We acknowledge before you the bitter divisions we have
created in your unity, O God.*

*We acknowledge before you, O God, the injustices that we
have committed in the name of justice, the insanity that we
have indulged in in the name of sanity, and the godless acts
that we have perpetrated in Your Name.*

*Forgive us our racism which labels some of your children
inferior because of their colour then puts them behind bars
for protesting.*

*Forgive us our greed which creates crushing poverty the world
round and jails the poor for stealing.*

*Forgive us our intolerance with labels your most sensitive
children 'mad' then packs them off to mental wards to be
'cured.'*

*Forgive the father who molests the daughter and cries out for
rapists to be castrated.*

*Forgive the employer who kills the spirit of his employees
every hour of every day while demanding the death sentence
for murderers.*

*Forgive the smugness of your officials, the complicity of your
churches. And forgive most of all, dear God, the hypocrisy
of us—the "honest citizen."*

Gracious God, forgive us, for we KNOW what we do.

Donna Lennick

INSTITUTION

Inside
Nothing grows deprived of
Sunny skies
Thousands die
In
Time
Unheard, with no opportunity
To bloom with grace
Instead, the buds wither
On stems of
Neglect.

by Cynthia L. Damiano

1: Night

Ellen Weston

Jodie woke.

The room was dark.

She could hear nothing but the pounding: the pounding of her head, the pounding of her heart. Fast, too fast, and louder than she would have believed possible. Worst still was the incredible pressure: a great weight, resting on her chest, seemed about to crush her.

She wondered what day it was.

She wondered how many pills she had taken.

She wondered if she would die.

She fell asleep again.

2: Images of "recovery" (Intensive Care)

From the nothing emerges day and a rim of distant faces. The floor is cold against my back and I feel my sweater bunched beneath me in a lump of buttons and belt. I want my arm to pull down my sweater but nothing happens.

The world shakes, slaps, cries, "Breathe! breathe!"

But I am not part of this turmoil and I simply drift, I slowly slip back and ease into out, somewhere.

Another fragment: light. Sharpening colour and shape of human head. Face. Distorted features bend over me, ugly with urgency, with anger.

"WHAT DID YOU TAKE? TELL ME WHAT YOU TOOK."

The sound is tremendously magnified and echoes painfully in this great glaring room. My eyelids, window blinds, shut out such piercing light.

Later. Perhaps it is later. I'm not sure; but things exist in patches, and so, in retrospect, the images seem to have a sort of order, a chronology. Like islands in an immense black ocean, they can be charted and defined in relation to one another though the sea swells between are unfathomable. Anyway, let me say: later.

Later, I swim into view of shore, briefly; and open my eyes. The horrifying brightness has been dimmed. There is no reason to want to see, and I close my eyes again. However I do not sink into what has held me: remain, floating on the surface only, bobbing gently up and down on the currents of sound. The room is a cavern of strained breathing. Antiseptic air gusts through the ventilation system. Shoes squeech on linoleum as murmur, once low and far off, now murmurs nearer and nearer.

"They really bug me, you know. Let them get it over with in private, quiet and neat. As if we don't have enough work to do."

"I don't know. Must be awful, don't you think?"

I wait for the answer. I have some interest in this conversation. They are, after all, discussing me.

One cold hand fingers my wrist gingerly. Whose?

I would express sympathy, agreement. I, too, find my presence here distasteful and I would remove my body from this place, the holy zone of painful breathings, if I were not

strung to this bed, to these machines, by so many tubes and wires. Held down also by tons of weariness. Again I sleep, or whatever it is I do when I am away from consciousness.

I remember, when I see him, the ringleader. Who kept yelling WHAT? HOW MANY? WHEN? TELL ME.

Who now, with a circle of white men and women and a nurse or two in attendance—who now, the ringleader, the bearded ringmaster, announces:

"A twenty-two year old overdose."

And a dozen people do not look at me, me pretending to ignore, me The Exhibit: do not look or speak, but move quickly away, beyond my hearing, and cluster in a curious herd, and glance back from time to time, and consult "my" chart, and finally move on to the next attraction.

Him they greet, and shake by the pale hand, and question. A human being, evidently, unlike the occupant of my bed.

I am a dishrag, limp, wrung out, draped over the faucet. I huddle in the corner of the bed furthest from the white-coated bustle. Let me evaporate. I do not wish to disturb. To profane. I have every respect for the carefully monitored life in this room. Life spelled out by the slow drip drip of the intravenous. Surely someone will speak to me soon and release me from this terror of silent guilt. But I cannot call, cannot move even. How dare I occupy a bed among all these sick people? If I am still, perhaps I will not have to feel their anger. Perhaps.

The old nun has a voice like gentle music. "How are you feeling now, my dear?"

"Tired." Hard to believe that sound came from me: faint and oddly-pitched.

Does she know what I am?

"Tired," she repeats, quietly, with a smile. "Don't you want some lunch? Your tray is here. A lovely bowl of soup?"

I shake my head.

"You rest for a while then, dear."

Her fingers sweep the hair back from my face in a smooth single motion before she goes away. Still smiling.

I am alive, and it seems I will live, and I ought to know what I feel.

Temperature, pulse and blood pressure time again.

I obediently lift a limp arm so the nurse can wrap the prickly material about it.

When she has finished, before she can go away without a work, again, I quietly ask, "How much longer do I have to stay here?"

She makes a sudden, startled movement. "So you do speak," she laughs.

Her voice is familiar.

"What was it you wanted?"

Her voice is one I have heard. I don't know which one, or when, or why I remember so clearly.

"I'd like to know how much longer I'm going to be here."

She is silent. Obviously she doesn't know.

"I want to leave." My voice is very level, very reasonable.

She looks surprised, uncomfortable. "I really don't think you should go until the psychiatrist has had a chance to talk to you. He knows you're here, and he'll be coming to see you soon."

I stare at her and repeat, "I want to leave."

She is silent for a moment, also staring.

"Soon," she says, turning. "The doctor will be here soon.

You just relax and be patient."

"I want to *leave*," I persist forcefully now.

"You can't." Her shoes squeech angrily away.

What does that mean?

I try to lie quietly. I make a singsong of her words. Someone is coming soon, a doctor is coming to talk to me. The nurse said so, she said so. Someone is coming soon.

I mumble the lines, over and over, until the phrases jumble together and lose all meaning.

Restless, stiff after lying in bed for many hours, I sit up. Cautiously: I am still attached to some of the strings which have made a puppet of me this day and days. I trace the remaining wires to their source, a small grey box on a shelf above my bed. A thin green line plays up and down on the screen. It dips and rises, dips and rises. Then sticks, down. After a moment it rises again, rises high, resumes a regular pattern.

What happened?

I continue to watch. I see a small white light flash on and off, many times. Then it pauses, as green sticks low again. Nothing for a moment. Then the light flashes, the line rises and falls again. In another minute or so, the interruption is repeated. The light's hesitation is longer, this time.

That light is my heart, not beating. My heart has stopped beating.

No sooner has the thought registered than the light flashes again, once only, pauses, flashes a few times in rapid succession, then slows, flashes at even intervals again. I watch for a while. The light stops every now and then, as the green line straightens out for an instant before bounding up again. Always the regular pattern returns, prevails.

Finally I grow tired. My head is heavy, feet and fingers numb, needled. I lie back in bed again, carefully, turn on my side. Out of the corner of my eye I can see the white light flash on and off.

What I feel is like fear.

After a few minutes, intent, my eyes flicker, try to maintain the vigil, fail, close; I sleep.

I wake to feel fingers on my flesh and open my eyes suddenly.

"It's okay, Jodie. One of the wires came off, that's all, and we weren't getting a proper reading."

Quickly she finishes, reties my gown.

Wires. So whose malfunction did I see, the machine's or mine? I think briefly, wonder about wires. I think, but it no longer seems to matter very much, and soon I fall asleep again.



Nira Fleischmann

What Makes Distance

by Robbyn Grant

I The Separation

Beyond the pale green walls and beige curtains the rain drips from above the window. Buses and cars run like silent miniatures in a toy store window. I am in isolation (odd—they call it the community ward). I feel big like a bloated child, up here, in this bed, watching from my window. A child unable to leave this bed, this place. An unborn child hooked to the umbilical cord of this steel i.v. pole. Hooked up to a bottle. Sugar water. Plugged into this and unplugged from the rest of the world out there, outside the window, outside the curtain that blocks the view of my bed from the door and whatever sounds of carts, trays, footsteps, the metal and glass clank and jangle that pass by and fade down the corridor. Isolated. Acted upon.

Outside the birds fly off toward the miniature scene. I too feel miniature when I do not look out the window. A diminished gnarl of a thing amid the ridges of bedclothes. A coil of flesh poking its black head out from the sheet. Watching the tiny cars and buses pass over the roofs of buildings below.

The waiting waiting waiting. For someone to come. For someone to connect me with life outside this room which is not life at all.

Long after the marriage is over I still feel the pain. Like the amputee still feels pain in the limb long since removed. Pain in the empty space.

I carry the thing with me long after it is gone. They have taken the i.v. out, yet, when I get up to go to the toilet I drag the pole with me. I can think to move no further from it now than its tether would permit when I was attached to it.

I am home. I have hurried all the way. I rush through a bath as if I could rush my way past all of this. As if I could wash this whole experience off me. As if then I would wake up and find everything back to normal and all this a drugged dream.

I am being baptized by the Reverend Brother Charles Pickett. It is Rockwall, Texas. I am 12 years old. I am afraid. I do not know what I am entering into—or if I am at all. I fear I am only going through the motions. I am 12 years old. Maybe it is too soon. Or too late.

I sit on the edge of the bathtub and the clots of blood drop into the water. The black and red clots spread in the water like ganglion. It is the sign. Everything in my body is restored to its normal order. The cycle begins again. There will be no child. I am born with the unborn.

II The Dislocation

The child nags me. I want to smash him. The man sleeps in the bedroom. I do not want him to go. He will. The child is an impediment to him. The man is an impediment to the child.

The child knows this. The child is afraid. The woman is afraid. The man is afraid. What are they afraid of?

She is afraid that the child will wake the man and cause him to go. The man does not come back when he doesn't get enough sleep. She is tense and nervous that a man sleeping in her bedroom is causing tension between the child and herself. That the child will cause tension between the man and herself. Always she feels there is someone coming between. She does not yet know who it is.

The child is perhaps afraid the mother will leave him. Replace him with the man who is bigger and understands as well as knows all the ways to please and engage the mother.

The man sleeps in his dreams. We do not know what they are. The woman thinks they do not include her. The man must leave to dream his dreams after he wakes. She knows this because she cannot dream her dreams here either. The man loves his dreams. She loves his dreams too although she thinks that ultimately they will exclude him from the reality which she calls her life.

The child talks with a stuffed toy whose pull string activates a tape recording inside. He repeats after the rabbit. Ooooo you're a cute bunny....Ooooo you're a cute bunny....I'm sleepy....I'm sleepy....Now hug me tight....Now hug me tightHey take me with you....Hey take me with you....Hey take me with you....Take me with you....Take me with you....Take me with you....Take me with you....

He is anxiously lonely. So is the woman. The woman thinks to satisfy everyone not least herself as some say. But her needs cannot be met if the other two are discontent or afraid. She feels she only has as much room as she can create for those around her.

Finally the child abandons the talking rabbit for an even louder toy. A fire station with a crank operated elevator. The indestructible plastic teeth gnash and grind the little box to the top of the building ringing the bell all along the way. The child smiles widely up at her and cranks the handle. The silent man is present but not visible in the scene.

The woman is anxious. To try and cause the child to lay aside each of his noisy occupations would make him shriek and yell. This too would wake the man. When the man wakes he will leave. He will leave she thinks even if he does not go.

She needs the man to sleep in the room. She needs him to be there and not to wake. She does not know why. But she needs him to be there.

When he comes to life the child will antagonize him. He will antagonize the child. The man and child are afraid of each other. He will leave. Then, she says, the child will hold her captive in her own house.

We do not know anything about the man. The absence of his presence or the presence of his absence is the strongest force in the present situation.

The child rides down the hall on a tricycle. It is blue and rusty and makes loud squeaks from all its joints. He rides back and forth between the mother and the door behind which the man sleeps. He smiles up and squints his eyes. She thinks to threaten and disarm her. She is disarmed. The words of reprimand fall back into her chest. She is not sure what the burning pain there is.

Who will the man be when he wakes up? Who will he cause the child to be? The mother?

She does not want to wake the man. She is not sure why, for she too is anxiously lonely. She knows that if the man wakes she will still be alone. She wants someone there with her so she will not be so lonely. She does not want to be alone in her aloneness. If the man wakes he will go.

The child climbs on her chair. Tugs at her housecoat. His fingers insist.

III

The Move

This time it is a stranger. He is my lover. He drives the truck as so many strange yet familiar men in my life have done. He drives the truck with me and all my earthly possessions out of town. Away from the man with whom I have felt at least familiar for the past third of my life. Though we too no longer know each other again. Drives my past back behind me. Out of sight. The tears cut like hot metal in my cheeks. Drop cold as metal on my chest. In the mirror the road wraps back behind the truck. The child on my lap sleeps into his future.

I am small again. It is Texas, Oklahoma, New Mexico, Rt. 66. The sun bakes the road, burns the land. The dust settles on it. Or the dry mouth of winter spews the dust about stark trees and tumble weeds. I am in the back seat of a car. I am being taken—moved—transported—somewhere. I do not really know where. There is no where I really know. It is all and always strange to me. The land. The people. The man driving the car. The strip of road. The edge of life that is visible beyond the window. I am in someone else's dream and I dream what passes by me.

Like a film strip the barren dusty colors and the long gray streak of highway reel by me. It is not real. It moves like film. I am real though static. I watch the monotony blab by. I am static. This road this landscape move by me. I am static though real. Outside everything moves but is not real. The mother in the front seat is real though she too does not move and is moved. The father behind the wheel thinks to move and moves the others. The father who does the moving is thereby made known by his effect behind the wheel.

IV

The Exit

Half way through my life I am sitting in a red booth. Drinking beer kissing a man. It is a strange city. It is a strange man though I know him as well as I know anybody. It is half way through my life. The speaker plays music updated from half my life ago. Things repeat. Things go

round. It is half way through my life. I wear overalls and a T-shirt. The booth is red. The music is thin. It is half way through my life. The exit sign is red and geometric. The waitress is friendly. It is at least half way through her life. The plants are grown by artificial light in this restaurant. The man to my right is half way through my life. Knows most of it. Lives in half of it. The music is from half my life ago. Since I fell for you. A quarter of a life time later people sing and play it in this restaurant. The exit sign is red. Always the exit sign is red. Half way through my life.

To my right a woman taps out a language on a deaf and blind man's hand. He laughs. The exit sign is red beyond them. They touch and talk. They talk through touch. The exit sign is red and geometric. They are together in their aloneness. Always it says EXIT. Outside it grows dark. The waitress whose life is also half over wears her skirt above her fleshy knees.

It is hard to find a place where you want to be. It is hard. It is so hard. He says. The man across from me.

The blind man taps his cane in code on the floor. She laughs. They have a joke no one else understands.

V

The Alienation

She needs to do something. I do not know what it is. She needs to do something that would make her feel good. She does not know what it is.

She gave out her key to people she thought she would not mind barging in on her. Now that is not so.

She says that pain is hurt and suffering is long time hurt. She bolts the door.

It is hard right now for her to accept the mutability of things. She knows for sure that some things do last a life time. Though she has not yet lived a life time. I do not know which ones. She does not know how she knows this. Sometimes she sees things very clearly. Sometimes she cannot see at all.

She cannot commit herself. Sometimes I cannot tell if she is being honest or confessional.

She does not know whether or not to unplug the phone. Sometimes she does not feel safe in her own house. She does not know what kind of invasion she fears.

She cannot sleep.

She unplugs it.

She replugged it.

She lay down.

Does she have the right to unplug her phone? Maybe someone who needs her will call. Maybe someone she needs will call.

In sickness and in health. In sickness and in health. What lasts? What recovers from its own disease?

I feel sick. She has a hangover.

Who is it I feel I cannot be truthful with? She thinks back.

She names the faces.

What would make her feel better?

Even her body will not co-operate. The head wants to lie on its back. The stomach on its side.

When someone shows her something she is often afraid she will not understand it.

She wants to see something.

She cannot see anything.

What does she want?

What would make her feel good?

What does she need?

The New Human Rights Legislation: What It Says What It Means How to Use It

By BONNIE BURSTOW

Introduction

In the first half of 1983 the Canadian government passed a very important amendment to the Canadian Human Rights Act. The amendment will be proclaimed fairly soon. The amendment specifies that people with present or previous emotional difficulties, mental handicaps, or alcohol or drug dependence are now included among the groups to be protected against discrimination. Shortly after the amendment was passed, two events occurred which somewhat restrict the Commission's ability to protect the new client group. What happened is:

1. A ministerial guideline was issued identifying actions for which the "emotionally disturbed" etc. could be "legitimately" disciplined.

2. In a relevant case, an employer appealed a decision of the Commission in the courts — *and won*.

The details on these and their implications will be discussed later.

Around this time, I was approached by the coordinator in charge of the implementation of amendments. The Commission, I was told, was worried about the influx of complaints from this completely new client group. They felt frightened. They felt they did not know enough. They felt inadequate. What they asked for is staff development work. Our discussions culminated in my writing a training manual. The manual offers a general introduction to the area, attempts to offset the medical model disorientation which the Commission has, offers facilitative suggestions and introduces distinctions which I felt could be used to render the ministerial guideline somewhat less problematic.

My involvement in the process puts me in a position to clarify the new legislation, explain what is involved, comment on shortcomings and suggest how to use the legislation effectively. The purpose of this article is to do that clarifying and make what suggestions I can. My thanks to Dorothy Collins for giving me permission to write it.

The Amendment

The relevant passage reads:

20. The definition of physical handicap in section 20 of the said act is repealed and the following substituted therefor:

"'disability' means any previous or existing mental or physical disability¹ including disfigurement and previous or existing alcohol or drug dependence."

(Bill C-141)

The import of the legislation as amended is that employees and potential employees cannot be discriminated against on the basis of *mental handicap or alcohol or drug dependence* just as employees and potential employees cannot be discriminated against on the basis of *physical handicap*. It means, correspondingly, that like the physically disabled, the emotionally disturbed, developmentally delayed and the person with alcohol or drug dependence must have *equal access to services*.

The Workplace

Vis-à-vis the workplace, on the surface it looked as if the legislation as amended gave the Commission a mandate to:

1. stop most forms of employer discrimination against this newly included group;

2. require employers to make what reasonable accommodations they could so that the emotionally disturbed persons, etc., who might otherwise have to quit their jobs because of disability would be able to remain.

The first point seems clear. To clarify the second, 'reasonable accommodation' is a concept which had already been built into the Act. Insofar as it could be required for other groups against whom discrimination was prohibited, the

Different Types of Disturbances

Commission reasoned, it could now be required for this new group.

When attempting to think through what 'reasonable accommodation' meant for this new group, the Commission came up with the concept of 'emotional stressor.' There are often work conditions which severely stress people with emotional difficulties and might culminate in their being fired and/or having to leave, or, correspondingly, not being able to accept the job in the first place. Where these stressors could be removed without great cost to the company, removing them constitutes *reasonable accommodation*. In such cases, employers, the Commission reasoned, *could be required to remove the stressors*.

This looked good — VERY, VERY GOOD! It looked as if we were getting a great deal of what we wanted. As noted earlier, however, a couple of monkey wrenches were thrown into the works. What happened was:

1. A guideline came down from the Ministry specifying that disciplinary action up to and including firing was warranted *where the mentally disabled person caused "disturbances in the workplace."*

2. An employer appealed a case in a different area where the Commission had required him to make "reasonable accommodation." The court *found for the employer*, maintaining that the Commission simply *did not have the authority to require "reasonable accommodation."*

To discuss individually, beginning with the guideline: The guideline, significantly, was written into both early and late drafts of the amendment. Rights groups protested and protested loudly against the section. Having it in, they asserted, opened the door to rampant discrimination. In deference to these groups, or what now seems more likely, to "*shut them up*," the objectionable section was deleted and the "cleaned up" amendment passed. What *went out the front door with great fanfare*, however, *quietly re-entered through the back door*. The objectionable section *returned as a ministerial guideline*. Having such an open-ended guideline clearly weakens the legislation. Moreover, creating a special guideline about disturbances in the workplace *for this particular client group and only this client group* serves to REINFORCE THE NEGATIVE IMAGE OF THE MENTALLY DISABLED held by officials and the public at large. The government's behaviour here is deplorable.

This weakening is matched by the weakening created by the court decision. The courts have established a very unfortunate precedent which effectively undoes a lot of the good work which has been done. Although the Act would seem to indicate otherwise, the Commission, it would now appear, does NOT HAVE THE RIGHT TO REQUIRE reasonable accommodation. It is a precedent which works against *our group* as well as *every other group disadvantaged in society*.

I regret these events. Such weakening notwithstanding, a gain *has* been made; and it is one we can make use of. As things now stand, the Commission is committed to:

1. protecting the mentally disabled against discrimination in the workplace in instances where no "disturbance in the workplace" has occurred;
2. attempting to *persuade* employers to make the reasonable accommodations necessary for their emotionally disturbed employees to continue working;
3. doing something about discriminatory hiring practices.

This in itself is good. In light of the fact that the distinctions introduced in the final draft of the training manual were not deleted, moreover, there is at least *some hope* that the Commission will distinguish between disturbances which warrant disciplinary action and disturbances *which do not* and will *find with the employee in latter instances*.

The distinctions suggested² in the manual are distinctions between disturbances which are

A	B
1. major	and minor
2. frequent	and infrequent
3. unprovoked	and provoked
4. real disturbances	and simply the intolerance of others.

It would be discriminatory, the manual suggested, for an employer to strongly discipline an emotionally disturbed person, etc., *for category B disturbances*. Where the disturbance in question had *any or all* of the B qualities, accordingly, it was argued, and the disabled employee was severely disciplined and/or fired, *the Commission should find with the employee*.

The first two sets of distinctions seem clear. To comment quickly on what is involved in the others, distinction 3 is intended to safeguard emotionally disturbed persons whose "disruption" may be traced to teasing and taunting by others. In such a case, the manual argues, *not the emotionally disturbed person* but *others* are primarily responsible for the disturbance. Disciplining the emotionally disturbed person, accordingly, constitutes discrimination.

The last distinction is somewhat similar to the third. It is intended to render the guideline inapplicable in instances where the mentally disabled person created no disturbance whatever but was *simply being reacted to intolerantly*. Examples that the Commission have been alerted to and, I think, accept, are: "dazed look and compulsive bodily twitching." As any of you who have been on psychiatric drugs know, such behaviour is a *common drug reaction*. The person can do nothing about it; disciplining the person for it, accordingly, constitutes *clear discrimination*. Other examples were in the area of idiosyncrasy. People who have undergone severe emotional crises may well have developed habits that look strange to others. It is not the idiosyncratic habits *per se* but *the intolerance of others* that are the problem. Once again, the manual maintains, *disciplinary action against the mentally disabled is discriminatory and should be disallowed*.

Emotional Stressors

I noted earlier that the Commission is committed to attempting to *persuade* employers to remove emotional stressors where these are a problem, albeit they no longer feel they can *enforce* such accommodation. The commitment seems a sincere one. The upshot is, if your job has built-in emotional stressors which are making it difficult for you to continue, you might well ask the Commission for assistance. Stressors identified in the manual and stressors, accordingly, which will probably be easiest for you to get officials to *understand*, include:

1. crowded and/or noisy working conditions
2. long work periods without a break
3. open-ended instructions

By all means, of course, introduce others where appropriate.

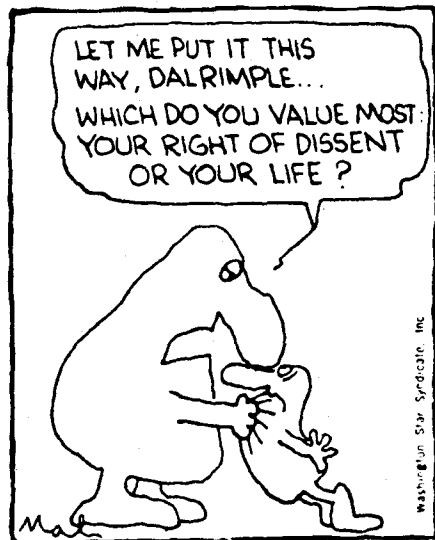
Discriminatory Hiring Practices and Policies

It is gratifying that the Commission prohibits discrimination in this area since it is an area where the mentally disabled generally meet with discrimination. I am not sure how much help the Commission will really be here, though. As things now stand, the Commission allows employers to disqualify the disabled from jobs which present obstacles to their functioning properly, this, note, *without really defining what constitutes a legitimate obstacle*. Without such definitions, discrimination is bound to occur. What is also problematic (though psychological testing has its place) — the Commission has no objection whatever to employers virtually bombarding potential employees with a battery of psychological tests. We all know that psychological testing is extremely trying for people who are vulnerable, for people who have undergone traumatic experiences, etc. Such bombardment, accordingly, is unlikely to result in a fair assessment. Another difficulty is: The Commission has no objection to employers asking questions like, "Have you ever been in a mental hospital?", "Have you ever had a 'mental disease'?", etc. You can always lie, of course, but *lying will jeopardize your position if you get hired and end up needing the Commission's assistance at a later date*. The Commission's response is that there is no reason to prohibit these questions. Asking them does not constitute discrimination. Indeed, it *does not*. But *we all know that employers tend to discriminate when told, "Yes, I have been in a mental hospital," and we all know that such discrimination is almost impossible to prove*. Overall, in fact, in these days of chronic unemployment where there are hundreds of applicants for each position, people are unlikely to be able to prove that discrimination ever had anything to do with their not being hired.

This notwithstanding, I think we can make some use of the Commission's prohibition against discriminatory hiring practices. When at interviews, people might be on the lookout for statements like, "Sorry, Mac, we don't hire ex-alcoholics," or "We don't care what else is wrong with you just so long as you ain't one of them manics. We hired a manic once and we sure won't make that mistake again." If an interviewer is stupid enough to say something like this, and some are, you have a case.

Equal Access to Services

As noted earlier, the mentally disabled are now assured equal access to services. Here the Commission *actually has the authority* to require reasonable accommodation. You are



most likely to be able to avail yourself of the "equal access" guarantee when it comes to:

1. banks, and
2. training programs.

At some time or other most of you have had the humiliating experience of having a bank employee tell you, "Don't bother bringing us your welfare cheque. We won't cash it." This is a *clear* violation. The Commission will act on it. Similarly, many have been repeatedly handed lines like "Oh, we'd take you in a course if you were more stable, but as things stand ..." Whether you are "stable" or not, *you have a right to manpower retraining*. You have the same right as the so-called "stable." Again, the Commission will back you.

As regards other *federal services*,³ organizations have been given a period of grace in which to effect the necessary changes. So satisfaction may take a while.

The Actual Complaint Process

Unfortunately, seeing justice done is not as simple as spelling out a few facts to a sympathetic person. The complaint process is *long, complex and uncertain*. You may have to interact with quite a number of people before you finish. Some of them, moreover, may be quite hard-nosed.

The first person you will see is the intake officer. The job of the intake officer is to hear your story, clarify what the complaint is, what the grounds are, and then fill out the appropriate forms. If your complaint reaches the next stage, an Investigator takes over. As is understandable given the nature of his/her job, the Investigator is usually the most "hard-nosed" of the officials. The Investigator is a bit like Jack Webb in the old Dragnet series. What he/she wants are "the facts, ma'am, and nothing but the facts." The Investigator may well ask you more questions. Besides talking to you, the Investigator will go to the place of business or wherever else the alleged violation occurred, will ask questions of everyone concerned, look for inconsistencies, ask more questions, and fill out more forms. While the investigation is in process, you *may* be asked to take certain psychological tests and/or be seen by a "specialist," though you *may not* be. If you are, here, as with everything else, you will have to make your own decision. Be aware, though, that if you refuse, the case may grind to a halt, or at least, be *seriously* jeopardized. If the Investigator agrees that the complaint should go further, a Mediator is now called in. As the title suggests, the Mediator attempts to mediate between you and the other party. Should mediation prove successful, and it often does, the process ends here. Should it not and should the Commission consider this a case to be proceeded with, it will now summon a Human Rights Tribunal. A Human Rights Tribunal consists of not more than 3 members, none of whom may *either* be a member of the Commission *or* anyone who has been involved in this case. The Tribunal may decide to dismiss the case. (That means you *lose*.) It may decide that discrimination has occurred and order a cessation of said discrimination. (That means you *win*.) And it may oblige the transgressor to compensate the victim. (That means you've *hit the jackpot*.)

If fewer than 3 people have made up the Tribunal, *either party* may appeal its decision so long as an appeal is registered within 30 days. When an appeal occurs, the Commission summons a Review Tribunal. The Review Tribunal will either dismiss the appeal (i.e., uphold the decision of the original Tribunal); or it will allow it and render the decision which, in its opinion, the original Tribunal should have rendered.

Here the process ends. It's not short. And it's not sweet. But you have some chance of seeing justice done.

Myths and Facts About the Process

Myth

Fact

1. The Commission can protect me while I am in a psychiatric facility.

2. I'm bound to lose. People at the office will all say I'm crazy. They'll use colourful language in describing my action. They will drag up my past. I haven't a ghost of a chance.

3. In areas where the Commission has no right to *compel* change but can only try to *persuade*, there's no point in going to them. My employer's a creep. He's hardly like to make a change he doesn't have to.

4. If I have any kind of case at all, I've got it made. Human rights people are *always* on the side of the underdog.

5. A Human Rights Tribunal has no real authority, so even if they find for me, nothing will change.

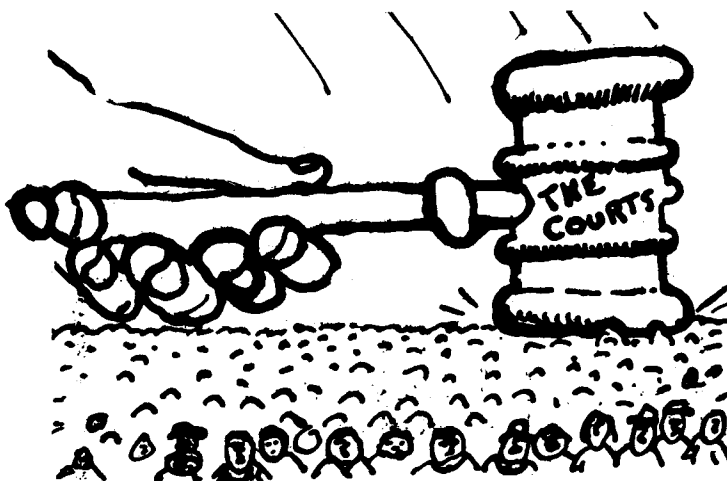
1. At present, psychiatric facilities are outside the Commission's jurisdiction.

2. It's conceivable you'll get "snowed." While I wish the odds were with you, the fact of the matter is they're not. But you *do* have a chance. The Commission is well aware that the other side will say you are crazy, will use colourful language, etc. The job of the Investigator is precisely to "cut through the crap" and find out what really happened.

3. Mediation often *does* succeed in such circumstances. Fortunately for us, even creeps are not immune to "consciousness raising."

4. The officials claim to be impartial. Now, of course, no one is ever *completely* impartial. Everyone has a bit of a bias, and with *some officials*, that bias may well be on your side. The bias, however, may be *too slight to really make a difference*. Moreover, the bias could easily be *on the other person's side*. An official may even have an *overwhelming* bias on the other side. An event which happened to Ruth Morris, once head of the Toronto Bail Program, is instructive in this regard. Afraid that an excon she had hired would be fired the moment she was no longer around, Ruth called up the Commission and asked what she could do to prevent this from happening. The official automatically assumed that what Ruth *really* wanted to know was *how to get around having to hire an excon*, and she proceeded to tell her. My own sense, from my limited interaction, is *overall*, the Commission's bias is *with the employer* but not overwhelmingly so.

5. In areas where it has jurisdiction, the Human Rights Tribunal has the same authority as a court of law.



Pointers to Keep in Mind When Dealing with the Commission

1. If you use concepts the Commission is familiar with, you have a better chance of winning. Accordingly, wherever possible refer to stressors, distinctions, and arguments they are aware of. Where these are inappropriate, of course, you'll have to improvise.

2. As the process may well prove trying, it is wise to establish a support network for yourself ahead of time.

3. If you find yourself agitated and alone at any point in the process or even at its conclusion, you might contact a self-help group in your area. Alternatively, you could advise the Commission you are in need of emotional support. They know that problems of this nature arise and they have lists of befriending agencies they can refer you to.⁴

4. Before approaching the Commission, practice explaining your case to a friend who is not already familiar with it. Practicing can help prevent you from getting flustered later. At the same time, you might get your friend to tell you what he thinks you've said and what impressions he is left with. Advance feedback can be useful.

5. You may have the misfortune of running into a particularly insensitive official. There are "bad eggs" everywhere, and even "good eggs" have "off days." If this happens, explain your case as best you can, but don't explode. Unfortunately, even *totally legitimate* anger is likely to be taken as an indication that you really *did* create a disturbance. It's the sort of thing that triggers people's latent prejudice. Suddenly you get transformed into a "raving lunatic" in their eyes, and their power of judgment goes. **DON'T LET THIS HAPPEN TO YOURSELF.** If the official persists in being insensitive, you're better off simply asking to be transferred to another worker.

6. If you lose, don't guilt trip yourself; and don't tell yourself it was "all a waste of time." The detail you're "kicking yourself" for forgetting to mention might not have "tipped the balance." You *stood up for yourself*, AND **THAT'S VALUABLE IN AND OF ITSELF.** Moreover, you may have sensitized officials to issues they had not previously considered; and your efforts, accordingly, may well help a future victim win.

Thoughts for the Future

I have clarified the amendment, the complications, and the process as best I can. And I have shared my thoughts on how one might best use what we now have. I have done what I set out to do, in other words, and it is time to end. In ending, I would like to identify some additional changes we might start arguing for.

Areas where I think we can at least effect a *better* compromise are:

1. the guideline discussed earlier;
 2. both the *employer's* and the *Commission's* use of psychological testing.
- Eventually, I think the government will agree that it is discriminatory having such a guideline for the "mentally disabled" only. And in both cases, I think the government *could be persuaded* to introduce needful distinctions, qualifications, and limitations.

The government might similarly be persuaded to restrict the types of questions employers are allowed to ask at job interviews. I would agree, of course, that there are *some* circumstances in which certain questions about emotional and physical states are in order. If the job involves operating dangerous machinery, for instance, it seems reasonable to find out if the person is epileptic and to disqualify him if he is. In most cases, however, the question is completely *unnecessary*, and not hiring a person because of epilepsy is *clear discrimination*. *The question accordingly, should be disallowed*. By the same token, the more general question, "Have you ever been in a mental hospital?" is completely unnecessary, is conducive to discrimination, and *should be disallowed*. A further change which this analysis implies is the need for *far more explicit criteria as to when it is and when it is not permissible to refuse to hire a disabled person*.

Finally, a more ambitious change we might also start lobbying for is the extension of the "equal services" guarantee to people in psychiatric facilities. At the moment, as mentioned earlier, psychiatric facilities are outside the

Commission's jurisdiction. The Commission, moreover, wouldn't want to touch this issue "with a ten foot pole." And it's the last thing in the world the medical profession would want. Nonetheless, let's start working on it. It would be nice, it would be VERY NICE, to begin making inroads here. As I am sure most readers agree, it is high time that people in psychiatric facilities were regarded as *bonafide human beings* entitled to *the same human rights as everyone else*. Being second-class citizens just isn't good enough.

NOTES:

1. By 'mental disability' is intended the person who's developmentally delayed, emotionally disturbed, or brain-damaged, or the expsychiatric patient or person suffering from so-called "mental diseases," et cetera. Although the labelling of a person by such terms as these in itself frequently is a matter of discrimination, the use of at least some of these terms is, unfortunately, unavoidable in a discussion such as this. Therefore, even though I will after this discontinue isolating these phrases by means of quotation marks, this *does not mean* that I necessarily *accept* the categories used. *That* might be the subject of another paper.
2. It is important to remember that the distinctions have the status of suggestions only.
3. The federal Commission, note, has no jurisdiction over *provincial services*.
4. My invitation to self-help and befriending groups is to assist the Commission in this area. After all, *it is your own people who are in need; and you are the ones best qualified to help them*. Cooperating with the Commission in this area, moreover, gives you an "in." Gain their respect, and they are more likely to be able to hear you when you ask for changes.

Support Incest Survivors and Other Victims of the Therapeutic State

A call to all ex-inmates and current inmates in psychiatric institutions and prisoners and ex-prisoners who are incest survivors, recovering alcoholics and/or drug addicts.

The therapeutic state is systematically setting us up against each other. i.e. Incest survivors are often incarcerated when they speak out and expose the men who are responsible for the violence committed against them. Recently, a 12 year-old incest survivor was jailed because of her fear of life-long reprisals from her father and society, which resulted in her decision not to testify against him.

A high percentage of people who are incarcerated either in psychiatric institutions or prisons are originally placed there as a result of drug addiction and/or alcoholism. Recovering alcoholics and/or drug addicts are intimidated into recovery with the threat of their imminent death, or "something much worse — insanity."

What are the conflicts for recovering people within the ex-inmate's movement? Is the issue of incest and/or drug addiction/alcoholism an outgrowth of the therapeutic state?

Are these issues separate from each other?

Can incest survivors and recovering alcoholics/addicts work within the ex-inmates movement?

We need feedback on these issues. Please share with us your struggles/conflicts around incest survival, drug addiction and/or alcoholism and incarceration in prisons and psychiatric institutions.

Please write to us and/or come to the 12th Annual International Conference for Human Rights and Against Psychiatric Oppression to confront these issues. If you are unable to come to the Conference, please write to us about these struggles.

Linda Lane
Barbara Wish
1232 Gaylord St. No. 4
Denver, CO. USA 80206.

ELECTROSHOCK


\$1.50



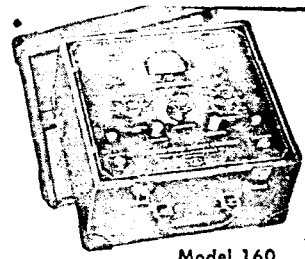
Published by Phoenix Rising.

Shock treatments get law's blessing

Psychiatric boards can over-rule patients



ELECTROSHOCK
IS A CRIME
AGAINST HUMANITY



Model 160
\$250
As illustrated with

PORTABLE
UNIT

The fight to refuse treatment

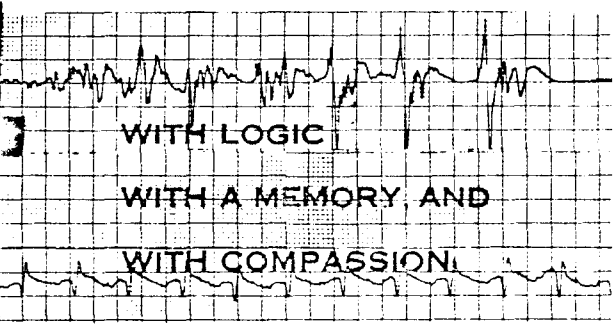
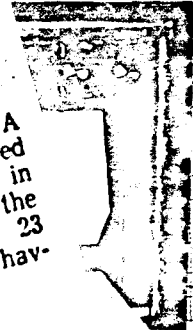
Involuntary psychiatric patients' next of kin have no say about electric shock treatments if doctors and a hospital psychiatric review board deem them necessary, an Ontario Superior Court judge ruled yesterday.

records of injuries accompanying ECT showed fractures of arms, legs, pelvis and spine, as well as choking and arrested breathing, occasionally followed by death.

AT LAST, A NEW ECT INSTRUMENT!!!

Shock treatment left mom blank

VANCOUVER (CP) — A woman who says she received more than 100 electric shocks in an experiment sponsored by the Central Intelligence Agency 23 years ago cannot remember having her first five children.



Now ECT procedures can be conducted in a truly scientific manner. The MECTA ECT stimulator and monitor is the most advanced in the field of Electro Convulsive Therapy.

8 months in zombie-like haze

I am very disappointed to see that the use of electroconvulsive therapy is to be continued. Speaking as a survivor of ECT

by Bud Osborn

great majority of whom feel they were harmed by it

Annihilation Therapy

Bini in 1942 suggested the repetition of ECT many times a day for certain patients, naming the method "annihilation." This results in severe amnesic reactions that ap-

ECT - 11

fragments come back
sometimes, a smell here,
a voice there, a face
that has changed,
a body never really
the same, people who are kind,
say, yes, you had
a nice visit, yes,
you were O.K.

then why
can't i remember?
desperately
i memorize everything
now
names, places, seconds,
ingredients
so i don't scare
anyone.

reality therapy by one
the dates, the days, the years
the implications of having been
through the dark deep glass
that was once only Alice's.

ECT - 12

thunderstorms are new,
terrifying, did anyone comfort
me as a child?

ECT - 13

the social worker comes
gently tells me
there is a slight disability
(in kinder words)
now she visits you
you tell her
there is no love
i crash like
a teenager
rejected. i take to bed
like victorian heroines.
i rage in my cell-like
cold bedroom. eventually...
i walk again your walk —
lie on the table again —
watch the needle go in —
i trusted Dr. O'N.
did he ever learn
there is no return walk.

ECT - 14

you look worried
i try to smile
a smile that might
stir a remembrance
in you — i am no longer merely
afraid of psychiatrists
their power terrifies
me, as an old
wound
throbs on my right temple
and i drink coffee
smoke cigarettes
tell no one —
not even you
who have been recently
shocked

ECT - 16

the cigarette butts
are rising in the ashtray
the people who know me
who i don't remember well
come take me to hospital
hand me over to the keepers.
the torture chamber
is upstairs i tell them
they do not know. i think
the good doctor loves me
will never again
take me
to that sterile room
will never again
watch me or feel my ribs
eat into his gentle hands
— i watch out for
the cruel
ones the ones with steel
in their eyes
for the good doctor
is gone.

by *Diane Elizabeth Fry*

ECT - 2

driving home
i saw the diamonds
in the snow
still i could not
remember how it was
i only saw
diamonds
in the snow
& wondered why

ECT - 6

do not speak
to me of pain
i am it
so also brothers
sisters lovers
stretched out
in desperation
... we submit
to degrees
of pain
— 2 days, a week
apart from the shocks
are administered
— there is a terror
in our eyes no smiles
can erase, there is a fear
in our ways no caress
can cancel, there is a morning
star near the moon before
the dawn.

Ten years later
i can write
without shaking
can stare at the sky
without ice starting
to flow through
my veins, can become
tough, can whisper
"how are you — doing"
without cracking up
ten years ... my
good doctors.



The Unfinished History of a Medical Scandal: Electroshock 1937 to Present

We are indebted to Leonard Roy Frank's *The History of Shock Treatment* (1978), and to many issues of *Madness Network News* for providing much of the information used in preparing this calendar. Although we are not citing specific references from these sources, we will be glad to provide them upon request.

1937-38

Italian psychiatrist Luigi Bini conducts electroshock experiments on dogs using 120 volts for 1/5-1/20 sec. with electrodes placed in the mouth and anus. The shocks produce severe convulsions and massive irreversible damage throughout the nervous system, including the brain.

1938

Italian psychiatrist Ugo Cerletti visits a Rome slaughterhouse where he sees pigs efficiently killed after being quickly stunned and rendered unconscious by electricity administered through large "tongs" on the pigs' heads.

Theorizing that epileptics rarely become "schizophrenic" and that epileptic seizures can cure "schizophrenia", Cerletti decides to use electroshock on humans. The first shock patient is a "schizophrenic" man arrested for wandering around a railroad station and forcibly taken to Cerletti by the police. Cerletti administers a shock of 70 volts which fails to produce unconsciousness. Over his patient's protests, Cerletti administers a stronger shock of 125 volts which produces a grand mal seizure and unconsciousness.

1940

Electroshock is introduced in the United States. In January Dr. Victor E. Gonda administers the first shock treatment in the USA at Parkway Sanitarium in Chicago. In February, psychiatrists David J. Impastato and Renato J. Almansi shock their first patient at Columbus Hospital in New York City.

1941

Lobotomist Walter Freeman admits that electroshock, insulin coma shock and metrazol shock cause brain damage which is "therapeutic." "It has been said that if we don't think correctly, it is because we haven't 'brains enough.' Maybe it will be shown that a mentally ill patient can think more clearly and more constructively with less brain in actual operation."

1942

Neurologists Bernard J. Alpers and Joseph Hughes publish a report on the first human ECT autopsy study which shows massive brain damage from electroshock, especially hemorrhages. Shock treatments spread rapidly in the United States. Over 250 psychiatric institutions use electroshock, insulin shock and/or metrazol shock. From 1935 to 1941, over 170 state institutions used shock on 68,688 patients.

1944

Lobotomists Walter Freeman and James W. Watts report that electroshock causes brain damage. "The evidence assembled from various fields of investigation in regard to shock therapy points definitely to damage to the brain."

1948

Multiple shock treatments are used to regress patients showing "little or no improvement". Psychiatrists Cyril J.C. Kennedy and David Anchel subject 25 patients to "two to four grand mal convulsions daily until the desired degree of regression was achieved . . . A patient had regressed sufficiently when he wet and soiled or acted and talked like a child of four . . ."

Psychiatrist Paul H. Hoch claims shock causes brain damage and tries to justify it: "This brings us for a moment to a discussion of the brain damage produced by electroshock . . . Is a certain amount of brain damage not necessary in this type of treatment? Frontal lobotomy indicates that impairment takes place by a definite damage of certain parts of the brain."

1948/51

Psychologist Irving L. Janis conducts classic studies on memory loss caused by electroshock. All 19 shock patients show serious, permanent memory loss, some extending back 10 to 20 years before shock. An intensive follow-up study shows serious memory impairments 3½ months to 1 year after the last shock.

1950

Psychiatrist and former American Psychiatric Association President Jules Masserman claims electroshock causes brain damage: ". . . these experiments supported the growing conviction among psychiatrists that electroshock and other drastic procedures . . . produce cerebral damage which charges the indiscriminate use of such 'therapies' with potential tragedy."

A 3-year old child is shocked by psychiatrist Lauretta Bender. She administers 20 daily shock treatments to this "mute and autistic" child in Bellevue Hospital, New York City.

1953

Shock deaths reported. Dr. W.S. Maclay, President of the Royal Society of Medicine, reports that in England during a 5½ year period, 1947-1952, there were "62 deaths associated with electroconvulsive treatment . . ."

1956

Psychiatrist Lothar B. Kalinowsky, a leading shock advocate in the USA, reports that drugs administered before shock treatments (such as barbiturate-anaesthetics, tranquilizers and the muscle-relaxant succinylcholine) increase risks including death.

1957

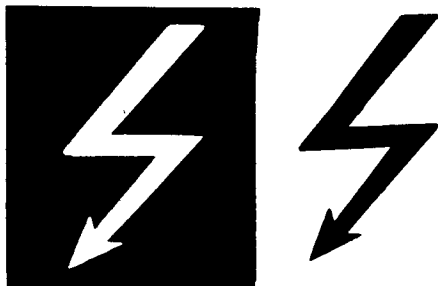
Psychiatrist David J. Impastato, a prominent shock advocate in the USA, publishes a report of a survey of 254 deaths following electroshock, including 40 previously unpublished deaths. Brain damage is found to be the leading cause of death in shock patients under 40 years old.

1958

Psychiatrists D. Ewen Cameron and S.K. Pande publish a report on their "complete depatterning" or brainwashing experiments conducted at the Allan Memorial Institute at McGill University in Montreal. The "depatterning" involves severe personality disorganization including massive, permanent memory loss produced by a combination of prolonged, drug-induced sleep (barbiturates and chlorpromazine) and intensive shock treatments. 26 patients, including 21 women, are subjected to "sleep therapy" and multiple shocks including "four or five shocks within a period of two or three minutes ... Complete depatterning is achieved somewhere between the 30th and 60th day of sleep and after about 30 electroshock treatments." After a 2-year follow-up period, all the patients showed "emotional blunting", loss of energy, severe memory losses and many "relapsed." (D. Ewen Cameron and S.K. Pande. Treatment of the Chronic Paranoid Schizophrenic Patient. *Canadian Medical Association Journal*, Jan. 15, 1958, vol.78, 92-96.)

1959

Electroshock is used as a torture technique during the Algerian War. ". . . psychiatrists in Algeria, known to numerous prisoners, have given electric shock treatments to the accused and have questioned them during the waking phase, which is characterized by a certain confusion, a relaxation of resistance, a disappearance of the person's defenses. When by chance these men are liberated because the doctor, despite this barbarous treatment, was able to obtain no information, what is brought to us is a personality in shreds." (See Frantz Fanon, M.D. *A Dying Colonialism*, 1959; also L.R. Frank, 1978, p.68.)



1960

Cameron publishes another article on "depatterning" schizophrenic" and "psychoneurotic" patients. During 1958-59, he has subjected 53 "schizophrenic" patients to prolonged "chemical sleep" for an average of 15-30 consecutive days and an average of 20-30 shocks over a 2-month period. During the first days, all patients were subjected to 4 or more shocks daily. At 2-year follow-up, virtually all patients showed massive memory losses, confusion and disorientation. The third and final state of depatterning involved "extensive breakup of behaviour . . . by means of intensive electroshock . . . in association with prolonged sleep." In this stage, the "depattered" patient "lives in the immediate present. All schizophrenic symptoms have disappeared. There is complete amnesia for all events of his life." In other words, permanent memory loss. (D. Ewen Cameron. Production of differential amnesia as a factor in the treatment of schizophrenia. *Comprehensive Psychiatry*, vol. 1, no. 1, Feb. 1960, 26-34.)

1961

Nobel Prize-winning writer Ernest Hemingway commits suicide by shooting himself in the head a few weeks after his release from Mayo Clinic in Minnesota where he had received a second series of shock treatments. A few months before his death, Hemingway told biographer-friend A.E. Hotchner, "Well, 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." (See A.E. Hotchner, *Papa Hemingway*, Random House, 1967, pp. 308-334; also L.R. Frank, 1978, p. 70.)

1962

Psychiatrists Cameron, Lohrenz and Handcock publish another article on their "depatterning" shock experiments with "schizophrenic" patients at the Allan Memorial Institute in Montreal. To "depattern" these patients, the psychiatrists subjected them to 12 shocks daily for the first few days; each patient was subjected to an average of 30-40 shocks; some had 65 within 1-2 months. Over a 3-year follow-up period, the patients were subjected to an additional 23-150 shocks. Only one patient showed "complete recovery." All patients showed "complete amnesia" or massive, permanent memory losses.

Ken Kesey publishes *One Flew Over The Cuckoo's Nest*: " 'The Shock Shop' Mr. McMurphy, is jargon for the EST machine, the Electric Shock Therapy. A device that might be said to do the work of the sleeping pill, the electric chair, and the torture rack. It's a clever little procedure, simple, quick, nearly painless it happens so fast. But no one ever wants another one. Ever.' "

1963

Shock doctor Ugo Cerletti claims he wants shock abolished. "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.' "

1965

An anonymous psychiatrist reports his personal experiences with electroshock! He had had 8 shocks during a 3-year period for depression. Although the psychiatrist claimed he suffered minimal or temporary memory loss, he couldn't remember the name of his shock doctor and "where I had met him before." After his second and last course of treatment, he experienced "many gaps in my memory" and needed a map to help him find his way around the subway. He also had "considerable difficulty in finding my way about my filing system, which previously was familiar to me . . . but now seems so strange that I am at a loss to know where to start."

Two Soviet psychiatrists (Anatoly Portnov and Dmitry Fedotov) report that shock causes brain damage and severe memory loss. "The method . . . involves pin-point hemorrhages in the brain tissue. A course of convulsive therapy is followed by a memory loss of retrograde or anterograde amnesia, which is a clinical manifestation of both the functional and the organic changes occurring in the brain due to the electric shock."

1967

Psychiatrist Lloyd H. Cotter reports that he subjected 250 unwilling Vietnamese patients to a series of unmodified shocks for the purpose of motivating them to work. After the shock treatments and 3 days of forced starvation, all "volunteered" to work.

In an independent, follow-up study of 79 of Cameron's "depatterned" patients, psychologist A.E. Schwartzman and psychiatrist P.E. Termansen find permanent and severe memory loss in 60% of 27 patients. The memory loss extends from 6 months to 10 years before the shock treatments.

1968

Six psychiatrists report that both bilateral shock (electrodes placed on both sides of head) and unilateral shock (electrodes placed on one side, usually the 'non-dominant' side) produce severe memory loss. "Both bilateral and unilateral ECT were found to produce statistically significant amounts of memory loss . . . there are no decisive differences that would dictate uniformly the preference of one treatment mode over the other."

1971

A 94-year-old woman in Minnesota is shocked because "she refused to eat and was . . . uncooperative, agitated, depressed, and paranoid." After 5 shock treatments, the woman shows "dramatic improvement." She is then discharged to a home for the aged. (Shocking the elderly has since become common practice in North America.)

1973

In a Massachusetts Task Force report on shock, ten psychiatrists comment on some adverse effects of electroshock: "Treatments leave irrecoverable gaps in memory and that a large number of treatments cause intellectual deterioration, seizures, or personality blunting akin to the effect of lobotomy."

Shock survivor Ted Chabasinski publishes his autobiographical account of his incarceration and shock experiences in Bellevue Hospital in New York City. At the age of 6, Ted was one of the youngest children in the USA to be shocked by Dr. Laretta Bender. (See Bender, 1950.) "I was one of the first children to be 'treated' with electric shock. I was six years old. I gave up that little boy for dead thirty years ago, but now he's come back to life, kicking and struggling. 'I won't go to shock treatment, I won't!' It took three attendants to hold me. At first Dr. Bender herself threw the switch but later when I was no longer an interesting case my tormenter was different each time . . . And so I spent my childhood waking from nightmare to nightmare in locked rooms with scraps of torn comic books and crusts of bread and my friends the mice, with no one to tell me who I was. And when I was seventeen and the shrinks thought they had destroyed me, they set me free. I was free."

(Ted Chabasinski. The other half. *Rising Up Crazy*. N.Y.: Summer 1973; reprinted in L.R. Frank, *The History of Shock Treatment*, 1978, 26-27; also in *Phoenix ising*, vol.2, No. 2, 1981, 16A-18A.)



1974

Shock survivor Marilyn Rice publishes her story in *The New Yorker* magazine. A leading economist for the U.S. government, Ms. Rice had been given 8 shock treatments for a depression she experienced after dental surgery which greatly disfigured her jaw and mouth. As a result of the shock treatments, she suffered permanent loss of both memory and research skills, and was unable to return to her previous work or to relearn the skills necessary for it. She files a lawsuit against shock doctor John E. Nardini for \$1,000,000. ("Annals of Medicine". *The New Yorker*, September 9, 1974.) See also '1975'.

Shock survivor Leonard Roy Frank publishes an autobiographical account of his hospitalization and shock treatments in California. Parts of Frank's medical file and correspondence are also included. Frank had been subjected to 85 shock treatments, including 35 electroshocks and 50 insulin coma shocks (many administered simultaneously). Shock had permanently erased two years of experiences before the last treatment.

The Network Against Psychiatric Assault (NAPA) demonstrates against the Langley-Porter Neuropsychiatric Institute, a major 'shock shop' in San Francisco. Demonstrators present hospital authorities with a petition signed by 1400 people demanding that Langley-Porter "stop the use of electric shock therapy immediately."

Shock's "effectiveness": Report of a shock machine in England that had not been working for two years. Patients claimed "the treatment had done them good . . . All the patients had been getting for two years was thiopentone and Scoline (anaesthetics)—and no one had noticed." (J. Easton Jones, M.D. Non-ECT. *World Medicine*, Sept. 11, 1974, p.24.)

1975

On January 20, the San Francisco Mental Health Advisory Board holds public hearings on electroshock. Over 100 people including many shock survivors and other ex-psychiatric inmates attend and give personal testimony against shock.

On March 19, NAPA protests against shock treatment at Herrick Memorial Hospital in Berkeley, California.

Shock doctor Allan M. Gunn-Smith admits to having "administered during the last 6 years more than 4000 ECT treatments to 200 persons mostly between the age of '65 and 100.'" at Stockton State Hospital in California.

Shock survivor Marilyn Rice lost her case against shock doctor John E. Nardini in a 12-day trial by jury.

Alabama Shock Case: In *U.S. v Codina*, 7 shock victims charge 3 psychiatrists and a hospital administrator with administering shock to them without their informed consent. The shock victims assert that the psychiatrists subjected them to "47 unmodified" shocks (without anaesthesia or muscle relaxant) over a 2-year period in Bryce Hospital in Tuscaloosa. They also claim the hospital violated 'Standard 9', a state law prohibiting the administration of shock, psychosurgery, "aversive" behaviour modification and "other unusual or hazardous procedures" without consent. Judge Frank M. Johnson, Jr. found the psychiatrists, including shock doctor F.D. Codina, not guilty of criminal or civil contempt.

1976

Neurologist John Friedberg publishes his book *Shock Treatment Is Not Good For Your Brain* (Glide, 1976), which features biographical accounts, interviews with shock survivors and clinical-research studies documenting brain damage and permanent memory losses resulting from electroshock.

NAPA and WAPA (Women Against Psychiatric Assault) hold a one-month sleep-in demonstration in the office of California Governor Edmund Brown, Jr. The demonstrators demand the absolute right to refuse treatment and other rights including minimum wage for work performed by inmates. Since Governor Brown fails to act on any of these demands, over 100 demonstrators and supporters hold a 'Tribunal on Psychiatric Crimes' in the Governor's office on July 14.

California passes a revised anti-shock law which is now codified in the *California Welfare and Institutions Code*, the first and only law in the USA which restricts electroshock. Among its provisions: the law prohibits administering shock to any child under 12; prohibits administering shock to any person who refuses it and is capable of informed consent; spells out informed consent; imposes a maximum fine of \$5000 for each violation of any part of the Act.



1977

Neurologist Robert J. Grimm issues an anti-shock statement to the American Psychiatric Association Task Force on ECT: "... where ECT is used to render patients into states, however temporary, indistinguishable from acute brain syndrome, as with multiple ECT technique programs, it is unconscionable. There is sufficient information from both past studies and more current electrophysiologic techniques to suggest that ... organic damage to the brain occurs with ECT ... the actual practice of ECT ... is neither uniform nor under routine surveillance ... this technique is unregulated either by science or by any professional attitude ... The risk ... is ... some permanent intellectual and psychosocial morbidity as a consequence of the procedure ... the 'risk-benefit' ratio ... (is) a vulgarity ... I know of no evidence that ECT has prevented suicide ..."

The Royal College of Psychiatrists in Great Britain publishes its position paper on electroshock, claiming: "There is substantial and incontrovertible evidence that the ECT procedure is an effective treatment in severe depressive illness ... There is good if not conclusive evidence that the ... convulsion is necessary for the therapeutic effects of ECT ... Long-lasting memory impairments have been identified ..." (The Royal College of Psychiatrists. Memorandum on the Use of Electroconvulsive Therapy. *Brit. J. Psychiat.* vol. 131, Sept. 1977, 261-272.)

1978

The American Psychiatric Association publishes its Task Force Report on ECT based on a survey of roughly 3000 psychiatrists, 15% of the APA membership. Among the report's many findings and recommendations: 22% of psychiatrists claim they use shock; almost one-third are opposed to shock; 16% believe it should be abolished or restricted; 41% believe that electroshock can cause brain damage. Concerning memory loss, the shock doctors say that 27% of their patients complain of permanent memory loss for the entire course of treatment, and 15% complain of permanent memory loss for the period "immediately prior" to shock treatments. The APA admits that "memory complaints long after ECT are common ... extensive ECT ... may lead to long-lasting or permanent impairments in memory ... memory for events that occurred days prior to ECT may be permanently lost." Still, the APA reports that shock is "effective" for "severe depression" and "severe psychoses", and it recommends informed consent.

Shock survivor and shock abolitionist Leonard Roy Frank publishes *The History of Shock Treatment* which features autobiographical accounts, anti-shock and pre-shock views of psychiatrists, a "Shock Doctor Roster," and "ECT Death Chronology" documenting 387 shock-related deaths reported in the English language literature.

1979

Psychiatrist Peter R. Breggin publishes *Electroshock: Its Brain-Disabling Effects* (Springer). Breggin asserts his "brain-disabling hypothesis" that shock "works" by always disabling the brain: it causes an acute organic brain syndrome. Over 100 animal and human autopsy studies, clinical studies, neurological studies and 6 detailed case histories are presented to support this position.

1980

The Canadian Psychiatric Association publishes its position paper on ECT. The CPA claims electroshock is a "safe and effective treatment modality", that electroshock does not cause permanent memory loss or brain damage, and that it should be administered for "depression" and "schizophrenia." Like the Royal College of Psychiatrists, the CPA believes the seizure itself is "therapeutic." "The therapeutic benefits of ECT are associated with the epileptiform discharge in the brain." W.J. Pankratz, M.D., *Electroconvulsive Therapy: The Position of the Canadian Psychiatric Association. Can. J. Psychiat.*, vol.25, 1980, 509-514.)

1981

Four British psychiatrists publish the report of a study which documents the shock-brain damage connection. CAT scans of "elderly depressives" showed brain damage or "frontal lobe atrophy" in 15 of 22 patients who had shock treatments. (S.P. Calloway, R.J. Dolan, R.J. Jacoby and R. Levy. *ECT and cerebral atrophy: A computed tomographic study. Acta Psychiat. Scand.*, 1981, vol.64, 442-445.)

1982

On November 2 the citizens of Berkeley vote by a clear majority (61%) to ban electroshock in their city. This is the first time citizens of any jurisdiction in North America are allowed to vote on a psychiatric or quasi-medical procedure. The shock ban ordinance makes electroshock a misdemeanor punishable by a maximum fine of \$500 for each offence. The anti-shock issue ('Measure T') was put on the ballot by the Coalition To Stop Electroshock through its successful campaign, including the collection of 2,452 petition signatures.

On May 17 during the 10th Annual International Conference on Human Rights and Psychiatric Oppression and on the occasion of the Annual Meeting of the American Psychiatric Association, a sit-in demonstration is held in the lobby of the Sheraton Centre Hotel in Toronto. Sixteen ex-psychiatric inmates have organized this non-violent civil disobedience to protest against the APA and forced treatments including electroshock. (See "The sit-in at the Sheraton." *Phoenix Rising*, vol.3, no.1, 1982, pp.15-17.)

The US Food and Drug Administration holds public hearings in Washington, D.C. on the reclassification of shock machines. Shock machines are presently classified in Class III, "high risk." The American Psychiatric Association lobbies the FDA to reclassify shock machines in Class II or "low risk." Many shock victims and anti-shock professionals testify against the reclassification. The FDA panel recommends reclassifying shock machines in Class II in January 1983.



1983

On January 13, Judge Donald P. McCullum issues a temporary injunction preventing enforcement of the Berkeley shock ban as a result of a lawsuit by California psychiatrists who claim that California state law pre-empts municipal law and that the shock ban violates the patient's right to choose ("treatment"). The shock ban has lasted 41 days; Herrick Hospital resumes shocking patients.

On March 15, 19 anti-shock demonstrators are arrested in Berkeley, California for blockading the entrance to the administration building of Herrick.

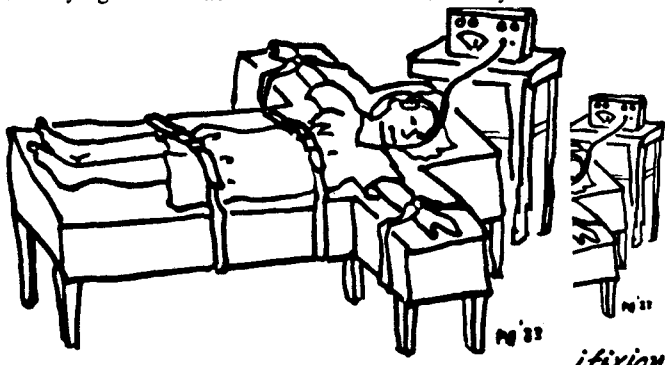
On May 1 at the Annual Meeting of the American Psychiatric Association in New York City, former US Attorney-General Ramsey Clark tells the psychiatrists: "Electroshock is violence."

On May 4 during the APA Annual Meeting in New York, non-violent civil disobedience is held at Gracie Square Hospital where live shock demonstrations are scheduled for interested APA members. In protest, 9 shock survivors peacefully chain themselves to each other and to the front door of the hospital. Police charge all demonstrators with "disorderly conduct"; within one hour everyone is released and given a traffic ticket.

On May 23-24 in Syracuse, NY during the 11th Annual International Conference for Human Rights and Against Psychiatric Oppression, non-violent civil disobedience is held at Benjamin Rush (Psychiatric) Center. Thirteen ex-psychiatric inmates, with the help of a 9-member support group, block the front entrance of the hospital for 15 hours.

On September 4 in California, Alameda Superior Court Judge Winton McKibben grants a motion for summary judgment, which supports the California psychiatrists' suit to overturn the Berkeley shock ban.

On September 27, a motion for intervention by the Coalition To Stop Electroshock in Berkeley is filed ex-parte, an informal hearing held before a research attorney who then makes a recommendation to the judge. The city, represented by Deputy City Attorney Manuela Scott, asks Judge McKibben to reconsider his previous ruling in the light of new evidence which involves unethical conduct by psychiatrist Martin Rubinstein (who had administered shock without informed consent at Herrick Hospital) and psychiatrist Ronald Bortman (charged with filing false insurance claims and with grand theft). Both psychiatrists represent the California psychiatrists in their lawsuit against the shock ban. On December 2, Judge McKibben rules against intervention by the Coalition and City.



ECT = Bloodless Crucifixion

On October 21 in Toronto, the first Public Forum on Electroshock and Other Crimes of Psychiatry in Canada is organized by the Ontario Coalition To Stop Electroshock. Many shock survivors and supporters give personal and political testimony against shock and other forced treatments in City Hall.

October 22 is the North American Day of Protest Against Electroshock. Protest demonstrations, vigils, and educational events are carried out by ex-inmate/antipsychiatry groups in Denver, Colorado; San Francisco, California; Boston, Massachusetts; Syracuse, New York; and Toronto, Canada. In Toronto, some 30 ex-inmates and supporters march to and protest in front of the Clarke Institute of Psychiatry, Ontario's 'shock shop.'

In December the first shock case in Canada is heard in Toronto. The case involves a woman inmate, "Mrs. T.", incarcerated as an involuntary patient in Hamilton Psychiatric Hospital since August 1983. Almost immediately after her admission, Mrs. T.'s psychiatrist, Paul Denew, has urged her to consent to electroshock, because he believes shock will relieve her depression and suicidal behaviour. Mrs. T. is competent and refuses. Dr. Denew then urges Mrs. T.'s husband and father to consent for her. Both also refuse. Then Dr. Denew and three other psychiatrists appeal Mrs. T.'s refusal to a Review Board which has the authority to overrule the refusal of any involuntary patient in Ontario. On October 22, the Board orders a series of shock treatments (up to 15) for Mrs. T., which are scheduled to start on November 2. Mrs. T. then retains lawyer/patients' rights advocate Carla McKague to represent her. In early November, the hospital agrees not to proceed with shock until the case is heard in court.

On December 1-2, the case is heard under judicial review by Madam Justice Van Camp in the Supreme Court of Ontario. Ms. McKague argues these basic points: 1. That electroshock is a form of psychosurgery as defined in the *Mental Health Act*; 2. That psychosurgery can not be administered to any involuntary patient in Ontario; 3. That therefore the Review Board exceeded its authority in ordering shock for Mrs. T.

Lawyer Peter Jacobsen, representing the hospital and Ministry of Health, attempts to discredit the expert medical opinion and testimony on behalf of Mrs. T. On December 5, Madam Justice Van Camp rules against Mrs. T. in claiming the medical-scientific evidence of brain damage caused by shock is "speculative", electroshock is thus not proved to be a form of psychosurgery, and therefore the Review Board can legally order shock. Before Mrs. T. can appeal on constitutional grounds, she agrees to be transferred to another hospital and another psychiatrist who promises not to give her shock.

Although the case is lost, Mrs. T. consequently succeeds in being spared shock. The case sparks considerable public and media concern over forced treatment. Health Minister Keith Norton tells the press he's "troubled" that shock without consent is allowed in Ontario.

On December 6, NDP Leader Bob Rae publicly criticizes shock and the lack of psychiatric inmates' rights in the Legislature. He asks Norton: ". . . how does the minister feel about a medical treatment of such seriousness and of such controversy being performed on a patient, not only against her consent but also against the consent of all the members of her family?" Rae also urges Norton to proclaim sections 66 & 67 in the *Mental Health Act*, which would give inmates more rights before review boards. (*Hansard: Official Report of Debates*, Legislative Assembly of Ontario, Tuesday, December 6, 1983, pp.3757-3758.)

In December, the *Canadian Journal of Psychiatry* publishes an article advocating the use of electroshock as "restraint." Psychiatrists Joel J. Jeffries and Vivian M. Rakoff describe how they forcibly subdued an "aggressive" and "threatening" 28-year old man diagnosed as suffering "a bipolar affective disorder." During two involuntary admissions to Toronto's Clarke Institute of Psychiatry in 1981, Jeffries and Rakoff subjected their unruly patient to a total of 8 shock treatments, including 4 administered in one day and 4 over two days, without either the patient's consent or that of his relatives. Before and after the shocks, they also forcibly subjected the patient to massive doses of Haldol ("250 mgs . . .") and chlorpromazine ("2400 mgs. daily.") In "restraining their patient, the psychiatrists violated Ontario's Mental Health Act by failing to seek approval (after the patient's refusal) from the local Review Board. Jeffries and Rakoff claim they couldn't wait a week for a board hearing because their patient presented an "emergency." Finally, the psychiatrists urge the legalization of electroshock to "restrain" difficult or "aggressive" patients. (J.J. Jeffries and V.M. Rakoff. ECT as a form of restraint. *Can. J. Psychiat.*, vol.28, Dec. 1983, 661-663.)

1984

On January 17 seven members of the Ontario Coalition To Stop Electroshock, three psychiatrists, and a psychiatric social worker, give personal testimony regarding shock at a meeting of the Local Board of Health in Toronto. The Board supports the Coalition in adopting a formal motion calling for an "immediate moratorium" on electroshock in Ontario pending further study and public hearings.

On January 18, Health Minister Keith Norton announces in the press that he plans soon to appoint "an international panel of experts" to study shock.

In February the press across Canada break stories regarding the complicity of the CIA (US) and the Canadian Government in funding brainwashing experiments conducted at the Allan Memorial Institute during the 1950s and 1960s. Procedures employed at the Institute as part of that "research" included "depatterning" (see reports for 1958, 1960 and—for a follow-up—1967: D. Ewen Cameron); "psychic driving" (repeated bombardment with verbal messages with guilt-ridden contents); and "photic driving" (exposure to rapidly flashing light until confusion and/or seizures result). Over 100 "schizophrenics" were "treated" with these techniques (often in combination, e.g., "sleep therapy", plus ECT, plus "psychic driving")—the majority of them women. Van Orlikow and 8 other survivors are currently suing the CIA for reparation. To date, the Government of Canada has not admitted contributing funds (\$500,000 over 14 years) or even having knowledge of the experiments.

The husband of a victim who died while in an insulin coma (part of her "treatment" for animal phobia) commented: "I always told her I thought she was being used as a guinea pig."

There was one woman, Catherine, who was my favorite patient on the ward. She had been abandoned up there at Napa State years and years ago when her husband wanted to run off with another woman. She had had 411 shock treatments. She said if her parents walked in right now she wouldn't recognize them. Catherine would say to me, "They took my past and they have my future and I can never get out of here so I just want to die but they won't even let me die."

Jackie Daymoon, "Diary of A Student Psych Tech," MNN, summer 1977.

Electroshock: A Cruel and Unusual Punishment

A Brief Submitted to the Local Board of Health — City of Toronto

Prepared by
BONNIE BURSTOW and DON WEITZ

on behalf of the
Ontario Coalition to Stop Electroshock

January 10, 1984
Toronto

Brief Introduction—History

Electroshock ("ECT" or "electroconvulsive therapy") is a major psychiatric procedure widely practised in many countries including Canada, Great Britain and the United States. Electroshock was introduced in 1938 by Italian psychiatrists Ugo Cerletti and Luigi Bini. In the 1930s, Cerletti and Bini were seeking a cure or new treatment for "schizophrenia". Since Cerletti believed that "schizophrenia" was rarely found in people with epilepsy, he assumed the seizure must play a preventive or "therapeutic" role. At a slaughterhouse, he saw pigs efficiently stunned by electric cattle prods applied to their heads. The electric shocks made the pigs docile. He decided to try a similar procedure on people.

Cerletti's first shock patient was an involuntary "schizophrenic" engineer. After the first shock (70 volts), Cerletti's patient was still awake and loudly protested, "Not another one! It's deadly!" Cerletti increased the voltage to 120 volts and shocked his protesting patient a second time, which produced the desired seizure and coma. Herein lies the invention of "electroshock therapy."¹

What is Electroshock? What Does It Do? How Does It 'Work'?

Today, the shock procedure is somewhat different from the "unmodified" type used until the late 1950s or early 1960s. Shortly before the "treatment", the person is forbidden to eat or drink. Then the person is administered a tranquilizer and anaesthetic, as well as a "muscle relaxant" (usually succinylcholine), which is so powerful that it totally paralyzes the body, including the diaphragm — the person can't breathe. That's why artificial respiration through oxygen is administered just before and after the seizure.

These additional procedures make the treatment "modified".

Two electrodes are attached to one side ("unilateral shock") or both sides ("bilateral shock") of the head while the person is paralyzed and not breathing. For a fraction of a second, 100 to 175 volts of electricity are passed through the person's brain. If directly applied to the heart, the current would instantly kill. Regions of the brain lying directly under the electrodes bear the brunt of the current; in almost every case they are the temporal lobes, the 'seat' of human memory. However, when it enters the brain, the electrical energy fans out unpredictably, hitting whatever lies in its path.

The direct immediate effects of each shock are a grand malseizure and coma; the person then sleeps for roughly thirty minutes to two hours. Upon waking up, the person experiences many of these reactions:

- Disorientation in time-space-identity
- Memory loss (some of which is permanent)
- Dizziness
- Confusion
- Severe headache
- Muscle ache(s)
- Physical weakness
- Nausea or vomiting
- Wild excitement
- Terror

Some shock doctors actually believe that fear is an essential part of shock's "therapeutic" effects.² Similar professional opinion has also been expressed about psychosurgery ("lobotomy") and insulin coma shock. We hasten to point out that fear or panic before *and* after electroshock, particularly on the first "treatment", is a common reaction experienced by the vast majority of people undergoing shock.

Other direct effects of electroshock reported in the medical literature are the following — they may be temporary or permanent:

- Breathing irregularities
- Heart irregularities (dysrhythmia)
- Cardiovascular complications (e.g. heart stopping)
- Delirium
- Loss of energy

Fractures
 Dislocations
 Stoppage of menstruation
 Impotence
 Bizarre sexual behaviour
 Ulcers
 Kidney ailments
 Abnormalities in brain waves
 Epilepsy
 Learning disabilities
 Intellectual impairment
 Permanent memory loss
 Loss of creativity
 Cerebral haemorrhage
 DEATH³

Since 1941, roughly 400 shock-related deaths have been reported in English language journals and books. This is a conservative figure. As psychiatrist Peter Breggin has pointed out, many shock-caused deaths are wrongfully attributed to other causes. The death rate from electroshock has been estimated as from 1 per 1,000 to 1 per 2,000 patients; the 1 per 1,000 rate is probably more accurate, and a much higher death rate (1 per 200) is found in elderly patients.⁴

Permanent Memory Loss

Since 1948-1950, when Professor Irving Janis carried out his classic studies on memory loss following electroshock, there has been ample evidence of permanent "retrograde amnesia" (forgetting events prior to the traumatic event, such as shock). As Janis and other investigators have shown, people who have had a few or many shock treatments forget many different things, places and events in their lives from months or years before the first "treatment".^{5,6} Furthermore, total permanent memory loss for experiences during and between shock treatments is extremely common.

Hugh Tapping permanently lost virtually his entire childhood (ten years) and his musical talent as a result of twenty shock treatments at Hamilton Psychiatric Hospital in the 1960s. At 11, Tapping received honourable mention in a music competition in piano; now he can't play a tune. Leorand Roy Frank, an internationally respected leader in the fight to abolish electroshock, permanently lost two years of experiences immediately preceding the last shock treatment as a result of 35 electroshocks and 50 insulin coma shocks in California. Nobel Prize-winning author Ernest Hemingway committed suicide shortly after a second series of shock treatments in 1961. Hemingway became suicidal after discovering that he could no longer write.⁷ That's how shock "cured" his depression.

The fact is that electroshock frequently erases huge chunks of people's memories, and this erasure is totally indiscriminate and unpredictable. Nevertheless, many shock doctors and investigators minimize or deny this fact by claiming that the memory loss is only temporary, and that full memory function will return within a few weeks to two months after the last shock. Research psychologists such as Larry Squire (a so-called 'expert' on shock-related memory loss) generally trivialize or invalidate the many serious complaints of long-term memory loss expressed by the patients-subjects in their experiments. Squire is such an 'expert' that he once failed to detect massive memory loss and brain damage in one of Dr. Breggin's patients. Any competent doctor or clinical psychologist knows that long-term memory loss is a definite indication of brain damage.

Brain Damage

In *Electroshock: It's Brain-Disabling Effects* (1979), psychiatrist Peter Breggin critically reviews and documents the medical evidence of shock-caused brain damage in over one hundred studies. In the many animal, neurological and case studies cited, the overwhelming conclusion is that electroshock causes some degree of brain damage. The greater the current and the greater the number of shocks, the greater the damage; the damage is cumulative with additional shock treatments. Electroshock is typically administered in a series or "course". For "depression" or "manic-depressive psychosis", the average "course" is eight to twelve shocks; for "schizophrenia", the average number is fifteen to thirty.

However, the vast majority of shock doctors and other psychiatrists repeatedly minimize or deny the fact that shock always causes brain damage, an "acute organic brain syndrome". They continue to insist that shock is a "safe and effective treatment modality", thanks to today's "modified" procedures such as tranquilizers, anaesthetics, "muscle relaxants" and oxygen, all of which, they say, prevent serious accidents, anoxia (lack of oxygen in the brain), and brain damage. The fact is there is *not one* credible scientific study which conclusively proves that electroshock does *not* cause brain damage or is medically safe.

Moreover, since the early 1950s, many studies on shock and brain damage (particularly Hartelius's elegant animal studies in 1952) have clearly shown that "unmodified" and "modified" shock cause similar devastating damage in the brain: widespread haemorrhages, tissue damage, blood clots, scarring, leakage in and disintegration of nerve cells, and cortical atrophy.⁸ Despite such clear evidence of brain damage, many shock doctors and other shock advocates have ignored or simply not bothered to read them, or neglected to cite them in current research. During the widely-publicized court case on electroshock in Toronto last month, it was discovered through cross-examination that *not one* of the four medical experts (including two shock doctors) testifying on behalf of the hospital had read more than one or two of these early studies which showed massive brain damage; some had read none! Instead, these "medical experts" had read only reviews of studies, which supported their pro-shock opinions or biases.

This contrasts with the American experts who testified for the inmate, who have actually read the studies. Psychiatrist Peter Breggin has written:

ECT is a dangerous, destructive intervention whose sole effect is the production of brain damage and dysfunction. It has no theoretical or scientific rationale, but can be understood in terms of the brain- and mind-disabling hypothesis . . . It produces a disabled, highly suggestible individual who for a time at least is less troublesome to others, and sometimes to himself. If ECT were subjected to the kind of scrutiny to which new and experimental drugs are now subjected, it would never be approved for research or clinical usage. . . it is time to stop its use in human beings. ("Disabling the Brain with Electroshock", in M. Dongier and E. Wittkower (eds.), *Divergent Views in Psychiatry*, Hagerstown: Harper & Row, 1981)

And U.S. neurologist Sidney Sament has said:

ECT produces effects identical to those of a head injury. After multiple sessions of ECT, a patient has symptoms identical to those of a retired, punch-drunk boxer. After one session of ECT the symptoms are the same as those of concussion . . . After a few sessions

of ECT the symptoms are those of a moderate cerebral contusion, and further enthusiastic use of ECT may result in *the patient functioning at a subhuman level*. Electroconvulsive therapy in effect may be defined as a controlled type of brain damage produced by electrical means. (Letter in *Clinical Psychiatry News*, March 1983 — our emphasis)

Shock Statistics

Government statistics on electroshock are extremely difficult to obtain. One reason is that the federal government and provincial governments have not published these statistics during the last five years, if not longer. As a result, shock statistics mentioned here are very incomplete.

For 1982, we estimate that at least 70,000 shock treatments were administered to roughly 8,000 people in Canada. We have shock information from only four provinces: Ontario, Quebec, British Columbia and Newfoundland. During 1981-82 in Ontario, 2,656 psychiatric inmates were subjected to 20,396 shocks (a decrease of only 2,500 shocks in the last four years). Ontario administered significantly more shocks to more people than the other provinces.

In North America, at least twice as many women as men are subjected to shock treatments. For example, in Canada in 1975 shock was administered to 2,062 female inmates (68%) and 952 male inmates (32%). The fact that a disproportionately greater number of women than men are shocked certainly suggests a *sexist* factor operating in the use of this procedure. Although we have no statistics on the ages or age range of people shocked in Canada, we also suspect that a disproportionately large number of elderly people have been shocked, which is the case in the United States.¹⁰

Fighting Back

In our informed opinion, electroshock is not a "treatment", but an ATROCITY, a CRIME AGAINST HUMANITY, which should be publicly denounced and immediately abolished. Professional organizations such as the Ontario Medical Association, the Ontario Psychiatric Association, the Canadian Psychiatric Association and the American Psychiatric Association have seriously misled and deceived the public and media into believing that electroshock is a "safe and effective treatment" for "depression", "manic-depressive psychosis", suicidal behaviour and "schizophrenia". Their evidence for making such statements is non-existent and unscientific. The truth is that electroshock is a violent destructive mind-control weapon used by psychiatry to enforce conformity — particularly upon women, the elderly and the poor. At the APA Annual Meeting in New York last May, former U.S. Attorney-General Ramsey Clark told the psychiatrists, "Electroshock is violence."

Last October 21st, in the Council Chamber of Toronto City Hall, the Ontario Coalition to Stop Electroshock hosted the first public forum on electroshock in Canada. Moderated by Alderman David Reville, the forum featured personal testimony and political statements from a panel of six shock survivors and many other ex-psychiatric inmates and supporters in the audience. They all told of shock's many destructive effects.

Then on October 22nd, the first North American Day of Protest Against Electroshock, about fifty shock survivors and supporters peacefully demonstrated in front of Ontario's "shock shop", the Clarke Institute of Psychiatry. The Clarke was chosen as the demonstration target because during the last seventeen years it has subjected more people to more shocks than any other psychiatric institution in Ontario. Similar groups in the United States also held anti-shock demonstrations on that day.

To become a physician, a person must solemnly swear the Hippocratic Oath, part of which is a vow to "FIRST DO NO HARM". Every time doctors shoot bolts of electricity through people's brains, they are violating that oath.

We ask you, informed citizens and health professionals entrusted with protecting the health needs and health rights of the people of Toronto, to join us in taking a public stand against electroshock. Specifically, we ask that you demand the *total abolition of electroshock in Toronto*. In speaking out, you will be giving a loud and clear message to all shock doctors, the medical profession, the Ministry of Health, and the Government of Ontario that electroshock will no longer be tolerated in Toronto. Electroshock will no longer be tolerated because it seriously violates Canadians' constitutional rights such as "the right to life, liberty and security of the person", and "the right not to be subjected to cruel and unusual treatment or punishment". Shock is cruel and unusual punishment — *not* "treatment".

Notes

¹Thomas S. Szasz. From the slaughterhouse to the madhouse. In Leonard Roy Frank (ed.), *The history of shock treatment*. San Francisco: 1978, pp. 8-11. Originally published in *Psychotherapy: theory, research & practice* 8:64-67 (spring 1971).

²Peter R. Breggin, M.D. *Electroshock: its brain-disabling effects*. New York: Springer, 1979, pp. 158-173.

³Leonard Roy Frank. ECT death chronology. In Frank, *op. cit.*, pp. 157-160. (Lists 384 shock-related deaths 1941-1977).

⁴Breggin, *op. cit.*, pp. 61-62. (Deaths and death rates.)

⁵Irving L. Janis. Memory loss following electric convulsive treatments. *J. Pers.* 17:29-32 (1948). Also see Janis, *Psychological effects of electric convulsive treatments*, *J. Nerv. Ment. Dis.* 111:359-382, 383-397, 469-489 (1950).

⁶A.E. Schwartzman and P.E. Termansen. Intensive electroconvulsive therapy: a follow-up study. *Can. Psychiatr. Assoc. J.* 12:217-218 (1967). (60% of 27 patients shocked 4 to 11 years before testing still complained of memory loss for 6 months to 10 years before shock.)

⁷A.E. Hotchner. *Papa Hemingway*. Random House, 1966. Also see Frank, *op. cit.*, p. 70.

⁸Hans Hartelius. Cerebral changes following electrically induced convulsions. *Acta Psychiatrica et Neurologica Scandinavica* (Supplement 77):1-128 (1952). Also see Breggin, *op. cit.*, pp. 38-73.

⁹*Phoenix Rising*, vol. 1, no. 3, Fall 1980 (shock issue), p. 13; vol. 4, no. 2, Fall 1983.

¹⁰Address by Leonard Roy Frank during a panel discussion at the Public Tribunal on Psychiatric Crimes, New York City, May 1, 1983.

Toronto Shrinks Shock Old People

By DON WEITZ

At least two shock doctors in Toronto have been administering electroshock to elderly psychiatric inmates for a number of years. Psychiatrists Kenneth Shulman (Sunnybrook Medical Centre) and Harry Karlinsky (University of Toronto) admit they administered an average of 9 shocks to each of 33 people, 62-85 years old (average age 72) over a 3-year period, 1979-1982. These and other disturbing facts were presented in a paper ("The Clinical Use of ECT in Old Age") at the 136th Annual Meeting of the American Psychiatric Association last May in New York City.

Before being subjected to a series of shocks, many of these old people were already suffering from various medical problems. At least eight had existing heart problems and/or brain damage. According to Shulman and Karlinsky, these included: "cardiac arrhythmias" (abnormal heart beats); "CVA (cardiovascular accident or a 'stroke') within previous year"; "mild cognitive impairment"; "spinal meningitis" and "Parkinson's Disease." Since these old and sick people weren't responding to "adequate" medication (antidepressants) and showed evidence of "dehydration or nutritional risk", Shulman and Karlinsky prescribed electroshock for them.

After the series of shocks which occurred over a few weeks or months, one inmate "suffered... two episodes of hypostatic pneumonia," which was directly caused by electroshock. After this "interruption", the inmate was subjected to more shocks, "a total of 17 treatments."

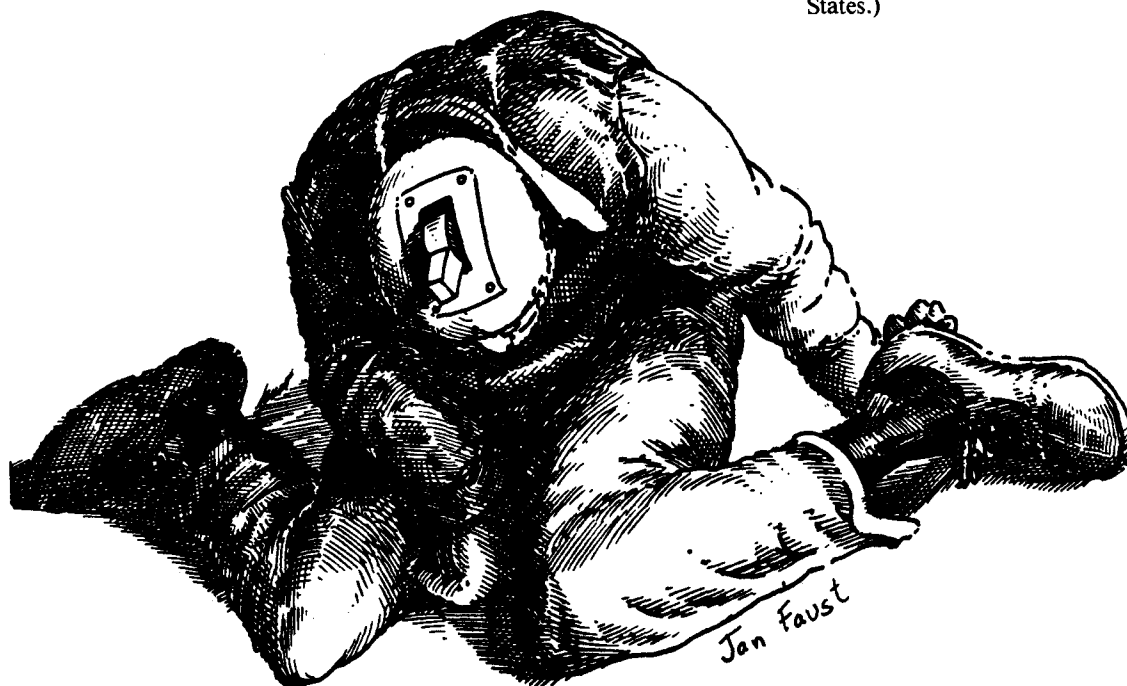
During a 6-month follow-up period, roughly 25% (8) of these old people were readmitted to hospital, 2 stayed in hospital, 23 were apparently discharged and six "received an additional course of ECT..." The results were predictably poor. Nonetheless like all other psychiatric investigators, Shulman and Karlinsky failed to define key terms such as "doing well" or "good response." Even they admit that six months after the last shock, "only 11 patients (33.3%) were doing well."

In their study, Shulman and Karlinsky also failed to administer standardized neurological or psychological tests of "cognitive impairment" to these patients before or after electroshock. In other words, these investigators didn't bother to find out if electroshock caused memory loss, other intellectual impairments or brain damage in any of their patients. We have no doubt that electroshock further damaged these people's brains.

Neither Shulman nor Karlinsky were sufficiently bothered by the "ethical issues involved in treating such an acutely distressed and vulnerable population." Instead, they simply concluded that "clinically one is compelled to use ECT on an urgent or humane basis."

We disagree most strongly with this conclusion. No doctor is medically or morally "compelled" to subject any person to electroshock. ECT is *never* justified. There are no "urgent" or "humane" reasons for a procedure that is destructive, unethical — criminal. As shock doctors, Shulman and Karlinsky have violated a fundamental ethical imperative in the Hippocratic Oath to which all physicians must swear: "ABOVE ALL DO NO HARM."

(Ed. Note: Our sincere thanks to Leonard Roy Frank in California for sending us a copy of this paper and making us more aware of the widespread practice of electroshocking the elderly in Canada and the United States.)



E.C.T.

Nira Fleischmann

I

Before sunrise, three days each week,
I watch the hired hands
Complete their routine preparations.

Chairs and tables carried out into the hallway.
White sheets stretched taut across beds.

All pillows are removed.

Space is cleared for oxygen and anaesthetic.
Last the shrouded cart appears
Wheeled in by capable technicians.

Such is the orchestrated rite which,
Executed deftly,
Can (in minutes) turn a room
Into a chamber.

Invited guests
In automatic step
Come next.
Ever-careful to maintain the practiced rhythm
Of this lunatic procession.

Outside the air grows heavy.
I imagine spectacles of smoke and fire;
Flashing burns and slow asphyxiation.

I think of torture for breakfast.

II

Eyes like smoldering charcoal
Peer at me and turn away.
I force myself to look. (it's not a matter of decision)
Feet twitch through half-open curtains
Drops of blood around a bed
A few electrodes on the floor, hastily discarded
the memories they've seered
Into embers and ash.

Mary Pincabe wakens beside me
Fighting the opiate sleep.
I notice a row of bruises up and down her arms.

There is no place for poetry in this poem.

III

A nurse serves Mary her breakfast on a tray.
Emptiness everywhere whispers the circus is over.

IV

Expert in public propoganda
They go to work on me—convinced
of euphemism. Sure of number.
Determined both will burn the terror
Splashed upon my face.

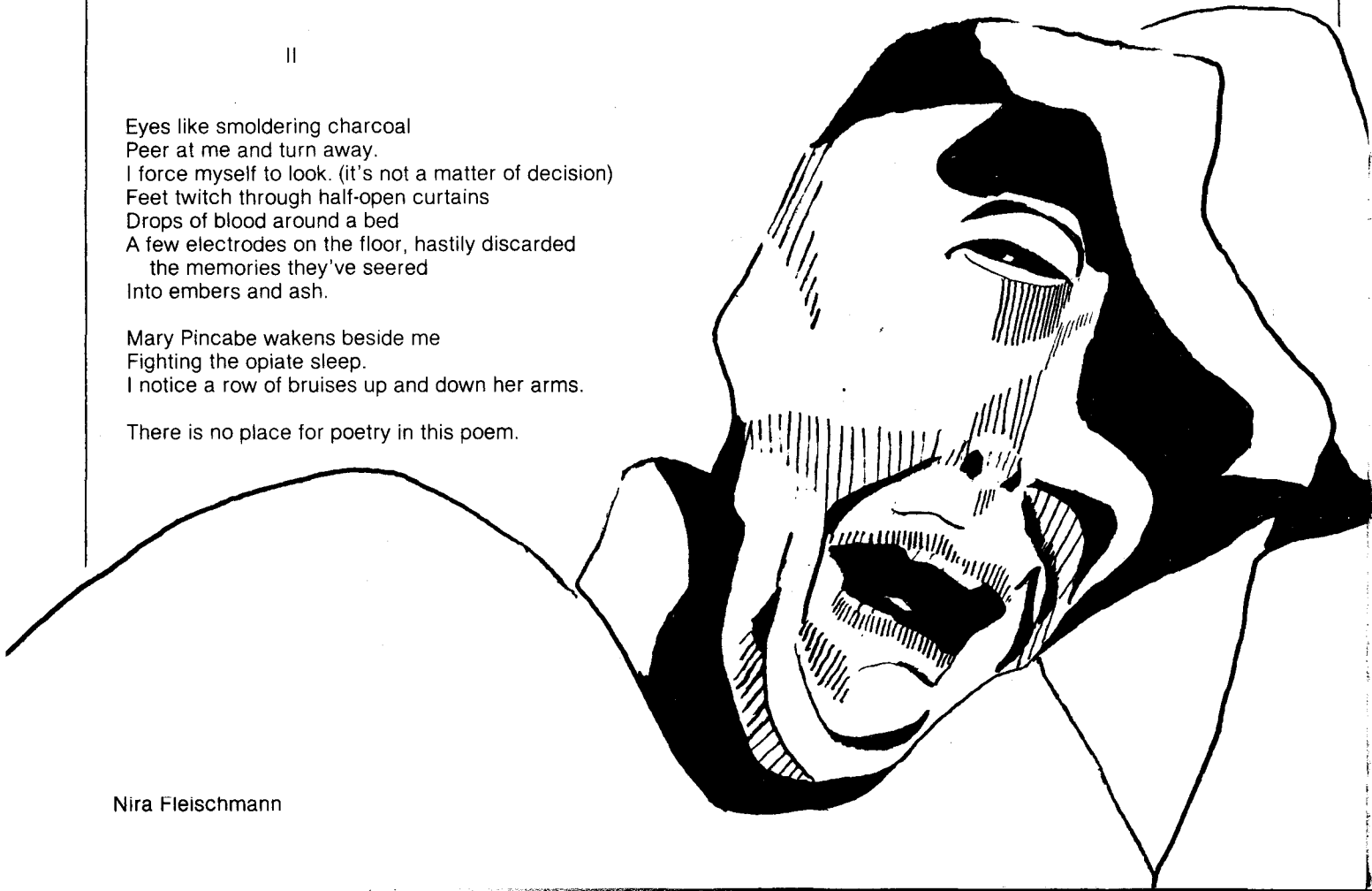
They try out some occupational tricks...Experiment.
They think it clever to baptize torture with initials.
They think it subtle to call it 'treatment'.
They talk of cures
Reciting tales of miraculous salvation.

I don't but it.
I've seen the disaster, the mistakes.

I call it electrocution.

V

I know they'd soon give up trying to con
A veteran.
Better save their reassurances
For those who need it more
For those who *will* believe
Stretched out some morning, waiting
On a cold, crisp sheet.



shocktrauma

Even today, the fantasy persists of being required to expose the body, of being attacked, wiped out, obliterated, of dying from electrocution, and of suffering permanent memory loss of impaired intellectual functioning. Therefore, a most important aspect of preparing a patient for therapy is to correct his/her fantasies in order to reduce anxiety, and in some cases, even get them to willingly accept treatment...

James Strain, M.D., "ECT: A Classic Approach Takes New Forms," *Psychiatry*, 1973.

David remembered little of his follow-up treatment. "Supposedly I did have some, and apparently what it consisted of was trying to make me parrot certain phrases. I was supposed to come back dynamic, aggressive, obedient ... Dr. Alexander deluded himself into thinking I was in a better state when I was in a worse state. And I thought everything was going smoothly and I couldn't remember anything. I accepted everything. I was pliable. I was obedient to authority."

"And now?"

"Well, it's possible that this will have some longterm benefits. Anything's possible. It's possible that death could have longterm benefits."

David, a pseudonym (*Bournewood Hospital, Brookline, Mass., early 70's*) *Voices From the Asylum*, 1974.

I came home from the office after that first day back feeling panicky. I didn't know where to turn. I was terrified. All my beloved knowledge, everything I had learned in my field during twenty years or more was gone. I'd lost the body of knowledge that constituted my professional skill ... I'd lost my experience, my knowing. But it was worse than that. I felt I'd lost myself ... I fell on the bed and cried and cried and cried.

—Marilyn Rice, in *The New Yorker*, September 9, 1974 (following a series of eight shock treatments).

(Dr. Cammer) points to anti-depressant drugs, hormonal therapy or electroshock treatments as three methods of pulling this depression victim out of her despair.

For all his patients suffering from depression, Dr. Cammer has strong advice: "If you are depressed, don't make a major decision. Don't retire from your job, don't sell your house or move to another city.

"Treat your depression and recharge your battery. Under stress, something happens to the brain and nervous system — not the 'mind.' It isn't the mind that cracks ...

"A depressed person is grateful when someone takes over, because he can't deal with anguish himself. The last thing a

friend or relative should say to someone in depression is 'You can snap out of it if you try.' Would you say that to someone paralyzed by a stroke?"

(Leonard Cammer, M.D.)

Banff, Alberta. A way of administering electroconvulsive therapy so that the shock reaches a fully conscious patient at the same time his most disturbing thoughts are present in the "mind's eye" has produced dramatic improvement in some previously hopeless cases, Dr. Richard D. Rubin said at the silver anniversary meeting of the Canadian Psychiatric Association...

Dr. Rubin described (his method):

"One case was that of a fireman whose particular hallucination was that he talked to Jesus Christ. I sat by his bed for 3 hours, waiting for this to occur, while he remained wired up throughout this time, a syringe of succinylcholine inserted in a vein, and my finger resting near a button.

"When his hallucination finally occurred, the 40 mg. of succinylcholine was injected to prevent risk of fracture and, at the very instant fasciculation was observed, the ECT was administered."

...Many of the people receiving ECT walked around like robots or zombies.

The day before I left, a woman was admitted for depression. Her husband had attempted suicide five years ago and threatened daily to do so again. She worked at a job that she hated and had difficulty with her daughter. She had been seen as an out-patient since July. She wasn't able to feel anger, although she said that pictures showed that her face was angry. Her expectations and her proposed treatment — Electric Shock! When I asked the doctor why he didn't treat the obvious with more reality testing, I was told that "women aren't ready to hear the truth."

One woman was afraid to tell anyone about her fears because she was afraid she would be called paranoid or crazy.

One woman was actually admitted for hitting her husband. She had been physically abused by him and her father for years. Her treatment: Shock.

My experiences in talking with these women regarding their hospitalizations were similar to those Phyllis Chesler recorded in *Women and Madness*. Most women considered themselves crazy. Many were confused, humiliated, naive and fatalistic about their hospitalizations. Most dealt with brutality (physical or mental) by blaming themselves or minimizing it. After all, they were the ones who were "sick" — weren't they?

Paula Fine. *Women and shock treatment*. *Issues in Radical Therapy*, 2-9-11 (Summer), 1974.

**FIRST HE
BRAINWASHED
THEIR MINDS. THEN HE
DESTROYED THEIR SOULS!**

Testimony on Electroshock

During Meeting of the Local Board of Health,

City of Toronto,
January 17, 1984

Not long after the shock case of "Mrs. T." was heard in the Supreme Court of Ontario in December, the Ontario Coalition To Stop Electroshock approached the Local Board of Health for support. Specifically, the Coalition sent the Board a letter and a critical brief on electroshock and urged the Board to take a public stand against it. The Board agreed to hear a deputation from the Coalition on January 17th. Several doctors who support the use of electroshock sought permission to make presentations also—which was granted.

Personal testimony against shock was presented by seven Coalition members, most of whom are shock victims: Shirley Johnson, Fred Serafino, Connie Neil, Hugh Tapping, Ralph Preston, Dr. Bonnie Burstow and Don Weitz. The pro-shock position was heard from doctors Brian Hoffman (Clarke Institute of Psychiatry), Dennis Kussin ('Queen Street'), and Andrew Wilson (Oakville-Trafalgar Hospital), as well as from psychiatric social worker Gilda Katz ('Clarke') Seven of the presentations are excerpted below. After hearing all the testimony, the Board passed a motion calling for an immediate moratorium on electroshock without informed consent pending public hearings and more research.

The following day, January 18, Health Minister Keith Norton announced his intention to appoint an "international panel of experts" to investigate electroshock in Ontario.

Don Weitz

I'm here as a member of the Ontario Coalition To Stop Electroshock. I have not had electroshock, I had the insulin shock atrocity 30-some years ago in the United States. It's still going on, I understand, in some quarters in Canada. I want to confine myself to objective, scientific facts from research on brain damage and electroshock. That research spans a period of roughly 45 years. The brain-damaging effects of electroshock have been known to psychiatry, to medicine for over 40 years.

Brain damage caused by electroshock is typically minimized or covered up in the medical-psychiatric literature. Shock doctors and other shock advocates repeatedly claim that shock doesn't cause brain damage or permanent memory loss which in itself is an indication of brain damage. There's also the myth propagated by psychiatry that ECT can prevent suicide and is "effective" as a bona fide treatment. This dishonesty must be exposed for what it is.

Regarding first, very briefly, the "effectiveness" studies. There have been 4 or 5 acceptable, scientifically-controlled studies—, 4 in the last 5 years. A model of evaluation of electroshock in 1959 by Brill and associates consisted of evaluation of four different groups: modified shock, unmodified shock, shock plus a sedative, nitrous oxide plus a 'simulated' group (that is, a group that had everything but the shock). They found *all* treatments equally effective, including the group that didn't get shock treatment. Lambourne and Gill in 1978 also found no difference between shock versus non-shock groups tested one day *and* tested six months after electroshock. There's another study by Freeman with two groups of "depressed" patients, shock versus non-shock. They also found no statistically significant differences after the last treatment. One of the more publicized studies in England by Johnstone and associates, called "The Northwick Park Study" (Trial), has also shown there are no significant differences between the people who had shock and those who had no shock on the measures of improvement. I will not go on anymore, except to say the "effectiveness" of electroshock has *never* been demonstrated acceptably in the literature.

Now for the permanent memory loss, *permanent memory loss*. The psychiatrists typically say, "Oh dear, it's OK. After a few treatments, your memory will come back; it's only transient." It's not transient, it's permanent and tragic as you'll hear from some people here today who will give personal testimony. From 1948 to 1951, Professor Irving Janis at Yale University conducted what is still considered the classic study on memory loss following electroshock. He found that of the 19 patients who had shock treatment when he re-

examined them one year later, they all complained (documented in testing) of memory loss going back 6 months. In fact, 3 1/2 months to 1 year after testing all the 19 patients still complained they couldn't remember things, sometimes going back 10 to 20 years *before* shock treatment. In a controlled study in 1972 involving people shocked versus not shocked it was also shown that some people couldn't remember a lot of things that happened prior to shock. The American Psychiatric Association Task Force Report itself admits, although grudgingly, in 1978:

Memory complaints long after ECT are common. Extensive ECT may lead to long-lasting or permanent impairments in memory. Memory for events that occurred days prior to ECT may be permanently lost.

I would suggest that it's not just days that are completely lost, it's *years*.

The animal autopsy studies provide further evidence of the brain-damaging capability of electroshock. I consulted Dr. Peter Breggin, an outstanding and internationally respected psychiatrist who opposes electroshock. From looking at the original studies, (not just the reviews of studies which most psychiatrists read), these are the major findings from animal experiments with shock. Ten were cited by Breggin: Many small hemorrhages in the brain, this is also (known as "petechial"); swelling of the brain, ("edema"), cell death. I quote from a study in 1942 by Alpers and Hughes:

Hemorrhage occurs with alarming frequency in experimental animals subjected to electric shock. It is probably fair to assume that there is some damage to the human brain.

The most classic study of shock on animals was done by Professor Hans Hartelius in Sweden (1952). This was a double-blind study where he independently examined the histological slides of animals after autopsy—he didn't know whether they were shocked or not, he did it blind. Not only did he correctly identify all 8 cats that were shocked from the slides alone, he added: "The question of whether or not irreversible damage to the nerve cells may occur must be answered in the affirmative."

Human autopsy studies are similar in their findings to animal autopsy studies. The common findings are: swelling of the brain, cell death, "acellular" areas, (i.e., no cells where there should be cells), multiple small hemorrhages, tissue destruction, sudden death. A common finding in human autopsy studies (I quote from a conclusion by Riese in 1948): "In all observations of sudden death after electroshock re-

ported so far, petechial hemorrhages, cellular changes and some glial proliferation stand out prominently as an almost constant whole." (Glial proliferation refers to scar tissue, there's plenty of that).

The fact that the current itself is the culprit in causing the damage has been clearly identified by Larsen and Vraa-Jensen in 1953 when they examined a 45-year-old man after four shocks. There were *no grand mal seizures produced*—that is crucial. There were only sub-convulsive shocks. And edema was found, hemorrhages were found, *and* damage directly underneath the electrodes. Breggin and others including Dr. John Friedberg have found further evidence that it is the current, not the seizure, that is implicated in the brain-damaging effects of electroshock.

Neurological studies also provide massive evidence which unmistakably points to brain damage from shock. These studies span 30-some years, 1951 to 1983. Findings include: irreversible brain damage; epilepsy, sometimes permanent; facial paralysis and paralysis of other parts of the body; seizures; (The seizure rate among people who have had shock is *five times* greater than it is in the non-psychiatric population, according to a 1983 study); incontinence; permanent memory and intellectual impairments, particularly in the elderly.

Deaths from shock treatment are usually minimized by psychiatrists or attributed to other causes. A number of neurologists in the United States are quite upset by such misleading attribution, like to heart problems, and so forth. But what triggered the heart problem in the first place?! What triggered the cerebral edema, the brain damage? The death rate is estimated by Breggin and others as 1 in 1000; for the elderly it's 1 in 200.

I want to end with a statement by a shock victim who had 85 shock treatments, 50 insulin coma shocks and 35 electroshocks. This is from testimony of Leonard Roy Frank, an internationally respected leader in the fight to abolish shock treatment in North America. In April (1983) in Berkeley, California, he said this:

The truth is that shock treatment causes pain, humiliation, brain damage, memory loss, learning disability, lethargy, apathy and sometimes even death. The evidence of severe permanent brain damage from shock treatment is conclusive. The brain damage is intentional and primary. Shock treatment is a stain upon our social conscience. It is incumbent upon all of us to do what we can to remove this stain. Those who know the truth about shock treatment and who fail to speak out are also on the hook. Silence is complicity.

Dr. Brian Hoffman

I have come today to talk about electroconvulsive therapy. I've been a medical practitioner for 18 years. I've had 11 years of training in psychiatry and in medicine. And I've been at the Clarke Institute of Psychiatry for 10 years as a staff psychiatrist.

Electroconvulsive therapy is the oldest surviving treatment in biological psychiatry. It is also one of the most controversial of any of our medical treatments. Clinicians in favor of its use continue to find patients who require ECT. Opponents to the use of ECT continue to be vociferous about the dangers and side effects suffered by patients given electroconvulsive therapy. The controversy concerning ECT is just the battle on one front. There are further attacks on the medical concept of mental illness, criticism of the involuntary

confinement of those who display severely disturbed and psychotic behaviour, and questions concerning the appropriateness of the pleas in court of "not guilty by reason of insanity."

In medicine we hope that patients with treatment, with care, with rehabilitation—we hope that these patients can once again enjoy life and return to function in society. However, the images of electroconvulsive therapy are negative, powerful and almost indelible in each of us. Even scientific knowledge is barely able to influence these images because of our fears—fears concerning the use of electricity on our brains. The images of electroconvulsive therapy are exaggerated by everyday associations with torture as in spy stories and in Nazi Germany, with bizarre research as in the movie of "Frankenstein", with the pre-anaesthesia electroconvulsive therapy as in last night's movie "One Flew Over The Cuckoo's Nest," and with suppression of social deviance and political dissidence as in the Soviet Union. It is virtually impossible to change these images. To the lay person even with the aid of scientific knowledge and research experiments, it is almost impossible to picture how electricity used on the brain can be a humane treatment for those who are seriously disturbed and used by a profession which is monitored both within and without. And it's surprising how the use of anaesthesia has greatly improved the image of surgery. You don't hear of patients yelling and screaming with pre-anaesthetic surgery, but this is the image of ECT. These are the statistics you are given by a previous speaker even though anaesthesia has been used routinely with electroconvulsive therapy for the past twenty years in Canada. The image for ECT may not in fact even change. When the average person hears that the patient is put to sleep with anaesthesia, his brain is stimulated, the patient wakes up and there is nothing to see. There is no yelling or jerking or screaming or convulsion. The patient wakes up similar to a minor surgical operation. For the correct treatment of the very serious medical disorders, he requires 8 or 10 treatments.

There is something frightening about the use of electricity on the brain. In fact, electricity does not have to be used. What is necessary is that the brain be stimulated in front where it has a seizure, similar to that suffered by any epileptic. It's not the electricity that is therapeutic, it is the stimulation inducing it to have a convulsion, to have a seizure. Such a seizure can be caused by gases or medications. Unfortunately, there is wide variability in the patient's responses to medications and gases, and so electricity, electrical current, is the most reliable and safest method of inducing a seizure at the present time.

Another part of the stigma associated with ECT is related to our wish or belief for everything to be rational and to be explained away. We are in an era of scientific thought, education and communication. We have difficulty accepting the fact that some people suddenly change and act beyond the limits of reason and sanity. Common sense dictates the things that we can see everyday on Yonge Street or in the news. Some will deny the existence of bizarre behaviour indicative of mental illness, or else they will grasp for simple explanations and simple treatments for these conditions. Mental health workers continue to see patients such as the young high school student who barricaded himself for three weeks without food in a bathroom with a radio receiver, because he believed he was picking up interplanetary messages from Mars. If you tried to talk to this man, he says, "I'm listening." If you say, "I insist on talking," he punches out at you. Simple explanations and simple solutions are not possible when you examine a man who has stood on a street corner for 7 days and 7 nights without speaking or without closing his eyes. Or if you try to speak to a young woman believing she has the power of God who begins to swear, spit at and kick in the groin anyone who enters her room. Her family is desperate. They want the best treatment possible. If they were your

relatives, you would want that. You go to doctors and hospitals only after you can't do anything, your friends can't do anything and people in the community can't do anything. The indications for modern ECT are clear: only conditions that are not responsive to your social interventions, to maintenance in the community, (people) who require hospitalization and who cannot respond to psychotherapy or present medication. They're a significant proportion. If you include severe psychotic depression, it includes severe manics and it includes severe schizophrenics.

This treatment has the potential for getting these people out of hospital, back into the community where they can respond to psychological and social treatments. Without it, they are confined to their delusions, their hallucinations, their social isolation and rejection by society indefinitely.

I hope other speakers will discuss the side effects. I was interested in what the previous speaker (Don Weitz) said. My reading of literature is very different. The side effects are well-proven in many many studies to be by-and-large minimal and short-acting. There is no evidence for permanent brain damage, and this was in fact the finding of the Supreme Court of Canada recently—sorry, Supreme Court of Ontario recently. We are concerned about the effects of ECT. Continuing research will be necessary to see if there are subtle and perhaps long-standing changes. With our current techniques, we cannot detect this over and above what all people who have mental illness suffer. People who are depressed or schizophrenic—they have trouble concentrating, they have poor self esteem, they have poor social skills, and they often feel like, even without treatment—they often feel like their memory has not returned to normal. With ECT, their memory does appear to be disturbed for some days or some weeks. We have modified the treatment in the last two decades. This time is getting shorter, and there is no evidence of permanent damage.

I will conclude by saying that there will be a need for further research—further research to modify the treatment. Previous speakers have not mentioned up till now our use of anaesthesia, our use of hyperoxygenation, our use of an could be deleterious. They haven't mentioned our new, pulsed-wave forms or our use of unilateral ECT. These have all been major advances in the use of ECT which we hope will be just as effective in treating a seriously disturbed patient and keep the side effects to a minimum. That's one area of research.

The second area of research will be to continue to monitor the long-term effects of ECT. The third area of research will be to eventually find an alternative, a more socially acceptable treatment. Currently, it does not exist.

Hans Kunov

Professor of Biomedical Engineering at the University of Toronto, (written statement):

After having carefully scrutinized the scientific literature on ECT, I have come to the conclusion that the procedure, even when administered in so-called modified version, is doing irreversible damage to brain tissue. Because of the brain's ability to reorganize the functional parts over time, some of the adverse effects of ECT appear to diminish with time. I am compelled by the evidence in the literature to conclude that substantial damage is inflicted as a consequence of ECT.

Dr. Dennis Kussin

I'm Director of Education at Queen Street Mental Health Centre. I guess I'd basically like to approach the issue in terms of the issues one needs to deal with in trying to make up one's mind about ECT. The first question that has been raised by previous speakers is the question: Is ECT effective?...My particular reading of the literature is similar to Dr. Hoffman's. One is impressed by the number of studies showing its efficacy in severe depression. The other question one has to ask: If it is effective, why is it effective? And again, people have talked about the fact that, well, it just may be effective because one is punishing people by giving them ECT, and depressives may have a need for punishment, so therefore seeing themselves getting that punishment procedure might be why they feel better. Again, this is a question that can be answered by science, and the studies have attempted to control by giving, for example, mock ECTs, that is, comparing a group that has actually received the convulsions with a group who think they've received it but don't. As a way of deciding whether or not it's the treatment itself or the thinking that one has had the treatment. Again, all these studies are reasonably well-controlled, and the majority of them show that ECT is an effective treatment for severe depression.

There is clearly a polarization of opinion between certain people advocating on behalf of patients' rights and the medical profession. Again, I'd like to say the polarization is not between good guys and bad guys. I'm here also advocating on behalf of patients' rights. I have personally nothing to gain from ECT. We all are advocating for the rights of those suffering from mental illness. It's not an issue of who's good and who's bad. It's really an issue of—as I said some of the issues that are involved, and you're going to have to make up your mind about it. I think it's utterly



simplistic if one can say the medical profession, the psychiatric profession don't care about people, and others do care about people. And nobody has a monopoly on caring.

If you're in my seat or in the seat of a psychiatrist who's dealing with someone who's suffering from a difficult kind of condition,...a medical practitioner is always an empiricist. One tries to do what works, what will cause the least amount of harm, prevent major harm occurring to the patient because of their suffering. So again, I would just like to clarify that the issue shouldn't be polarized around good guys and bad guys, those that don't care and those that do care. The issue is to some extent a scientific one, to some extent an ethical one.

Then the question one has to ask is: Effective how long? And is it effective just for acute depression? Is it effective on a long-term kind of basis? And again, my particular reading of the literature shows that ECT is fairly effective in the acute management of severe depression. No one is claiming that I know of, and from my particular reading of the literature no one should claim that ECT changes long-term patterns of behaviour that might lead one into depression, longstanding senses of low self-esteem or people who have acted in such a way over a long period of time that are going to expose them to subsequent depressions, getting into terrible relations that then work out badly that get one depressed. No biological treatment in my view is going necessarily to alter these patterns.

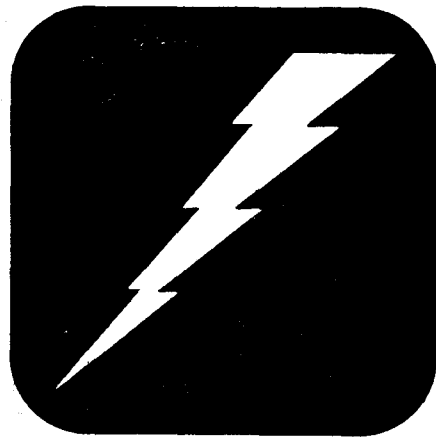
The issue of death has been raised, and the statistic given of one in a thousand. Certainly, the vast majority of the reputable studies that I've read, including the American Psychiatric Association's Task Force on ECT showed nowhere near those kinds of figures ... In fact, there's a recent study suggesting that the incidence of death is higher in patients treated with medication than with ECT. But again, I don't want to get into the specifics of the debate, because there's tons of literature on either side.

I can tell you that the major and I think reputable organizations like the American Psychiatric Association, the British Psychiatric Association, the Scandinavian studies, the Canadian Psychiatric Association when looking at the issue have come up on the side — the side effects are not that severe and are outweighed by the benefits of the treatment... The one that concerns most people is the issue of memory disturbance. There is no question that there is short-term memory disturbance caused by ECT lasting up to two or three months. This is very disturbing for patients. Again, the majority of the studies show that this is not long lasting. The question of long-term memory deficit is a difficult question. Most of the studies, again by my reading of the literature, tend to show that it's hard to document long-term memory disturbance in a significant number of patients having received ECT. On the other hand, most studies, many studies have shown that patients who have received ECT, especially bilateral ECT, especially when they received a lot of treatment, *complain* of some memory disturbance. And reputable researchers who found no deficits there do report nonetheless that some patients continue to complain of memory disturbance. And the question there is what is this about. One possibility is that there is some subtle memory disturbance in *some* patients produced by the treatment — that we don't have the tools to find. But there are other possibilities, including that if one has had an experience of two or three months of severe memory loss it may attune one much more to one's memory and worry one much more about one's memory. Again, I'm just pointing out the complexity of the issues involved and again to underline that when it's been looked at by a number of reputable researchers, they haven't been able to find any major evidence of long-term memory loss, although there may be something there. The other thing is that people who are chronically depressed also complain of memory disturbances.

The third point I'd like to talk about is the concept of the risk-benefit ratio. The issue isn't that ECT is a completely benign procedure. I know of no treatment in medicine that's effective that doesn't also have side effects. And unfortunately, there's almost a direct correlation between the efficacy of a treatment and the severity of some of its side effects. People die from insulin, people die from aspirin and almost any medical procedure has some side effects. The real question that one has to ask all the time is: How severe are the side effects? Are the benefits of the treatment outweighing the severity of the side effects? ... There is ample evidence that the kind of depression we're talking about is not your or my kind of sadness, unhappiness when things don't work out for us. We're talking about severe depression, people who are not sleeping, not eating and whose perception of reality is altered by their depression.

And the consequences of not treating are also quite severe. There's a high incidence of suicide in these patients, there's a terribly high incidence of morbidity in these patients, and there's a tremendous incidence of suffering in people who are untreated, and it can go on for years. So the issue isn't just around the treatment itself but also what happens if you don't treat.

I'd like to make other issues that I think will help orient you in terms of approaching this subject. The issue of treating someone against one's will is another issue that isn't specific for ECT, since other people are treated against their will with other modalities of treatment. That is not an issue only for science. That's an ethical issue that's an issue for both science and for the public and for society to grapple with. And anybody who tells you that the issue is easy or clear, I think is either not close enough to the issue or not dealing with it, in my view, appropriately. On the one side, there is the ethical concern of taking away somebody's civil liberties. On the other side, there is the ethical concern about allowing somebody to harm themselves or others while their judgement is impaired by a mental illness. Those of us in the medical profession tend to err on the side of treatment in the sense of not allowing somebody to hurt themselves or someone else when they have what we think is a treatable condition. But the issue is not an easy one to decide.



Connie Neil

The experts are using words emotionally to present people who have difficulties with society or whatever in a very poor light. I hear them talking about "treatment" using very soft words. Well, I was raised in Ontario and have lived here most of my life. I went to Ryerson, where I studied radio and television arts... I was an actress but I was trained at school and won 'Best Actress'. In between school years, I went to the Banff School of Fine Arts ... and I was given the lead in the play there. When I came back to take my final year at Ryerson and was in competition again, I won Honourable Mention. So, acting was something that I was very good at.

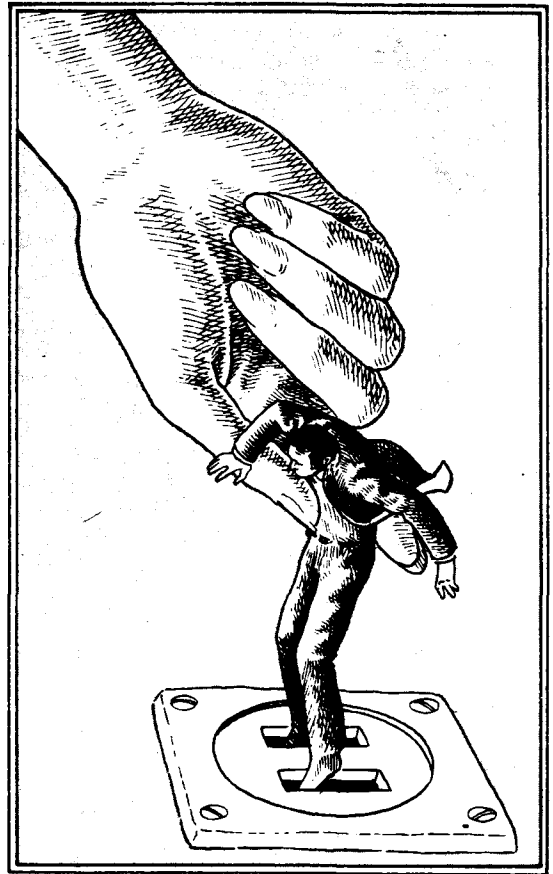
After I graduated, I very quickly got married, very quickly had a baby and very quickly ended up in the "Crazy House." First, I was given as an outpatient a shock treatment, which I had a very bad reaction to. On the basis of me having a very bad reaction to it, I was instantly committed and given a full course of shock treatments — that is, about 20 shock treatments.

Now, I wasn't doing anything that was really very strange for me, but I was in a strange place. I had a family who was really rather bizarre, and so the way that I behaved and the kinds of things that I did, my training, everything, meant that I behaved in ways that were not considered ... well, today I suppose you'd call it "straight." But the problem was that when I went to live in somebody else's home, my in-law's home, and they were really not that keen about seeing me there. They kind of liked the baby alright, but they really didn't want me around. She was the daughter of a minister, my mother-in-law, and a registered nurse. And so, there was really an awful lot more weight to whatever she had to say about the way I was behaving than there was for what I had to say, about the way I was behaving.

Now what I experienced then were heavy shifts of mood — way up and way down. After I had the shock treatments, I was never institutionalized again. It was a mistake: other people who have heard about this including psychiatrists have admitted that what happened at that time was a mistake — it shouldn't have been done. But the fact is, that for the rest of my life I have to live with it.

A person who does not have a memory is not able to perform as an actress. I'm still able to do things — that is, I'm able to do them in a very limited way as a kind of a hobby. I have to work *terribly hard* to do it. Recently, I did a public theatre appearance. I had to drive around with the tape on saying the lines over and over and over and over. Previously, I'd just do a couple of readings; we'd all sit around reading the play, directions, etc. and that would be enough. I don't have this quick ability anymore. I don't like to appeal to emotionalism, but I'm furious about the whole thing. I mean my life changed radically.

Aside from that, while I was at the Banff School of Fine Arts I was also studying playwriting. As anybody knows the kind of creative writing that you do — such as playwriting — depends very strongly on what you are made up of, what your past memories are, your past relationships, how you deal with other people, how other people deal with other people — all of these things. I can't write anymore. Well, I can write articles, I can write things where you sit down and you learn it once, because as soon as I learn something, within a period of a couple of weeks I won't even really know, unless I see — there it is, it's published and it's got my name on it. Then I know, that, yes, I wrote that.



Since the shock treatment, I'm missing between eight and fifteen years (of memory and skills), and this includes most of my education. I was a trained classical pianist; I had my Grade 8 'practical' and my Grade 2 'theory.' Well, the piano's in my house, but I mean it's mostly just a sentimental symbol. It just sits there. I don't have that kind of ability any longer. It's because when you learn a piece and you perform it, it's in your memory. But it doesn't stay in my memory. None of these things stay in my memory. I lost people by losing the eight to fifteen years. People come up to me and they speak to me and they know me and they tell me about things that we've done. I don't know who they are, I don't know what they're talking about although obviously I have been friendly with them.

Doctors have said to me when they enquiring about my medical history: "Where did you have this operation? When did this thing happen?" I can't remember. I keep a list of things like that. One doctor who was an orthopaedic surgeon said to me when he was questioning me about different operations that I had, "Have you had shock treatment?" And I said, "Well, yes I have." And he said, "Most people find that things as large as the major operations that you've had are important enough for them to remember." So what can you say to this?

The medical profession knows what shock treatment does. I'm willing to admit that it doesn't do it to everyone. I think that it affects creative people more strongly because of the areas of the brain that they use. I was given modified treatment; I was also given another kind of treatment too; but mostly what I had was bilateral modified treatment ... By "effective", I know that it is meant that they diminish the person. They certainly diminished me . . . I am certainly nothing like, and my life is nothing like it would have been. It is nothing like the way I was headed. Certainly not in the

direction that I am now. I work as a payroll clerk for the Public Works Department. I write little figures, and that's about all at this point I am really confident of doing. There are some other things that I could do in other areas, but this is something that is all I can do now. And it's the *direct* result of the treatment.

I think that it should not be allowed to happen to other people. There isn't anything really that can be done to help me in this situation. I've learned to handle it the way I can, but I only came to speak here because I would not like what happened to me to happen to any other person, no matter who they are and no matter what they are doing.

Bonnie Burstow

I am also here on behalf of the Ontario Coalition To Stop Electroshock. I am a private psychotherapist, and I have also worked in mental hospitals. I have worked in the mental health field for 11 years. I have seen somewhere between 100 and 105 people in my practice who have received electroshock. So it is a procedure, the effects of which I personally am very familiar with.

What I have seen as a clinician are people with varying degrees of memory loss—some very minor, some very, very extensive, some very temporary, some absolutely permanent. I have seen people forget entire skills that they have developed, so that if they used to be a writer—they can't write. They used to play the piano—they can't now play the piano. They used to have a profession they could do—they no longer have the skills because the memories of those skills have been wiped out by electroshock. I have seen people who never had migraines before electroshock who have migraines 5 or 6 days out of 7. I have seen people with even the entire memory of their life wiped out from electroshock—and it's never come back.

I am asking people to consider the severity of a treatment capable of producing effects that dire. No, not everybody has effects that dire, but an instrument capable of producing effects that dire simply shouldn't be used. We are playing a game of Russian Roulette with people's lives here, and I do not believe we have the right.

There have been many arguments given by the medical profession in defense of this procedure. One argument is that people "perk up" after electroshock. Often, I would like to say, people do indeed "perk up." The reason they "perk up" is they can't remember what it was that was bothering them. They cannot *work through* what is bothering them. So that very thing that allows them to "perk up" is itself *counter-therapeutic*. It is the very thing that makes it most difficult for them to solve their problems and make perceptions in their lives.

We've also been told that electroshock is "helpful" because it zaps people out of "depressions." I would like to say once again that, yes, sometimes it does zap people out of "depressions." However, what is helpful to people from a therapeutic point of view is not being zapped out of depressions but in fact learning to cope with depressions. The person ends up as somebody who's never able to, never having to work through depressions. Electroshock comes in and interferes with that very process of working through, so the person ends up somebody who's never able to, never having gotten the skill of knowing how to come out of that depression. The person also ends up with a very interesting existential message given them by the treatment. That is: "You are absolutely *not OK*. You are *so not OK* that we can not begin where you are. We have to zap you to some arbitrary

place that you are not." I have heard, I have seen clients who, when they first got electroshock, were very happy with it. And I've heard that those same people would be happy with it for 5 years, and then would say 10 years later that they'd ruined their whole lives as people who were not OK and who had to be zapped out of things—as a result see what in fact this had done to them. I've seen many people dramatically change their opinion after they've assessed how they've led their life from there on in.

Another argument given by the medical profession in defense of electroshock is that some people are "untreatable" by any other means. That is, that there are people in such dire condition, they are like "vegetables" that we couldn't get to in any other way. Let me begin by saying that I've never met a "vegetable." I'd like to go on from there by saying, however, that I've dealt with extremely depressed people. I have interacted on a clinical level with people so depressed that they hardly ever have moved, with people so depressed that they didn't eat, etc. And we were able to work through that depression without giving them electroshock, without giving them any brain-damaging treatments.

The reality is not that these people are "untreatable", but that at present the psychiatric profession has not learned the therapeutic skills to treat them. I do not think that people should be brain-damaged because of the lack of skills of a particular profession. If the help of other professions are needed, then bring in those other professions. In light of all this, I would ask people first to support an endorsement to abolish electroshock. In the event the Board does not feel capable or ready to endorse this, I would ask that they ask the Minister of Health for a moratorium on electroshock while a group of qualified researchers look through the present literature and hold public hearings to determine the safety and effectiveness of this procedure. In the event the Board is not prepared to do that, I ask that in the absence of a moratorium they at the very least ask the Minister of Health to have a panel of social scientists look into the present literature and hold these public hearings and come up with recommendations on the basis of them.

Shirley Johnson

I'm a shock therapy victim, a survivor that is still struggling. The damage done to my brain and other parts of my body is still very evident. I am still being treated to try and compensate for this damage.

Just over 15 years ago, I was diagnosed as a "schizophrenic". I was given 6 to 8 shock treatments for depression a year after my fourth child was born. I did not give my consent to this therapy, and I'm very sure my former husband would not have signed the paper if he had known it would do so much damage to me. I remember being very anxious about these treatments, since I was not told about them, about what was involved. I remember of having the feeling of being led to the slaughter since it seemed hopeless to stop them — and trusting the doctor since I was very young at the time. The terrifying feeling on treatment mornings, knowing that when they put the needle in my arm and put me to sleep it meant blackness again, and waking up with a stifling, splitting headache, not knowing where my room was and why this was happening to me.

When I mentioned to my doctor that these treatments were not doing me any good, it didn't seem to matter. But finally after the series was finished, he could see I was right.

The memory loss is especially painful, since I could not remember a lot of times while the children were growing up. The two young girls more so, since the shocks were closer to their birth. The two older children — I do not remember their graduation. Many times, my family and friends would bring up happenings that I had to question them about, to

test whether the memory would return. Usually not.

I feel so alien many times because of this damage. I used to cover up a lot of times, thinking that if I listened more and rested a lot before going out, it would be easier and comfort me just being in society. One of my children's school interviews was terrifying, because I didn't want to reveal what I had experienced, and the gaps in my memory — I was still in the closet. Finally when the anxiety got so bad, I would completely avoid people and especially social gatherings where I was supposed to know certain people and remember their names. This became very, very difficult.

The physical damage I started to be aware of when the right side of my body showed definite signs of weakness. This was because the shock therapy was given more on the left side of my brain — which meant more electricity there. It became very difficult to lift with my lower spine and middle back; they became so very weak. I had to go for physiotherapy and exercise many times. I still have to do that. When I'm very tired, there are times when my mouth will not form the words. At times, I have lost the use of my right arm and my right leg. Usually, a lot of rest will help bring this back. The imbalances that I'm now trying to correct — it seems like mountains to overcome.

When my other son was diagnosed as "schizophrenic," he chose to take his life while in hospital rather than be exposed to additional shock therapy. I had no idea of the damage to him; shock had taken away his ability to study and enjoy his hours and his music and also ... sharing the experience his mother had come through.

We are here testifying as survivors of shock, but there are many that don't survive. The pain and hardship that it causes cannot be justified. For those that might be faced with the possibility of deciding for shock treatment, it is not justified.

There are alternatives, and we must look at those alternatives. With faith and determination, we will overcome.

Hugh Tapping

I am a victim of torture. In 1984 psychospeak it's called "treatment." I have been brutalized ... it's called "Clinical Intervention." My brain, and my life, are a shambles. I have been "cured."

For the past several years I have been trying to make people aware of the evil perpetrated by a minority of the medical profession. It is not pleasant to repeatedly go over the details of a horrifying, brutal assault. Like a rape victim, I have found it necessary to publicly and repeatedly describe the moment-by-moment details of what was done to me. Describing my experience causes me to relive the horror — which leads to a day and sleepless night spent in fear and loathing. I've a real case of the January blahs, and I've just despaired at yet another attempt at schooling. So I'd rather not put myself through it again today. However, if any member of the Board feels the need to know the specific details of what shock feels like, go ahead and ask me about it when I've finished my address.

Medicine generally has a rational, scientific basis. Unsuccessful treatments, even misdiagnoses, may be explained by

the theoretical framework in which the profession operates. Shock is no exception. The theoretical basis — the supposed benefit of grand mal seizures — is totally discredited. Ask the Epilepsy Association about just what good seizures do...

For example, in 1976, in the Canadian Journal of Psychiatry, C.G. Costello, Professor of Psychology at the University of Calgary writes that "All the studies attempting to evaluate the therapeutic efficacy of E.S.T. were at fault methodologically."

Another example: More than 40 years ago, the American Journal of Psychiatry reported, "To put it bluntly, I do not believe that we can scramble brains and expect to have anything left but scrambled brains." (anon. vol. 99, pp 90-93, July '41).

The vast majority of the profession agrees: less than 1 in 4 psychiatrists uses shock. Yet there is still so much fear of criticism in the profession that I have myself spoken to a psychiatrist, practising in a Toronto hospital, who is adamantly opposed to shock. He sees it as a political procedure used on the poor, the elderly, youth, and above all — on women, the most powerless, *not* the most disturbed. He will not say so publicly. He fears being labeled a "radical" and having his career put in jeopardy.

The most notorious example of the sort of professional egomania he fears was probably Dr. Ewan Cameron of Montreal: President of the Canadian Psychiatric Association, the first President of the World Psychiatric Association, later President of the American Association, and a C.I.A. agent experimenting with shock and L.S.D. as brainwashing tools in Quebec (Project M K ULTRA). If the profession's powers-that-be are not more humane today — why has this man not been publicly repudiated by the profession?

The shockers talk about it as a life-saver. "Patients so disturbed that they are a danger to themselves — something must be done." A convincing and guilt-inducing argument, except that the claim has no available proof. The percentage of suicides under a doctor's care of any kind is unknown. Instead, shock advocates fall back on professional reassuring presentations of anecdotal "evidence:" they have patients who've been shocked who will assert that without it, suicide was inevitable, etc.

That is hardly surprising: Dr. Lothar Kalinowsky, a well-known shock advocate, in one of his publications asserted that complaining about shock, especially memory loss, is a sure sign of incomplete treatment, and a reliable indicator of the need for more shocks!

Most of the medical profession goes to great lengths to avoid seizures — a few deliberately induce them.

Great efforts are made by most to help amnesiacs — but a few deliberately cause it.

Fifteen volts, applied below the belt, is commonly called torture. Ten times that, applied to a living, human brain, has a different name.

The burden of proof for this bizarre violation of normal, conservative practice must rest with its advocates. They have had almost half a century to provide it. What is the situation today?

Eight years ago, a Congress of the World Health Organization heard that "EST is an entirely empirical form of therapy having no scientific rationale, opinions within the profession are divided, and it is not devoid of complications."

Last year, former American Attorney General Ramsey Clarke told the annual convention of the A.P.A. that "Electroshock Is Violence."

Today, I am telling you that it is still done over a thousand times a month in Ontario, and it is disgusting.

I urge this Board to do all in its power to order a Moratorium on Shock in Metro to be continued until such time as the necessary research has been done.

ANTI-SHOCK CONTACTS: GROUPS & INDIVIDUALS

Note: Groups and individuals who are actively working to abolish electroshock and wish to add their names, addresses and/or phone numbers to this Anti-Shock Contact List should write to: *Phoenix Rising, Box 7251, Station A, Toronto, Ont. M5W 1X9.*

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ECT As Restraint: Illegal and Undesirable

Excerpts from "ECT As A Form of Restraint," J.J. Jeffries, M.B. and V.M. Rakoff, M.B., Canadian Journal of Psychiatry, Vol. 28, Dec. 1983.

"The question arises whether ECT can reasonably (and legally) be considered a form of restraint."

"In the particular case under consideration in this paper, legal opinion was sought and the opinion given was that this was primarily an issue of clinical judgement, in circumstances where ECT might be considered safer and more humane than chemical or cuff restraint."

"The patient's mother could legally have given permission for us to proceed with ECT as treatment. She did not wish to do this because, although she felt that the treatment might very well be helpful, she was afraid her son would bear a grudge against her afterwards because of her signature on the consent. We respected this as a reasonable judgement by the mother."

"...it was again decided that ECT was needed. As in the first instance, consent was not available but this did appear to present a psychiatric emergency in which control was necessary to protect others from the patient."

By ELAINE NEWMAN

In the December 1983 issue of Canadian Journal of Psychiatry, an article appeared in which J.J. Jeffries, M.B. and V.M. Rakoff, M.B. reported a case in which electroconvulsive therapy was administered to a patient at the Clarke Institute of Psychiatry without the patient's consent, without consent of his nearest relative, and without an Order of the Regional Review Board.¹

The treatment was justified by the authors on the following basis:

1. The patient was aggressive and abusive, physically and verbally.
2. The patient failed to respond adequately to large doses of diazepam, haloperidol and paraldehyde, administered pursuant to a program of rapid neuroleptization.
3. The nearest relative would not sign a consent to ECT, and it was either assumed or determined that it would be a week before a Review Board could be convened.
4. A clinical decision was made that ECT for this patient, in these circumstances constituted "restraint".

The case report reflects that this use of ECT was successful, and that behaviour was thereby sufficiently modified as to enable the physicians to remove the patient from physical restraint and to institute a course of chemical treatment to which the patient did provide consent.

The authors therefore advocate that ECT be "legalized" as a form of restraint, and that it should be specifically mandated by the legislation.

A Clear Violation of the Legislation

It is the opinion of this author that the facts of this case reflect a clear violation of Ontario's *Mental Health Act*². Under present legislation, ECT is not permitted as a form of restraint.

The Act's definition of "restraint" is limited. " 'Restrain' means keep under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient."³

The definition contemplates only the limited use of physical holds, mechanical devices such as straps or jackets, and drugs. Even the broadest interpretation of this definition would not allow for the reasonable inclusion of electric current as a permitted form of restraint.

Electroconvulsive therapy is a form of treatment, not a form of restraint. It is a more aggressive intrusion than holding, confining, or sedating. It goes beyond the notion of mere control, well into that part of medicine and psychiatry which forms active treatment.⁴

As such, electroconvulsive therapy may not be performed without the consent of the patient, or his nearest relative. If the patient or relative do not consent, the physician favouring ECT must apply to the Regional Review Board for an Order directing the specific course of treatment for the involuntary patient.

Doctors Jeffries and Rakoff report that their legal advisors concluded that their unauthorized use of ECT was justifiable as the result of "clinical judgment". With my respect to the authors and their legal counsel, I suggest that this course was in no way justified by either the facts or by the legislation, and constituted nothing less than a battery upon the patient—it was an intentional, unauthorized application of force upon his person.

Disregarding the Regional Review Board

As a form of therapy, the proposed ECT program should have been presented as a proposed course of treatment to the members of the Regional Review Board. This is one of the most basic protections provided by Ontario's *Mental Health Act*.

The members of the Board (which must include at least one lawyer, one psychiatrist and one lay person) hear the application and decide if the treatment may be performed. In so doing they hear from the doctor proposing treatment. They hear from one other psychiatrist from the same facility, and they hear from another outside of the facility. The patient has the right to be heard in this proceeding, to be represented by counsel, to cross-examine, to call witnesses of his own, and to make representations and argument.

The Board can only order treatment if it determines that:

- a) the mental condition of the patient will be or is likely to be substantially improved by the treatment, and
- b) the mental condition of the patient will not or is not likely to improve without that treatment.⁵

The importance of the Review Board process is further emphasized by the recent proclamation of section 66 and 67 of the *Mental Health Act*. The sections strengthen the rights of the involuntary patient by among other things, ensuring that a lawyer will be available to him, and ensuring that the hearing will be conducted according to principles of fairness and natural justice.

With this step the legislature has emphasized the importance of the Review Board proceedings, and underscored the belief that they are hearings which must be conducted in a fair and cautious manner, with rights of the patient protected.

Where a physician disregards the needs to take a treatment question to the Board, where any professional disregards the process by which he is legally bound, a dangerous thing happens. The protections of legal process are lost. The safeguards of the entire legislative process are abandoned. And a decision affecting the life and the future of another is made upon the sole discretion of the individual physician.

There is a place in our judicial system and in our network of mental health law for individual discretionary decision making. We do delegate certain decisions to the individual discretion of our physicians. But society as a whole has reflected its position on this issue through the elaborate, historical, legislative rule-making process. That legislature has provided the mechanism for a cautious, almost judicial approach to rendering treatment decisions in mental health. That process protects the patient in countless ways, both substantive and procedural, and it may not be ignored by professional people, however well intentioned, who place their clinical judgments above the judgments of our society and our laws.

If the problem is one merely of the availability of the Board, as it may have been in this case, then procedures must be adopted which will enable that Board to convene on an urgent basis. It is not a justification for disregarding the process.

Mandating ECT as Restraint

Based on their success in this one reported case, Jeffries and Rakoff advocate the "legalization" of electroconvulsive therapy as a form of restraint.

The suggestion is troublesome, based as it is, on this single, isolated clinical experience.

The suggestion is troublesome, coming as it does, at a time when even the judiciary has lamented the minimal scientific data available on the short and long term effects of ECT.⁶ This is a factor which should cause us to guard against use of ECT rather than to increase its applications.

The suggestion is troublesome, given the nature of ECT and the usual emergency conditions under which restraint is required. The circumstances do not permit the kind of cautious preliminary diagnosis and appreciation of patient history which is advisable prior to administration of ECT.⁷

Jeffries and Rakoff, cont.

"Subsequently his behaviour was quite well controlled and he presented no serious management problems. The emergency ECT was therefore discontinued."

"He slept for 4 hours but awoke verbally abusive. Shortly thereafter he received 2 further ECT lasting 90 seconds and 30 seconds. Thenceforth he was well controlled and quite pleasant in his interactions."

"He was unwilling to give consent and it was inappropriate for his mother to do so and a clinical decision was made that ECT for this patient constituted "restraint." Indeed, the clinical course was even more gratifying than one could have optimistically predicted and suggests that for this particular patient (and perhaps others like him) ECT should be considered the 'restraint of choice.'"

"...the patient had a history of bipolar affective disorder, and his behaviour was a disabling consequence of his illness."

"There can, in short, be little doubt that the ineffectiveness of medication, the history of previous response to treatment, the grave danger to the patient and others, places the ECT he was given in the category of medical treatment."

Jeffries and Rakoff, cont.

"Physicians may, however, be unwilling to use this particular approach because it is not dealt with in the current Ontario Mental Health Act."

"This case strongly suggests that use of ECT as restraint is warranted and should be legalized when there is convincing evidence to support such action."

"While the authors emphasize that ECT used simply to restrain difficult people constitutes a misuse of an effective medical treatment, it nevertheless has a carefully defined place in the armamentarium of safe and humane techniques of restraint."

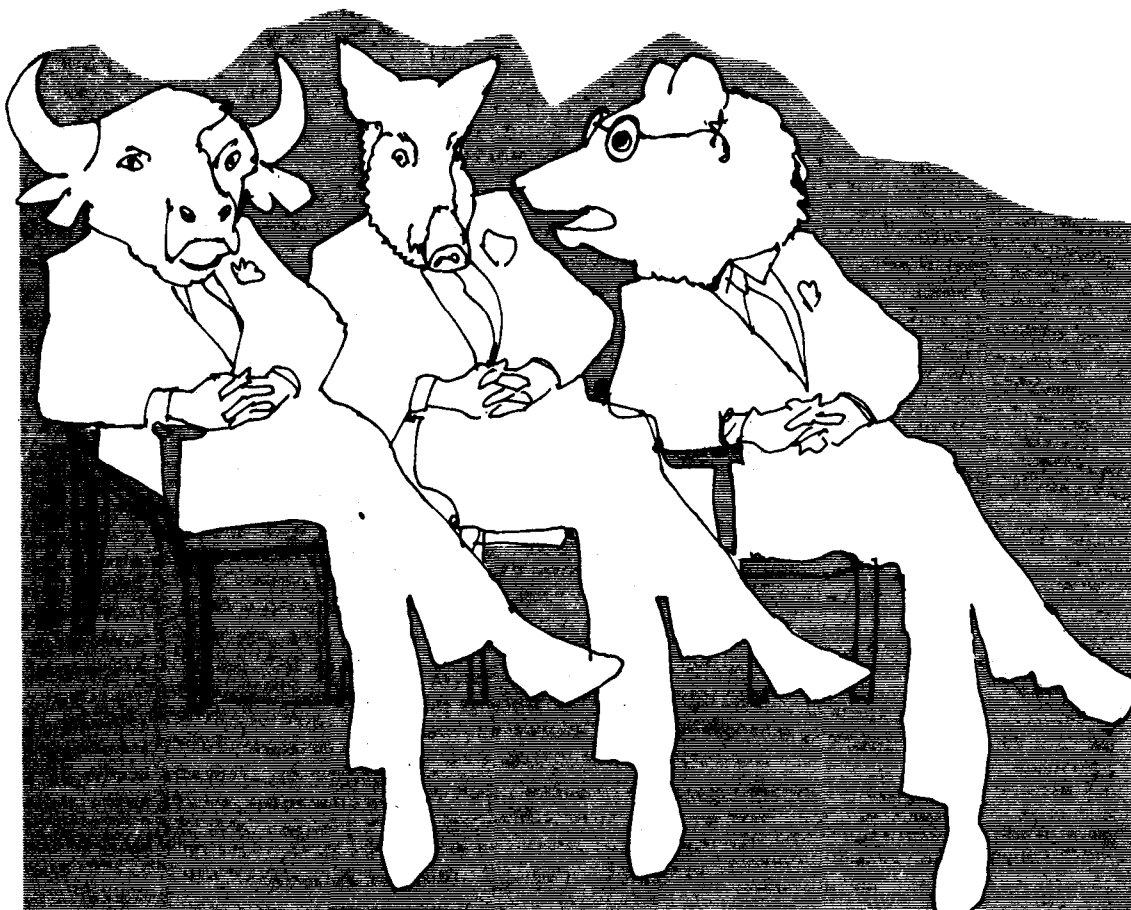
The suggestion is disturbing, given the intense nature of the intrusion which ECT causes upon the body. If the Canadian Charter of Rights and Freedoms has any vitality in the area, then this is a time for examining the *least* restrictive restraint methods for the involuntary patient, and not a time for expanding the arsenal of the most intrusive.

The suggestion is most disturbing, given the concerns of the community of academics, psychiatric patients and former psychiatric patients, supported by a growing proportion of medical professionals⁸, who question whether ECT can be medically and legally justified under any circumstances, and particularly in cases where the patient and his family withhold consent.

Footnotes

1. Jeffries and Rakoff, "ECT as a form of Restraint", 1983 Can. J. Psychiatry 661
2. R.S.O. 1980, c.262
3. S.I (a)(t)
4. For judicial discussion of ECT as a form of treatment, see for example, *Price v Sheppard*, Supreme Court of Minnesota, 1976, 239 N.W. 2d 905, *New York City Health and Hosp. Corp. v Stein*, Supreme Court of New York, 1972, 70 Misc 2d 944, 335 N.Y s.2d 461.
5. S. 35(5)
6. *D.T. v. Bd. of Review for the Western Region of Gary Wood*, yet unreported, Supreme Court of Ontario, December 5, 1983, Madame Justice Van Camp.
7. Pankrat 2, "Position Paper on Electroconvulsive Therapy", 1978, Professional Standards and Practice Council Canadian Psychiatric Association.
8. See for example, Burgdorf, *The Legal Rights of Handicapped Persons*, 1980, Brookes Publishing Co. Inc., Baltimore, Maryland.

*Elaine Newman is a lawyer at ARCH
(Advocacy Resource Centre for the Handicapped)*



Shock Bibliography:



Selected Annotated References on Electroshock with Special Emphasis on Brain Damage

prepared by DON WEITZ

To order copies of this bibliography, please write to: Ontario Coalition to Stop Electroshock, Box 7151, Station A, Toronto, Ontario M5W 1X9. Cheques or money orders should be made payable to: "Ontario Coalition to Stop Electroshock". Please indicate on cheque or in an accompanying note that this is for the bibliography.

For shock survivors/ex-psychiatric inmates/antipsychiatry groups, cost per copy is \$1.50 plus .50¢ mailing charge (total cost per copy \$2.00). (U.S. \$1.25 + \$1.50. \$1.75 total).

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Free to anyone currently an inmate of a psychiatric institution or prison.

For Example:

1952 Hartelius, H. Cerebral changes following electrically induced convulsions. *Acta Psychiat. Neurol. Scand., Supplement 77:1-128.* 57 cats, 41 shocked, 16 controls not shocked. 4 to 16 shocks. In subgroup of 16, all 8 shocked and 8 unshocked correctly identified by blind microscopic examination of brain specimens. Damage: changes in vessel walls, acute cerebral edema (brain swelling), multiple hemorrhages, massive tissue damage. "... the question of whether or not irreversible damage to the nerve cells may occur must be answered in the affirmative." ("The definitive study on the brain-damaging effects of electroshock." — Breggin, 1979)

1978 Frank, Leonard Roy, ed. The history of shock treatment. Self-published.

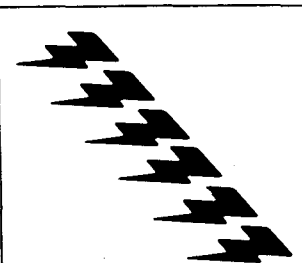
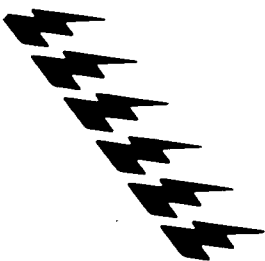
Compiled and thoroughly researched by a shock survivor, an outstanding collection of writings on shock and its devastating effects. Contents include pro-shock opinions of shock doctors, personal protests by shock survivors, a "Shock Doctor Roster", an "ECT Death Chronology" listing 384 deaths, and dramatic illustrations. (Copies available from Leonard Roy Frank, 2300 Webster St., San Francisco, CA 94115, or from Phoenix Rising, Box 7251, Station A, Toronto, Ontario M5W 1X9.

1979 Breggin Peter R. Electroshock: its brain-damaging effects. New York: Springer Publishing Company.

This internationally respected anti-shock psychiatrist amasses an impressive body of clinical/case history/research/autopsy evidence to support his thesis: that shock "works" by always disabling the brain. Over 100 humans and animals studies reviewed, showing massive brain damage by shock. Also 6 detailed case studies of modified shock.

Anti-Shock Books Available in Toronto

The History of Shock Treatment by Leonard Roy Frank (self-published, 1978), and *Electroshock: Its Brain-Disabling Effects* by Dr. Peter R. Breggin (Springer, 1979) are being sold at two book stores in Toronto: SCM Book Room, 333 Bloor St. W. (ph: 979-9624), and The Bob Miller Book Room, 180 Bloor St. W. (ph: 922-3557). Frank's *History of Shock Treatment* is also available for \$8 at the Phoenix Rising Office, 1860 Queen St. E. (ph: 699-3194). Although out of print, the book *Shock Treatment Is Not Good For Your Brain* by Dr. John Friedberg (Glide, 1976) is also available in the Medical-Science Library of the University of Toronto (St. George Campus).





Rights and Wrongs

Shock Case:

A Defeat

And Victory

By Don Weitz

The public and media were recently surprised to discover that electroshock ("ECT" or "electroconvulsive therapy") is still legal and can be forcibly administered as a "medical treatment" to any person in a psychiatric facility in Ontario—in fact across Canada. The inter-related issues of electroshock and forced treatment were highlighted by the recent legal case of Mrs. T. (She does not want to disclose her name.) Mrs. T. is a 35 year-old psychiatric inmate who refused to submit to electroshock last year. Almost immediately after her involuntary admission last August to Hamilton Psychiatric Hospital, her psychiatrist (Dr. Paul Denew) began pressuring Mrs. T. to consent to shock. Mrs. T., who was (still is) competent, flatly refused. Convinced that Mrs. T. was suicidal and therefore in immediate need of electroshock, Dr. Denew also pressured Mrs. T.'s husband and father in early September to consent for her. They also refused.

Despite these refusals and the fact that Mrs. T. was judged competent, Dr. Denew and three other psychiatrists (The *Mental Health Act* requires two other doctors) asked the Western Regional Board to overrule Mrs. T.'s refusal. (There are 5 review boards in Ontario). After a hearing on October 12, the board agreed with the psychiatrists and ordered a series of shock treatments (up to 15) for Mrs. T starting November 2.

In late October on behalf of his wife, Mr. T. retained lawyer/patients' rights advocate Carla McKague to prevent the hospital from administering electroshock to Mrs. T. An immediate application was made, supported by an affidavit by Mr. T., for an interim injunction to forbid the hospital from proceeding with shock until the court could decide whether the board had authority to

authorize shock. But the hospital voluntarily agreed to postpone shock until the case was heard.

In his affidavit, Mr. T. claimed that electroshock is a form of psychosurgery as defined in the *Mental Health Act*; the *Act* prohibits psychosurgery for any involuntary patient. He also attached a list of over thirty references from the medical literature showing the "serious and permanent deleterious effects of ECT." These effects include permanent memory loss, brain damage and many other serious complications including death. He also claimed that shock has not been proven to prevent suicide. Mr. T. asked the court to decide "whether the Board of Review has jurisdiction to authorize ECT."

The case was scheduled to be heard on December 1 as a matter of urgency under *judicial review*. A judicial review is a court procedure involving a review of an action or decision by any administrative tribunal, such as a review board. A judicial review is not an appeal, and the court has no authority to decide if the tribunal's decision is right or wrong. Under judicial review, the court can only decide if: 1) the review board followed correct procedures in reaching its decision, and 2) the review board had the power to make its decision. Further, during a judicial review, the court only sees the record of proceedings before the board, affidavits and transcripts of cross-examinations as evidence. There are no live witnesses and jury.

Acting for Mrs. T., lawyer McKague obtained affidavits from expert medical witnesses who stated that electroshock has many serious risks including brain damage. These witnesses were: Dr. Peter R. Breggin (a psychiatrist in the USA and author of *Electroshock: Its Brain-Disabling Effects*, 1979); Dr.

Hans Kunov (Professor of Biomedical and Electrical Engineering at U. of T.); and Dr. Sidney Sament (a neurologist in the USA). Representing the hospital, lawyer Peter Jacobsen (Attorney-General's Department) had testimony from four medical experts: Dr. Barry Martin (psychiatrist and head of electroshock at the Clarke Institute of Psychiatry); Dr. Brian Hoffman (another 'Clarke' psychiatrist); Dr. Henry Berry (neuro-psychiatrist), and Dr. Thomas Morley (neurosurgeon).

The case was heard on December 1 and 2 before Madam Justice Van Camp in the Supreme Court of Ontario. In her argument, Ms. McKague addressed the issue of "onus of proof." Onus of proof is a legal point. If you're attacking the authority or right of a tribunal such as a review board to make a decision, and if that attack depends upon a particular fact, then you have to prove that fact. Ms. McKague argued that Madam Justice Van Camp should not consider onus of proof but instead consider the *principles of statutory interpretation*. One of these principles states that if the wording of a statute (written law) is ambiguous or can be interpreted in two or more ways, the judge should choose that interpretation which infringes least on the person's rights. More specifically, if Madam Justice Van Camp was uncertain as to whether the definition of psychosurgery in the *Mental Health Act* does or does not include electroshock, she should interpret it as including electroshock, since that would least violate the person's right to refuse treatment. Madam Justice Van Camp rejected Ms. McKague's argument in ruling that the definition of psychosurgery in the *Act* is not ambiguous. Ms. McKague argued that psychosurgery is in fact a form of psychosurgery and cited the full de-

finition in section 35 of the Act:

“psychosurgery” means *any procedure, that by direct or indirect access to the brain, removes, destroys, or interrupts the continuity of histologically normal brain tissue, or which inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behaviour or treating psychiatric illness, but does not include neurological procedures used to diagnose or treat organic brain conditions or to diagnose or treat intractable physical pain or epilepsy where these conditions are clearly demonstrable.* (my emphasis)

To support her argument, Ms. McKague cited expert medical testimony about many relevant animal and human autopsy studies and studies of permanent memory loss, all of which showed evidence of brain damage resulting from electroshock. In rebuttal, lawyer Jacobsen argued that electroshock is a safe and effective medical procedure; he also tried to discredit Ms. McKague’s expert medical witnesses. For example, Jacobsen challenged the credibility of Dr. Peter Breggin in pointing out that Breggin had not admitted any patient to a psychiatric hospital during the last ten or more years; he labelled Dr. Breggin “a gadfly.” Dr. Breggin, it should be noted, works to prevent hospitalization and many of his patients include people diagnosed depressed or suicidal and who have experienced electroshock.

In response, Ms. McKague challenged all of Jacobsen’s witnesses. For example, she asserted that Dr. Morley admitted during cross-examination that he was “not qualified” to discuss the effects of electroshock or psychosurgery. Dr. Martin cited only one study to support his belief that electroshock prevents suicide. In fact, that study found that it did not prevent suicide. She also pointed out that Dr. Hoffman had read virtually no original studies on electroshock and brain damage; he relied on summary/review articles. Madam Justice Van Camp chose to believe the “impartial” testimony of Dr. Berry.

On December 5, Madam Justice Van Camp announced her decision:

...study is needed of the effect of the administering of ECT in Ontario under its present form. What has been put before me is either speculation or possibilities.

The wide-ranging investigation that has been done of the research, reports and editorial comment over the years in other countries by those who have done original research and others does not, either in any one respect or cumulatively, provide proof that ECT destroys or interrupts

the continuity of normal brain tissue. It is not sufficient to say that each of animal research, human autopsy studies, EEG, the study of electrical current, leaves unanswered some questions. A collection of uncertain possibilities does not lead to a positive conclusion.

The research cited is of methods which have changed. It leaves unanswered questions which are necessary to an analysis of it. The researchers themselves have not drawn the conclusion that the applicant asks this court to draw. I recognize that, in their scientific caution, the researchers have not closed the door, but their conclusions are adverse. It may be that the questions they raise will inspire other researchers who may find the answers. But at the moment, the material is not sufficient to lead to the conclusion of permanent damage to brain cells or the continuity of normal brain tissue.

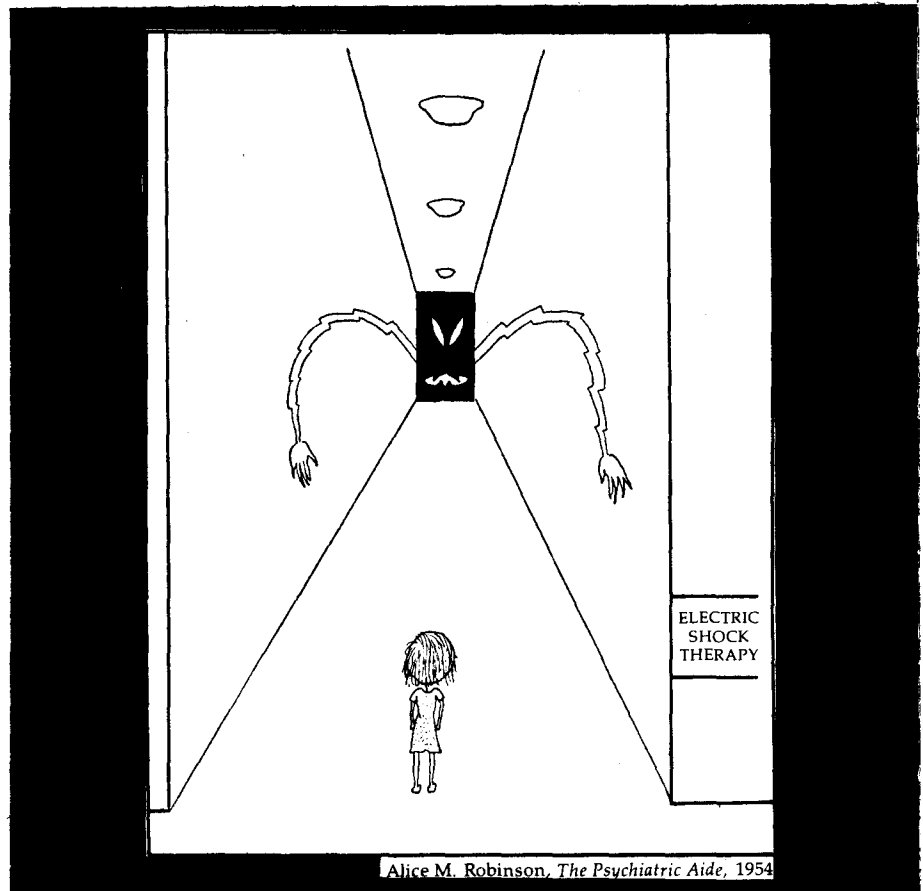
Since ECT does not then come within the definition of psychosurgery, the Board of Review had jurisdiction to authorize the treatment.

Shortly after the court decision, Mrs. T. instructed Ms. McKague to apply for leave to appeal to the Court of Appeal. Documents for leave to appeal were filed on December 8. Although *Charter* arguments had not been raised in the original hearing because of time pressures, they were about to be raised

on the leave to appeal application. The constitutional argument was to be based upon section 7 of *The Canadian Charter of Rights and Freedoms*: “the right to life, liberty and security of the person and not to be deprived thereof except in accordance with the principles of fundamental justice.”

However, on December 10, as a result of an agreement between the Ministry of Health and Mrs. T., she was transferred to another psychiatric institution and psychiatrist, who undertook not to administer electroshock to her. Consequently, there were no legal grounds to appeal and the application for leave to appeal was withdrawn.

Although the case was lost, it was a clear victory for Mrs. T. since she was spared electroshock, and the case marked the first court challenge of electroshock or probably any other psychiatric “treatment” in Ontario or Canada. The media gave a lot of attention not only to the case but the issues it raised: the brain-damaging effects of electroshock, forced treatment, the dictatorial power of review boards and lack of inmates’ rights. It also sparked considerable political debate and government attention. Immediately after the court decision, Ontario NDP leader Bob Rae raised Mrs. T.’s case in the Legislature and confronted Health Minister Keith Norton. On December 6, Rae asked Norton:



"...how does the minister feel about a medical treatment of such seriousness and of such controversy being performed on a patient, not only against her consent but also against the consent of all the members of her family?" Rae also criticized Norton and the provincial government for failing to proclaim sections 66 and 67 of the *Mental Health Act* which would give psychiatric inmates the right to cross-examine witnesses during review board hearings, the right to see their medical records and the right to appeal a review board decision to the court. Since 1978 when

these amendments were passed by the legislature, these important rights have not been proclaimed. To date, no reason has been given.

In the legislature and media, Health Minister Norton has stated that he is "somewhat troubled" by the fact that electroshock and other psychiatric procedures can be administered without consent. Mainly because of this case and the educational-political activities of the Ontario Coalition To Stop Electroshock, Norton recently announced his intention to appoint an inter-

national panel of experts, possibly including shock victims or ex-psychiatric inmates, to investigate electroshock in Ontario. It's still uncertain whether Norton will appoint shock victims or empower the panel to hold public hearings. However, one thing is certain. There will soon be test cases under *The Charter* challenging the constitutionality of electroshock and other forced psychiatric treatments in Ontario — probably this year. It's about time!
Note: My sincere thanks to Carla for her valuable assistance in preparing this article.

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.

Ahmad Khalil. Nova Scotia Hospital, Dartmouth, N.S.

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

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

Aquino, Manny. Nova Scotia Hospital, Dartmouth, N.S.

Arndt, Hans. Northwestern Hospital, Toronto, Ont.

Bhattacharyya, Amal. Nova Scotia Hospital, Dartmouth, N.S.

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

Buffett, Larry. Nova Scotia Hospital, Dartmouth, N.S.

Dr. E.R. Camunias, Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.

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

Cornish, David. Alberta Hospital, Edmonton, Alta.

De Coutere, Ivan. Nova Scotia Hospital, Dartmouth, N.S.

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.

Fleming, Russel L. Penetanguishene Mental Health Centre, Penetanguishene, Ont.

Dr. Y. Gosselin, Ottawa General Hospital, Ottawa, Ont.

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.

Holland, Lieselotte. Nova Scotia Hospital, Dartmouth, N.S.

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.

O'Brien, Jim. Nova Scotia Hospital, Dartmouth, N.S.

Dr. J. O'Reilly, Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, 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.

Poulos, Harry. Nova Scotia Hospital, Dartmouth, N.S.

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.

Singh, Manbir. Nova Scotia Hospital, Dartmouth, N.S.

Dr. I Sirchich, Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.

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

Stacey, Don. Nova Scotia Hospital, Dartmouth, N.S.

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

Dr. R.E. Stokes, Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.

Tomlinson, Mary. Nova Scotia Hospital, Dartmouth, N.S.

Varan, Lily R. Ottawa General Hospital, Ottawa, Ont.

Villacastin, Sisino. Nova Scotia Hospital, Dartmouth, N.S.

Wood, Bill. Nova Scotia Hospital, Dartmouth, N.S.

Yoon, Suk. Nova Scotia Hospital, Dartmouth, N.S.

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

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

Our shocking lack of laws

By DICK CHAPMAN
Staff Writer

Today in Ontario, mental patients certified as "involuntary" can be forced to have their brains zapped with electricity or their veins injected with mind-bending drugs.

In the late 1950s and early 1960s, the nine Canadians — among them the wife of an MP — were patients at a Montreal psychiatric institution. There, instead of simply being treated, they were used as guinea pigs by the CIA. They were drugged, shocked and subjected to a mind-control technique called

Barbaric practice must be abolished

Shock treatments must be outlawed. Every shock treatment kills 50,000 brain cells. I have been given 48 shock treatments for schizophrenia which have permanently damaged my

Tues

No shock without consent
Except in the most extraordinary matters of life and death, nobody should be forced to take medical treatment they don't want. Yet Ontario Supreme Court Justice Mabel Van Camp has ruled that the law says otherwise.

VISION

Day in electric shock

jurisdiction of psychiatric review boards.

Van Camp made the ruling in dismissing a woman's appeal against having electric shock treatment (Electro-Convulsive Therapy or ECT).

Protesters demand an end to electro-shock 'torture'

By John Munch Toronto Star

As a teenager, Hugh Tapping played Rachmaninov and Brahms. Today, at age 35, he cannot play a note.

He blames electro-shock treatment he was given "as a 17th birthday present."

shock should be abolished as a form of so-called "treatment," said Don Weitz, spokesman for the Ontario Coalition to Stop Electroshock, which organized the protest.

"Elec Woman Given ECT Commits Suicide"

It 'made me a zombie,' patient says

By Radha Thampi Toronto Star

Fred Serafino and Shirley Johnson are a Hamilton couple who say they are finally piecing together their "shock-shattered" lives.

"It took us a long time to sort out things, you know. But I guess, finally, we are getting there," says Serafino, 30, a nursing orderly who says shock therapy "made me a complete zombie" for

Brain transplants without consent next?

Serafino recalls the period after his shock treatments as a terrible time. "I even had problems catching my breath," he says. "I had transfers. I

The Sunday Sun, October 23, 1963

SAYING NO TO SHOCK

Members of the Ontario Coalition to Stop Electroshock marched yesterday from City Hall to the Clarke Institute of Psychiatry to protest the controversial treatment. The coalition says that since 1966 the institute has given 23,000 shock treatments to more than 2,500 people. Members say the treatment is violent, causes memory loss and should be banned.

Frantic psychiatrists push shock treatments

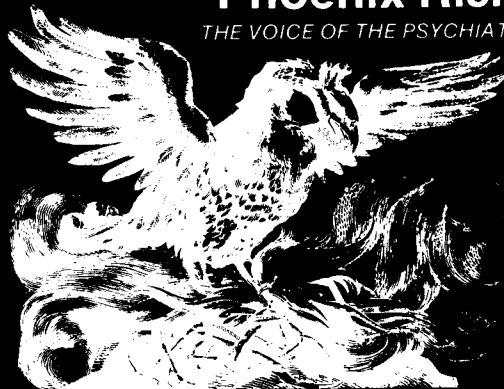
94-Year-Old Woman Shocked

Three-Year-Old Boy Shocked

“To put it bluntly, I do not believe that we can scramble brains and expect to have anything left but scrambled brains.”

(Anonymous, American Journal of Psychiatry, Vol. 99, pp. 90-93, July 1942)

Phoenix Rising
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Secret Tests

In February of this year the Canadian press broke the story that the Government of Canada, the CIA and the US Army funded brain-damaging "treatments" conducted by psychiatrist D. Ewen Cameron at the Allan Memorial Institute in Montreal from 1950 to 1964. Through its Defence Research Board, the Canadian Government gave \$500,000 to Cameron over a 14-year period; Government officials, however, are still denying or refusing to admit knowledge of Cameron's disabling "treatments" and their devastating effects. In addition, the CIA gave \$64,000 to Cameron from 1957 to 1961, and the US Army gave up to \$75,000 a year for 20 years (1949-1969) to the Allan Memorial for "truth serum" experiments. (This information came to light through applications made by The Province in Vancouver and The Toronto Star under the Access To Information Act.

From 1950 to 1964, Cameron—the "founder of Canadian Psychiatry" and former President of both the American Psychiatric Association and World Psychiatric Association—subjected over 100 "schizophrenic" and "depressed" psychiatric inmates (mostly women) to his "deprogramming" experiments. "Deprogramming" is a euphemism for destroying human identity by various brain-damaging techniques. Cameron's "deprogramming" techniques included: repeated electroshocks (as many as 10 per day and up to 60 in a month); prolonged "sleep therapy" (involving drug-induced sleep for days or weeks at a time with massive doses of barbiturates or insulin comas); LSD injections; "psychic driving" (repeated bombardment with tape recorded guilt-producing messages played for hours at a time while "patients" were unconscious or even conscious); "photic driving" (repeated bombardment with flashes of light, about 15 per second, which caused severe headaches, tension and/or hallucinations); and "isolation" or solitary confinement for days at a time.

As a direct result of such "treatments," virtually all of Cameron's victims suffered massive and permanent memory losses, brain damage and many other lifelong intellectual and emotional disabilities. In a 1960 journal article, Cameron himself admitted the massive memory losses. He partly described a "deprogrammed schizophrenic" patient in these terms: "All schizophrenic symptoms have disappeared. There is complete amnesia for all events of his life."

Nine Canadian victims of Cameron are suing the CIA for \$1,000,000 each for the psychiatric tortures they were forced to endure under Cameron from 1957 to 1963. One victim is Val Orlikow, wife of David Orlikow, NDP M.P. from Winnipeg. In 1981, Ms. Orlikow received \$65,000 including legal costs from the Allan Memorial in an out-of-court settlement. She and other Canadian victims may soon launch a class action suit against the Canadian Government as well.

In this issue, we're pleased to publish a transcript of a special documentary broadcast on "the fifth estate" program of CBC-TV on January 17th this year. We thank the CBC for its permission. For further accounts of Cameron's tortures and the CIA connection, please see previous issues (Vol 3, No. 3, pp. 22-25; Vol. 2, No. 2, 1981, p. 24) and the book Search For The 'Manchurian Candidate': The CIA and Mind Control by John Marks (1979). We will publish further articles on Cameron and the CIA/Canadian Government connections in future issues.

Eric Malling, reporter, fifth estate

In Winnipeg, Val Orlikow spends a lot of time tending her plants. It's one of the few hobbies she has left. She used to devour books and write long letters. Now she can't concentrate on a book for more than a single page, and writing a letter is beyond her. She's on medication 24 hours a day. If she wasn't married to David Orlikow, an NDP member of parliament, she might never have learned the full story of what happened to her.

In 1956, suffering from depression after childbirth, Mrs. Orlikow was referred by her Winnipeg doctor to a top psychiatrist in Montreal. Unknowingly, she was about to become a part of a cruel C.I.A. experiment codenamed MK-ULTRA.

In Langley, Virginia, outside of Washington, stands the headquarters of the Central Intelligence Agency, protected

by walls of secrecy as high as the trees. Stored inside computers like this one is what's left of the C.I.A. files on the MK-ULTRA Project. Convinced the Soviets and Chinese had perfected brainwashing during the Korean War, the agency sought to perfect its own techniques, both to protect its agents and to use as a weapon.

John Gittinger, former C.I.A. operative

Who did you meet with in the safe-housing?

Eric Malling

The C.I.A. man overseeing the project was John Gittinger.

John Gittinger

There was continued pressure put upon anybody within the agency in connection with trying to explain or understand brainwashing. So, we were charged with rather an elaborate attempt to try to find out chemical, psychological,

**Published with permission from the fifth estate.*

any kind of means that people could use to influence the behaviour of other people.

Eric Malling

In Montreal on the side of the mountain overlooking the city stands an ancestral home bearing a name worthy of an Edgar Allan Poe horror tale—Raven's Crag. Donated to McGill, Raven's Crag became the Allan Memorial Institute for the Treatment of Mental Illness. Here the C.I.A. channelled money for MK-ULTRA, Sub-project 68, which becomes a real life horror tale.

The project chief in Montreal was Dr. Ewen Cameron, world renowned Chairman of the Department of Psychiatry at McGill and Director of the Allan Memorial Institute. The C.I.A. secretly funded the medical experiments through a front in New York City, called, of all things, the Society for the Protection of Human Ecology. Documents show that the agency had been impressed with earlier work done at McGill in sensory deprivation, work that was useful in designing sophisticated torture techniques later on. But at the time, brainwashing looked even more promising, and Dr. Cameron was the perfect one to carry out the work—an American citizen with a world class reputation operating outside of the United States.

Dr. Cameron certainly had the credentials. At various times president of the Canadian, the American, and even the World Psychiatric Association.

Dr. Ewen Cameron (excerpt from speech)

These are the days and ours are the occasions—

Eric Malling

In an address to colleagues from around the world, Cameron showed that he certainly knew the potential of the human mind—for good and bad.

Dr. Ewen Cameron (excerpt from speech)

And it is his mind, no less, which may destroy mankind.

Eric Malling

Val Orlikow came to the Allan for her post-partum depression.

Mrs. Velma Orlikow, former patient

Everybody in the hospital was very much in awe of Dr. Cameron, and he strode the halls like a giant. And people would say, "Oh there but for God, goes god." And to me, I thought how could he possibly ever take me for a patient. Who am I? I mean this great man who's done all these marvellous things. And boy, I better work hard, and I better do everything he tells me to do. And you know, I don't want to lose this opportunity to get well.

Eric Malling

Like Mrs. Orlikow, Mrs. Jeanine Huard of Montreal, came to Dr. Cameron depressed after childbirth. The depression was made worse by a hearing problem that coincided with the birth of her child. She too was in awe of Dr. Cameron.

Mrs. Jeanine Huard

He was a very, very impressive man. And I was told he was the best doctor in North America. So he would look at you a few minutes, ask you a few questions, and then proceed with the treatments.

Mrs. Velma Orlikow

But I never saw him once, in all the times that I saw him, that I wasn't afraid. Every time I went down to his office, I would shake with fear. And everytime I'd see him coming down the hall, I'd shake with fear. But I adored him.

Eric Malling

Dr. Elliot Emmanuel knew Cameron.

Dr. Elliot Emmanuel

He was an authoritarian, ruthless, power-hungry, nervous, tense, angry man—not very nice.

Eric Malling

At Raven's Crag, Dr. Cameron went farther with drugs

and electric shock treatments than any of the U.S. researchers in the MK-ULTRA Project dared. His aim was to wipe the mind clean. Then he would implant new messages by forcing the patient to listen to a hypnotic repetition as many as a quarter of a million times. This was called psychic driving.

Most of the drugs used in the program were experimental—and some dangerous. There was the tranquilizer Artane, a paralysis-inducing Anectine, and Curare which pygmies tip their arrows with to paralyze victims, bulbocapnine—another experimental tranquilizer, and lysergic acid diethylamide—the hallucinogen LSD.

In her room at Raven's Crag, Mrs. Orlikow waited for her first treatment.

Mrs. Velma Orlikow

Well, I saw a tray with a hypodermic—with a needle, a syringe—and the card on it had my name so I looked a little more closely. And it was lysergic acid diethylamide. And my husband was a druggist and I knew a lot of drugs but I'd never heard of that one. And so I phoned a friend who was a psychiatric nurse, and I said, "Do you know what it is?" And she said, "I've never heard of it." But she had a friend who was a psychiatrist, so she phoned her friend. And she called me back and she said, "He said that this stuff causes a poisonous psychosis." She said he had said not to take it. Well I thought, you know, he's a very Freudian psychiatrist and doesn't believe in any medication of any kind. And after all, here is Dr. Cameron—I mean he's the big doctor and he's known all over the world, and he wouldn't do anything that would hurt me, etc. And so, I took the injection, and I didn't like it. And it really did create a poisonous psychosis.

Eric Malling

LSD, with all its frightening mental images, was scarcely known at the time. But the C.I.A. secretly brought some in from Switzerland where it had just been developed.

Mrs Velma Orlikow

The room became very distorted and I thought my bones were all melting. And I just wanted to scream that I wanted to get out of there. And I saw the squirrels outside, and I thought, they're not squirrels, I'm the squirrel. I'm in this cage and I can't get out. And I started to throw myself from side to side in the room. And I couldn't write. They had given me a pencil and paper and asked me to write down, but I couldn't write, I couldn't do anything. I couldn't focus, I couldn't—I don't know—it was like some kind of funny hell I'd fallen into, and I couldn't get out. And I don't know how long that went on. It was just a terrible nightmare. And I just felt that my life was threatened—I could never go back to what I'd been.

Eric Malling

Robert Logie of Vancouver was eighteen when he came to the Allan complaining of trembling and severe leg pains, diagnosed as psychosomatic. Like Mrs. Orlikow and Mrs. Huard, he had no inkling he was to be part of a C.I.A. experiment.

Robert Logie, former patient

The LSD was very horrifying and they gave it to me for about 12 or 15 times. One minute I would see the doctor there, the next minute I wouldn't see him there. And they were asking me all kinds of questions. And I remember them telling me that I was getting smaller and smaller, and I really felt myself getting smaller. And they were bringing me back in time, way back. At one point I almost felt like I was just about to be born, really, that far back in memory. They were really probing, asking all kinds of questions. I felt I didn't have any control—I had to answer, I didn't feel I had any control. I was completely—like they had complete control over me.

Eric Malling

Mrs Huard, like the others, was forced to pay for the so-

called treatment—massive electric shocks and all the drugs.

Mrs. Jeanine Huard

They would give me as much as forty pills a day. And I would ask the nurse, what is that? They would say it's a new drug and they only name it by a number.

Eric Malling

What did all those drugs do to you? How did they make you feel?

Mrs. Jeanine Huard

I was very very strong will-powered, so these drugs kind of desensitized me. They would lower my reactions; they would lower my resistance.

Eric Malling

As well as the experimental drugs and massive electric shock treatments, Mrs. Huard was subjected to psychic driving. Hypnotic-like messages were repeated over and over to a sleeping patient, sometimes for as long as 16 hours in a row. They were a key part of the mind control experiment. This is how Mrs. Huard remembers one of the messages.

Simulated message

Why are you running away from your responsibilities, Jeanine? Why, Jeanine? Why? (voices overlapping)

Mrs. Jeanine Huard

I would try very strongly not to be—not to let my mind be catching all the messages but they would lower my resistance so much with the other drugs. But I couldn't do otherwise than listen.

Eric Malling

Did you ever ask them how any of this was making you better?

Mrs. Jeanine Huard

No, I didn't ask questions. I would just say, I don't want to go through it again. And I would cry. I didn't want it, you know. I knew way down in my heart I knew it wasn't good. But ah, you know, how could you fight? You're in a hospital where it's supposed to be the best with the best doctors. So what can you do?

Mrs. Velma Orlikow

I'd say "I can't, I can't take it anymore. I can't stand it. I don't think this is doing me any good. I feel worse." And he'd walk down the hall a little way with me and put his arm on my shoulder, and "Come on now, lassie, you know you're going to do it." And finally I'd say, "Well, okay," and off we'd go to my room and he would give me another injection and then pat me on the shoulder and off he'd be again.

I had LSD, I believe, a total of 14 times. And sometimes there would be four days between the injections and sometimes there would be one consecutive day after the other. And some of them I managed to write down things in my notes to Dr. Cameron.

Eric Malling

A newly declassified C.I.A. document shows there was at least one voice of protest at the agency as the experiments got underway. One agent wrote, "Does Project Officer approve these immoral and inhuman tests? I suggest that all who are in favour of the above intended operation volunteer their heads for use in Dr. so-and-so's noble project." The names were deleted.

In her hospital room, a terrified Mrs. Orlikow tried to hide like a child at the sound of Dr. Cameron's approaching footsteps.

Mrs. Velman Orlikow

I heard him coming and I hid in the washroom in my room. And I thought "Well, I'll go and sit on the toilet and nobody will see me." Anyhow, that didn't work because he knocked on the door and he said, "Now come on, lassie, we know you're in there, and come on, you come out and let me give you your injection." And I said, "No, I'm not taking any more injections. I can't do it. I don't care if I die. I

can't. I can't do it any more because this is killing me and that's all there is to it. I can't do it." Well, he wasn't very happy about it. However, after a little discussion, he turned on his heel and left the room.

Eric Malling

The electric shock treatments were administered on an unprecedented scale. It was called depatterning. The mind was short-circuited so the psychic driving hypnotic messages could be planted on a clean slate. There is now no known use of electric shocks on such a scale—even in Soviet mental asylums where political crimes are punished.

Dr. Elliot Emmanuel, psychiatrist and former colleague of Dr. Cameron.

As you probably know, electroshock treatment has been given for depression for something like 40 years now. It's a very successful and useful treatment for severe depression that doesn't respond to other things. But depatterning is a use of electroshock treatment in a totally different way in which instead of giving the shocks say two or three times a week, they're given two or three times a day for three or four weeks, reducing the patient to a sort of animal-vegetable state from which it's hoped that they would recover in a more healthy state of mind. It didn't work.

Robert Logie

I was there for a while and I thought, "I don't want to stay here." And I started to run away from the hospital, and they grabbed me, and then they put me on sleep treatment. They kept me asleep for 23 days, and while I was asleep they were shocking the heck out of me with electric shocks and playing tapes.

Mrs. Velma Orlikow

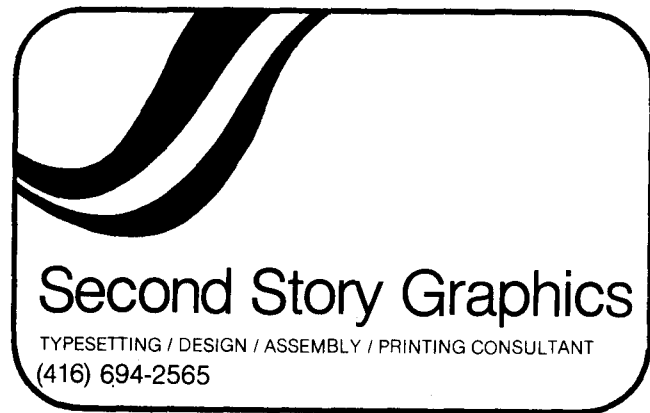
There was another lady who had the same kind of psychic driving that I did, and she was a very wiry, slender lady with lots of pep and zip, you know. And she'd go to the dances and this and that. And one day she just wasn't there. And when we asked where she went, they said, oh well, you know, she's gone to another hospital. Well some time later, I was in the day hospital, and I happened to ask a nurse if she'd heard what had happened to this lady. And she said, "Oh that's her sitting over there." And I looked, and there was a fat lady that looked like she was made out of dough. She didn't know me, she didn't know herself, she didn't know anybody. She was gone. Now that's death.

Eric Malling

Did you ever try to get away from there? Did you ever say, "I'm just not going back"?

Mrs. Jeanine Huard

I tried. I was home for the weekend, and I had a pass for the weekend—that's how they call it. So when I was there I said, "I'm not going back there." So I telephoned or somebody else in the house telephoned. And they said, "If you're not coming back we're sending the police after you." So I remember being so upset. I was crying, I didn't want to go in, and it was really like a concentration camp.



Mrs. Velma Orlikow

There was a gentleman who jumped off the roof of the Allan. I don't think he had LSD, but he had sleep therapy with psychic driving, you know, with the driving tapes under his pillow. And they told him he was going to go home, and he'd just come out of sleep therapy. And he just jumped—he went around, big smile on his face, said goodbye to everybody, went up on the roof—and jumped off. And landed at the back door of the Allan, which was a dreadful, awful thing. I don't think he was more than 30—and he was just gone—just gone. And there was this big, washed area at the back door. Nobody would go in and out of that back door for a long time. And everybody in the hospital spoke in hushed tones—and everybody was affected. They would not talk about it. It was as though it did not happen.

Eric Malling

In 1973, all MK-ULTRA files under the control of the technical services division chief of the C.I.A. were ordered destroyed by the Director, Richard Helms. But in a bureaucracy as vast as the Central Intelligence Agency it's difficult to destroy everything. And the damning evidence of the Cameron project surfaced after a Freedom of Information Act suit. It revealed Mrs. Orlikow had reason for her nightmares and her doubts.

Mrs. Velma Orlikow

I've heard that it was the most brutal program under MK-ULTRA in the States and in Canada, that this was the most brutal. It was an awful feeling to realize when I found out this that the man whom I thought cared about what happened to me didn't give a damn. I was a fly—just a fly.

Eric Malling

Her husband, David Orlikow, NDP member of parliament for 22 years, remembers the cost.

David Orlikow

We had Blue Cross coverage but Blue Cross did not cover treatment in a mental hospital. So what we did after the first year was to sell the house which was really the only money that we had. And my daughter and I moved in with Val's mother, and we stayed there almost three years. It was tough but the financial cost was really a small part of the cost if you're talking about cost. It really disrupted our lives.

Eric Malling

Mrs. Orlikow sued the Allan Memorial Institute last year it quietly settled out of court for \$50,000. But that's only the amount she estimates she had to pay for what she thought was treatment. Apart from giving Mrs. Orlikow her money back, the Allan has done nothing to compensate Cameron's other victims.

But in the U.S., a former C.I.A. director, Stansfield Turner, promised to Congress the agency would try and track down victims of the MK-ULTRA Project in both Canada and the U.S. so they might get compensation. The C.I.A. wrote the Allan this recently declassified letter. Addressed to Maurice Danger, then director, it said, "It has been our understanding that there are no remaining records of Dr. Cameron's research that might reveal the identities of

patients under his care during the time period in question. However, by way of leaving no stone unturned, we now enquire whether this information might be reconstituted through patient records, financial records or other hospital records. Sincerely yours, Daniel B. Silver, General Counsel, C.I.A." So even the C.I.A. made some effort to find the victims, but little help from Montreal.

There's no record of the Allan ever attempting a search of all its medical records, although Cameron's successor admits it would be easy enough to do. C.I.A. documents show that 53 people in Montreal were subjected to the MK-ULTRA experiments but only 9 of those have been positively identified. Apart from Orlikow, Huard and Logie, there were three Montreal housewives, one of whom is now institutionalized. There is a Montreal businessman who never really got his life together again after the experiments. And another man who's been destitute for most of the time since. Ironically enough, one of the victims is now a psychiatrist practising in eastern Ontario. She obviously functions well enough, but after the experiments ten years of her memory was wiped right out.

The McGill project was abruptly terminated in 1964 and so Dr. Cameron returned to the United States. Three years later he died suddenly of a heart attack. Subsequent evaluation of Cameron's work in Montreal by his successor showed that the intensive shock therapy was not only medically useless but potentially dangerous. Cameron, though, never revealed how much he knew about the C.I.A. sponsorship of his work.

Robert Logie was later given cortisone treatment for the pains in his leg that brought him to the Allan in the first place. It worked, but his mind is a different story. He now has joined with Mrs. Orlikow, Mme. Huard, and six other Canadians in a massive law suit against the United States government.

They contend that they sought treatment and instead were made unwitting victims of C.I.A. experiments. The nine Canadians are seeking \$1 million apiece in damages from the U.S. government. The C.I.A. intimidates many American law firms, but this case is being fought by a lawyer who defended Lillian Hellman and Arthur Miller during the McCarthy witch hunts for communists. In preparation, the lawyers have interrogated every C.I.A. agent involved in MK-ULTRA including former director Helms.

With the trial expected to start soon, Joseph Rauh sums up the case with his junior partner, James Turner.

Joseph Rauh

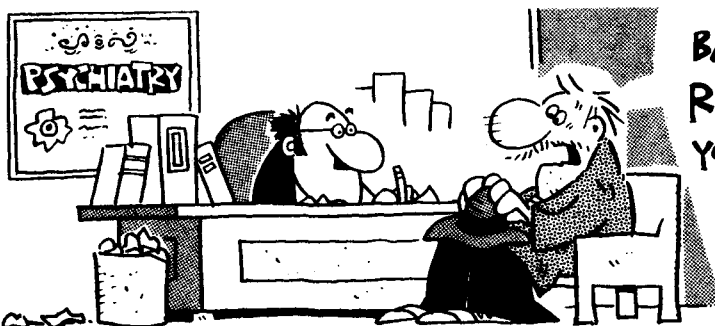
What did we get out of Gittinger?

James Turner

All right, John Gittinger is the former C.I.A. staff agent who testified that at his request the C.I.A. contacted Cameron and informed him that a front in New York would support his work. As a result of that, Cameron received C.I.A. funds to finance the LSD and brainwashing experiments.

Joseph Rauh

In other words. Cameron, all he did was what the C.I.A.



**BACK IN TOUCH WITH
REALITY?.. DON'T
YOU HAVE ANYTHING
BETTER?**

was in effect asking him to do, and what he said he was going to do, and he did it.

James Turner

And then they paid him money for it.

Joseph Rauh

And then what about Gottlieb now? We've got a lot of stuff out of Gottlieb. Here's one of his depositions. We got him—I take it he said, "I'm going to wash my hands of this. I approved the project but I don't have to take care of the Canadian citizens who are going to be affected." Is that fair?

James Turner

That's fair. He admitted that they took no steps whatsoever to guarantee that people wouldn't be injured if it could be avoided or to make sure that people even knew that they were participating in an experiment.

Joseph Rauh

This guy, Gottlieb, has got quite a record doesn't he, on negligent action ahead of time, I mean before this ever—

James Turner

He was personally involved in an experiment that resulted in the death of a U.S. army—

Joseph Rauh

Is that the one where they put the LSD in the Cointreau of a guy named Olsen?

James Turner

Yeah, and then he jumped out of a window and committed suicide in New York City. They managed to cover that up too.

Joseph Rauh

I like a man who is general counsel of the C.I.A. His name is Larry Houston. And at that time he said this was culpable negligence. He was a general counsel. And they went on, left a guy on the job who had been guilty according to their own lawyer of culpable negligence. What about Helms? We took his deposition too—it's right here.

James Turner

Yes, it's an awful thick deposition. He didn't remember a whole lot. There's a major case of forget-me's. The only thing we really got out of him was that he instructed Gottlieb—the C.I.A.'s Dr. Gottlieb—to destroy the records.

Eric Malling

When the story broke about the covert C.I.A. activities on Canadian soil, the United States sent a formal apology to the Trudeau government. But External Affairs Minister Allan MacEachen has refused to release that document to Mrs. Orlikow and the others in the law suit.

This declassified State Department letter shows why. Addressed to the Canadian Embassy, it reads, "This is with reference to your request for the views of the U.S. Intelligence community concerning possible release by the Canadian government of certain documents relating to the Orlikow matter. Your request was given careful review on the basis of which it has been requested that the Canadian government withhold from the public disclosure the documents in question."

Joseph Rauh

We moved heaven and earth to get the correspondence and the documents of the discussions between the Canadian government and the United States. The United States won't give it to us because they're covering up their wrong. The Canadian government won't give it to us because they're scared of the United States government. Both of them are holding back all of the information about this. I think the case could be broken if the Canadian government would say to the C.I.A., "We're not going to cover up for you any longer. We're going to give this material to Mr. Orlikow for his case."

Eric Malling

If the Canadian government has this apology from the U.S., why in the world do you think they wouldn't release it?

Joseph Rauh

I just think the Canadian government is a little bit like international wimps in the case of the United States. I don't know why they're so scared of us. We're not going to do anything. I don't think the Seventh Army is going to attack Montreal because you give us that material.

Eric Malling

I understand, though, that the American position is that this kind of C.I.A. material can't be released for national security reasons. Maybe that's true.

Joseph Rauh

Security—my neck! First, the C.I.A., everything they forget. Then when they have to stop forgetting because it's ludicrous, then they say it's all national security. What is national security about the apologies of the United States to Canada? They get very belligerent the Canadians with Russians when they shoot down the 007 with some Canadian citizens on it. But when the C.I.A. covertly does something to the citizens, ruin the lives of many of these citizens, well the Canadian government is doing nothing. I don't know why.

Eric Malling

Canada made forceful representations on behalf of the Toronto businessman who was kidnapped by bounty hunters, taken back to Florida. That wouldn't indicate that they're afraid to make a ruckus down here.

Joseph Rauh

That was a pretty easy situation. I mean, my god, you kidnap a Canadian, take him to the United States. Heavens above—and furthermore who do you have to fight there?—a couple of bounty hunters. Here you're fighting the C.I.A. That scares Canada.

Eric Malling

I'm surprised that if your case is as strong as you say that the American government isn't trying to get an out of court settlement, pay out a bunch of money and just hope it will go away.

Joseph Rauh

When the C.I.A. went into this brainwashing stuff, what they call the MK-ULTRA Program, when they went into that they injured lots more people than the nine we are suing for. They injured a great many other people.

Eric Malling

Here in the United States.

Joseph Rauh

Here in the United States. They may feel that they've got so many skeletons in their closet that settling with us, even though we're clearly right and they would like it to go away, would hurt them as a precedent. I can't think of any other reason that they're being so really rough on us.

Allan Lawrence

I think there is a duty on the government to release in a matter such as this, all of the information it has.

Eric Malling

Allan Lawrence is the Conservative justice critic in the Commons.

Allan Lawrence

If there has been government complicity or government negligence, so be it, you know. It's far better to make a full disclosure and a full confession of your sins in a matter such as this. It's always a difficult thing for anybody to sue a government or sue an agency in the government. And if you don't have the cooperation of your own government in doing it, you have a few strikes against you right off the bat.

If the process was reversed, if it was some sort of a secretive Canadian operation taking place in the United States, I'm sure all hell would break loose down there as far as beating of breasts and waving of flags and what-not.

Eric Malling

This material came from the States. Perhaps they're bound

by, if not law, good manners to not turn it over if the source of the information doesn't want it turned over.

Joseph Rauh

I don't know about manners. I don't know about international manners very much. But I know this—if I were in charge of a government to whom nine citizens that we are suing for have been brainwashed without their knowing, have had their lives impaired, and have it done by a foreign agency under cover without the government of Canada knowing it, I would find a way to help those people instead of hindering them.

Eric Malling

We tried to ask External Affairs Minister MacEachen why the government of Canada is not helping these Canadian citizens who are victimized by agents of another country. But for more than two months, Mr. MacEachen has been unavailable to discuss the matter.

What do you want to tell Mr. MacEachen, for example, about what happened to you, how you feel about it now?

Mrs. Jeanine Huard

I would tell him to try what we've been through and see what he would have to say after, because only when you go through such an experience, one can say how bad it can be and how painful.

Mrs. Velma Orlikow

I'd say, come on, get off your horse and help us. We need some help from our government. We're innocent victims of something that happened that should never have been. And you can't put us back where we were, but at least do something to help us now. Do something to stand up and say this can't happen in Canada.

Eric Malling

What can you possibly get for your clients out of this case?

Joseph Rauh

You can't get their health back. That's not possible. And

they're older people and some of them may die during this stonewalling by the C.I.A. And some of them may get worse. One of them at least is in an institution now. I mean the thing is very much needing of speed to get recompense. You can get some money; that's all you can get. That's all you can get when a doctor misoperates on you. You don't get your health back. There's no way we can get their health back. But what we can get them is some funds to help ameliorate their old age with the damage that's been done to them by this lousy performance that occurred through the C.I.A. by Dr. Cameron mistreating them and hurting them.

Eric Malling

One thing which triggered Mrs. Huard's initial depression was growing deafness in one ear. That was later corrected with minor surgery, but no surgery can undo Dr. Cameron's work at Raven's Crag.

Mrs. Jeanine Huard

I cannot go to sleep without any medication. I have migraine headaches that last for a week at a time. Doctors cannot find the cause. I have slight amnesia. I have a lot of trouble to concentrate.

Robert Logie

I've never been able to sleep without medication since the sleep treatment. I went through years and years and years of severe depressions. I dream about it, all my waking hours I think about it. It's eating me up.

Mrs. Velma Orlikow

I've been hospitalized. When I first went home to Winnipeg, I attempted to take my own life because I couldn't endure the way I felt. And I have a chronic need—I'm very dependent on other people. And I have a chronic depression which at times gets worse.

Mrs. Jeanine Huard

Not being with my family, not being able to follow a career, not being able to study anymore, which I wanted to do very much—I would say it cost me my life.

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—Vincent Canby, NEW YORK TIMES

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—Stewart Sheingold
Professor of Political Science
Univ. of Washington

GIVING THEM THE BIRD

We're awarding *two* Phoenix Pheathers this time. Our first Pheather is jointly awarded to Mrs. T., a psychiatric inmate, and Carla McKague, a Toronto lawyer and psychiatric inmates' rights advocate. Last August, Mrs. T. (a pseudonym) was committed to Hamilton Psychiatric Hospital in Ontario because she was judged suicidal. Within two or three weeks of admission, psychiatrist Paul Denew pressured Mrs. T., her husband and father to consent to electroshock. They all refused. Despite the fact that Mrs. T. was competent, Dr. Denew and three other psychiatrists appealed her refusal to the Review Board, which promptly ordered a series of shock treatments for Mrs. T.

On behalf of Mrs. T., Ms. McKague succeeded in delaying the shock treatments until the case was heard in the Supreme Court of Ontario. In court, Ms. McKague argued that electroshock is a form of psychosurgery as defined in the *Mental Health Act* and, therefore, the Review Board had no authority to order shock (The *Act* outlaws psychosurgery for involuntary patients). Madam Justice Van Camp ruled in favor of the Board on December 5. A few days after the court decision and with Mrs. T.'s consent, the Ministry of Health transferred her to another hospital and psychiatrist who promised not to give her shock.

The case marks the first court challenge to electroshock or any other psychiatric "treatment" in Canada. Specifically, the case highlighted the fact that shock causes brain damage and that review boards, *not* courts, have absolute power over psychiatric inmates in Ontario including the power to incarcerate and order treatment against the inmate's will. Although the case lost, Mrs. T. was spared electroshock. The case also sparked considerable national publicity and public outrage and should encourage constitutional challenges to electroshock and other forced treatments.

Our sincere congratulations to Mrs. T. for her courage, and to Carla McKague for her outstanding advocacy efforts. (See "Rights and Wrongs" section for a more detailed discussion of the case.)

Our second Pheather is also jointly awarded to Theresa Lussa, a former psychiatric inmate, and Judge Guy Kroft in Manitoba. Last November in Winnipeg, Ms. Lussa was picked up by the police and forcibly taken and committed to the Health Science Centre—apparently for causing some disturbance. At the time, she was not violent, threatening or suicidal; she was being treated by her doctor for "lithium carbonate psychosis." Without her knowledge, Magistrate John Nixon committed her to the Centre where she was incarcerated for two weeks. While incarcerated, Ms. Lussa also was not informed of her legal rights including her right to contact a lawyer, and she was forcibly treated with psychiatric drugs. The drugs' "side effects" also prevented her from contacting a lawyer.

Lawyer Harry Peters filed a *writ of habeus corpus* demanding that the hospital immediately release her. On November 17, the case was heard in the Manitoba Supreme Court before Judge Kroft. In his decision, Judge Kroft ruled that Ms. Lussa was illegally incarcerated because her constitutional rights were violated, and should be immediately released. He found that the hospital and the magistrate violated sections 7, 9 and 10 of *The Canadian Charter of Rights and Freedoms* in illegally depriving Ms. Lussa of her liberty, arbitrarily de-

taining her in failing to prove she was a danger to herself or others, and failing to inform her of her legal rights including the right to contact a lawyer. Judge Kroft noted: "I am not satisfied that the fact there was a sign posted in the ward convinces me that she was informed (of her rights)...there is some obligation to show, not only that the necessary information was given, but that it was understood; or alternately... that the person in question was able to understand."

The case marked the first time a judge has used *The Charter* in securing the freedom of a psychiatric inmate in Canada. The judge's decision also serves notice to the staff and administration of all psychiatric facilities as well as the police and courts in Manitoba that psychiatric inmates and prospective inmates must be *fully informed of their legal rights*, especially when loss of freedom is at stake. Our sincere congratulations to Theresa Lussa for showing courage in standing up for her rights, and to Judge Guy Kroft for asserting and protecting constitutional rights of psychiatric inmates.

We award our first Turkey Tail to Dr. Brian Robertson, current director of The Allan Memorial Institute in Montreal, for his defense of Dr. Ewen Cameron and Dr. Cameron's brainwashing experiments at the Allen in the 1950's and 1960's (see "Secret Tests" in this issue):

"...There was a lot of pain inflicted on a lot of people, but that's research.

I'm not saying we'd use his methods today, but this type of thing went on in the early days of medical research as well. Thousands upon thousands of kids had their tonsils removed with great pain.

But this work was not given to people just to torture them. In light of his theories, what Dr. Cameron was doing made perfect sense. The fact that his theories were wrong sometimes does take away from his motives. Pain and suffering suffered by people here does not take away from the compassion Dr. Cameron felt for his patients.

...(Dr. Cameron) was a very determined man who felt one must take some risks for progress...He was a man of great authority and he was doing nothing appalling given that period in psychiatry."

(Toronto Star, February 26, 1984)

On the contrary, Dr. Robertson, what is evident is that it was not Dr. Cameron's "theories" which were "wrong", but his moral values which were—far from compassionate—in-humane. Evident, too, that such moral relativism as Dr. Cameron's and Dr. Robertson's can be used to justify *anything in the name of "science" or "research": as Nazi apologists so well knew—as apologists for brutality and torture have always known.*

We're awarding another Turkey Tail to two Toronto shock doctors, psychiatrists Kenneth Shulman and Harry Karlinsky. Drs. Shulman and Karlinsky recently admitted that they subjected thirty-three old people (62-85 years old) to an average of nine shock treatments at Sunnybrook Medical Centre during a 3-year period (1979-82). Before receiving this brain-damaging procedure, many of these old people already had serious medical problems including heart conditions, strokes and brain damage. There is little doubt that most, if not all, of these old people were further damaged by the shock treatments authorized and administered by Shulman and Karlinsky. For their insensitivity to the problems of old people and for unethically inflicting brain damage on vulnerable people, Shulman and Karlinsky deserve this award. (See 'Toronto Shrinks Shock Old People' in this issue for more details.)

Quotations From Dr. Freud*

The Founder of Psychoanalysis
1856 (Freiberg, Austria-Hungary)—1939 (London, England)

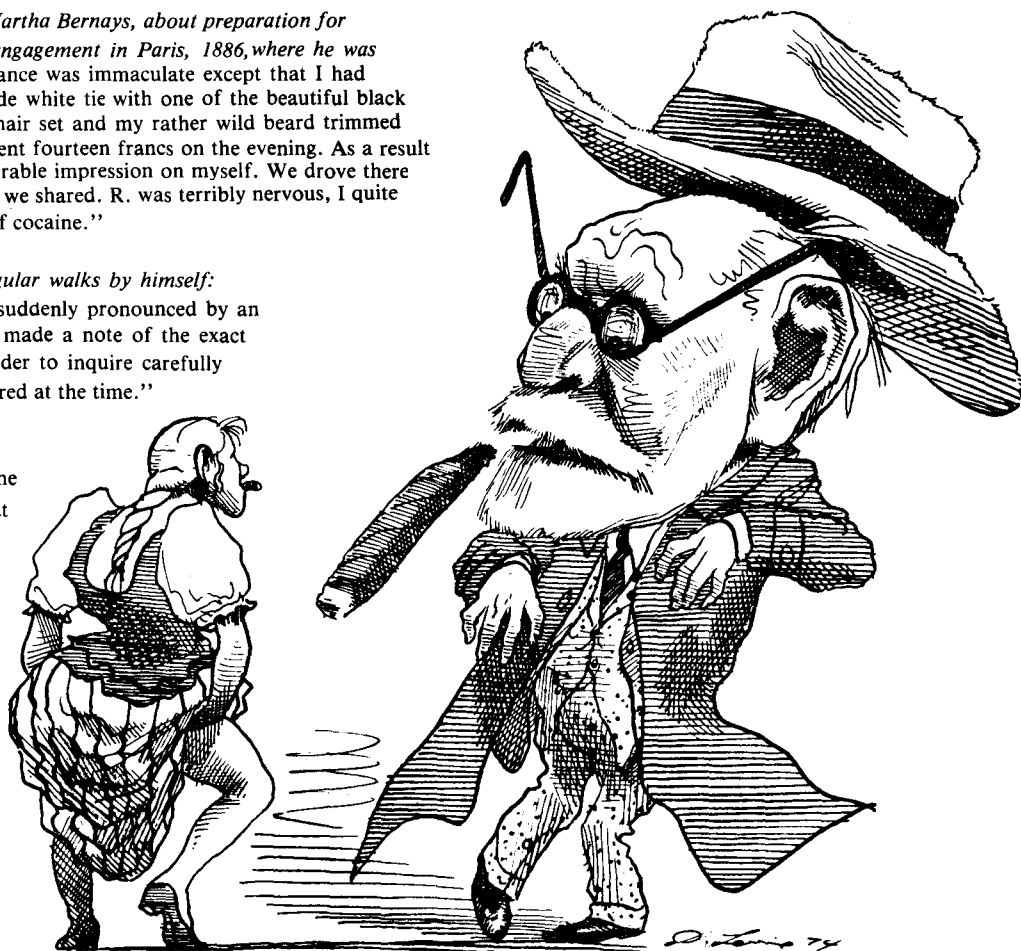
Compiled by Leonard Roy Frank

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1. From a letter to his fiancée, Martha Bernays, about preparation for a professionally important social engagement in Paris, 1886, where he was doing graduate work: "My appearance was immaculate except that I had replaced the unfortunate ready-made white tie with one of the beautiful black ones from Hamburg ... I had my hair set and my rather wild beard trimmed in the French style; altogether I spent fourteen francs on the evening. As a result I looked very fine and made a favorable impression on myself. We drove there in a carriage, the expenses of which we shared. R. was terribly nervous, I quite calm with the help of a small dose of cocaine."

2. During this period he took regular walks by himself: "Frequently, I ... heard my name suddenly pronounced by an unmistakable dear voice ... I then made a note of the exact moment of the hallucination in order to inquire carefully of those at home what had occurred at the time."

3. "I consider it a great misfortune that nature has not granted me that indefinite something which attracts people. I believe it is this lack more than any other which has deprived me of a rosy existence ... Every time I meet someone I realize that an impulse, which defies analysis, leads that person to underestimate me."



4. In his day dreams he would hurl himself at a runaway horse, bringing it to a standstill. Thereupon some great person would step out of the carriage, press his hand, and say: "You are my savior — I owe my life to you! What can I do for you?" (1886)

5. "I have often felt as though I had inherited all the defiance and all the passion with which our ancestors defended their Temple and could gladly sacrifice my life for one great moment in history." (1886)

6. "I am not, so far as I know, ambitious."

7. "Do you suppose that some day a marble tablet will be placed on this house, inscribed with the words, 'In this house on July 24, 1895 the Secret of Dreams was revealed to Dr. Sigmund Freud.'" (1900, the publication year of *The Interpretation of Dreams*)

8. "I am not really a man of science. I am by temperament a conquistador."

9. "A man like me cannot live without a hobby-horse, a consuming passion, 'tyrant'. I have found my tyrant, and in his service I know no limits. My tyrant is psychology."

10. "Sexual excitement is of no more use to a person like me." (1897)

11. "All my libido (energy) is given to Austria-Hungary." (1914, on the outbreak of World War I)

12. "When I am not cheerful and master of myself, every single one of my patients is a tormenting spirit to me."

13. "My state of mind depends very much on my earnings."

14. "Today I resumed my practice and saw my first batch of nuts again. I must now transmute the nervous energy gained during my holiday into money to fill my depleted purse." (letter written in 1910 to Swiss psychiatrist Carl G. Jung. Jung joined the psychoanalytic movement in 1907 and broke with Freud in 1912. Their differences were personal as well as theoretical. A major problem was Freud's emphasis on sexuality and aggressiveness in understanding human nature, whereas Jung zeroed in on ethics and spirituality. Jung died in 1961.)
15. "Paraphrenics (the term Freud used for 'schizophrenics') display two fundamental characteristics: megalomania and diversion of their interest from the external world—from people and things. In consequence of the latter change, they become inaccessible to the influence of psychoanalysis and cannot be cured by our efforts."
16. "In private life I have no patience with lunatics. I only see the harm they do."
17. "Enclosed the certificate for Otto Gross. Once you have him, don't let him out before October when I shall be able to take charge of him." (letter to Jung, May 6, 1908. Jung committed Gross, who escaped following a short course of involuntary analysis.)
18. "The moment a man begins to question the meaning and value of life he is sick."
19. "The experience of the first five years of childhood exerts a decisive influence on our life, one which later events oppose in vain."
20. "The goal of psychoanalysis is to substitute for neurotic misery ordinary human unhappiness."
21. "The neuroses are without exception disturbances of the sexual function."
22. "My medical conscience felt pleased at my having arrived at this conclusion." (*referring to his theory concerning the sexual origins of neurosis.*)
23. "In the sexual processes we have the indispensable 'organic foundation' without which a medical man can only feel ill at ease in the life of the psyche"
24. "I know nothing about stuttering, but it seems to me that the motive might be oral eroticism."
25. "Suppose a child has no family. Suppose the mother dies at childbirth and the father brings up the boy; what happens then?" "The boy would then usually become homosexual." "It would be interesting to investigate such cases." "It is not necessary. We know how they work out without that." (*from American psychiatrist Joseph Wortis's Fragments of an Analysis with Freud*)
26. "You cannot be a good teacher ... unless you have a certain amount of homosexual drive, which you sublimate into sympathetic interest for your pupils."
27. "Naturally homosexuality is something pathological. It is an arrested development."
28. "People who dream often, and with great enjoyment, of swimming have usually been bed wetters."
29. "The wish to be able to fly signifies in the dream nothing but the longing for the ability of sexual accomplishment."
30. "There is a humorous saying: 'Love is home-sickness', and whenever a man dreams of a place or a country and says to himself, still in the dream, 'this place is familiar to me, I have been here before,' we may interpret the place as being his mother's genitals or her body."
31. "Do you remember my always saying that the medieval theory of possession, that held by the ecclesiastical courts, was identical with our theory of a foreign body and the splitting of consciousness? But why did the devil who took possession of the poor victims invariably commit misconduct with them, and in such horrible ways? Why were the confessions extracted under torture so very like what my patients tell me under psychological treatment?"
32. "Sadism is all right in its place but it should be directed to proper ends."
33. During World War I, Julius Wagner-Juaregg, one of Europe's foremost psychiatrists who was awarded the Nobel Prize for Medicine in 1927, regularly tortured so-called war neurotics with electric shocks. Such "disciplinary treatment" (his term) often succeeded in forcing Austro-Hungarian soldiers to give up their "illness" and return to the front. After the war a government commission investigated the many bitter complaints about this cruel technique, which he disguised as therapy. The commission called in Freud as an expert witness. After interviewing one of the victims who claimed that he "had been wronged" by Wagner-Juaregg, Freud refuted the claim stating, "I know that the motivating force in (Wagner-Juaregg's) treatment of patients is his humaneness." The commission absolved Warner-Juaregg of any wrong-doing. Ironically, Freud himself, before introducing psychoanalysis, had used painful electric shocks in treating one of his patients. In *Studies in Hysteria* (1893-1895), he wrote, "We recommended (for a woman said to be suffering from hysteria and a muscle disorder) the . . . faradization of the sensitive muscles, regardless of the resulting pain, and I reserved to myself treatment of her legs with high tension electric current, in order to be able to keep in touch with her . . . In this way we brought about a slight improvement. In particular, she seemed to take quite a liking to the painful shocks produced by the high tension apparatus, and the stronger these were the more they seemed to push her own pains into the background." In the next sentence he referred to his method as "my pretence treatment." (information and quotations drawn from Thomas S. Szasz's *The Myth of Psychotherapy*, pp. 86-91)
34. In 1919 Freud wrote to one of his followers, "Our psychoanalysis has had some bad luck. No sooner had it begun to interest the world because of the war neurosis than the war comes to an end." (Same source as above: Szasz commented, "So wrote the man idolized as the greatest mental healer of our age.")
35. "It is really a stillborn thought to send women into the struggle for existence exactly as men. If, for instance, I imagined my gentle sweet girl (*referring to his fiancée*) as a competitor, it would only end in my telling her, as I did 17 months ago, that I am fond of her and that I implore her to withdraw from the strife into the calm uncompetitive activity of my home." (1883, letter to Martha Bernays)
36. "Modesty in woman was originally designed to hide the deficiency in her genitals."
37. "Women experience childbirth as equivalent to at last coming into possession of a penis of their own."
38. "The only thing that brings a mother undiluted satisfaction is her relation to her son. Even a marriage is not firmly assured until the woman has succeeded in making her husband into her child and acting the part of mother towards him."
39. "The causes of conflicts between mother and daughter arise when the daughter grows up and finds herself watched by her mother when she longs for real sexual freedom, while the mother is reminded by the budding beauty of her daughter that for her the time has come to renounce sexual claims."

40. "American women are an anti-cultural phenomenon. They have nothing but conceit to make up for their sense of uselessness. You have a real rule of women in America ... They lead men around by the nose, make fools of them, and the result is a matriarchy ... In Europe, things are different. Men take the lead. That is as it should be." *'But don't you think that it would be best if both partners were equal?'* "That is a practical impossibility. There must be inequality, and the superiority of the man is the lesser of two evils." (*Wortis*)

41. "The significance of the factor of sexual overestimation can best be studied in the male, in whom alone the sexual life is accessible to investigation, whereas in the woman it is veiled in impenetrable darkness, partly because of cultural stunting and partly on account of the conventional reticence and insincerity of women."

42. "You know, Jung, what you have found out about this patient is certainly interesting. But how in the world were you able to bear spending hours and days with this phenomenally ugly female?"

43. "Psychoanalysis is in essence a cure through love."

44. "My love is something valuable to me which I ought not to throw away without reflection ... If I love someone, he must deserve it in some way ... If he is a stranger to me and if he cannot attract me by any worth of his own or any significance that he may already have acquired for my emotional life, it will be hard for me to love him. Indeed, I should be wrong to do so, for my love is valued by all my own people as a sign of my preferring them, and it is an injustice to them if I put a stranger on a par with them."

45. "Love cannot be anything but egotistical."

46. "An intimate friend and a hated enemy have always been indispensable to my emotional life."

47. "If this grandiose commandment (*'Love thy neighbor as thyself'*) had run *'Love thy neighbor as thy neighbor loves thee'*, I should not take exception to it. And there is a second commandment, which seems even more incomprehensible and arouses still stronger opposition in me. It is *'Love thine enemies'*."

48. "Jesus could have been an ordinary deluded creature."

49. "Paul with his truly Jewish character has always appealed to me."

50. "The effect of the consolations of religion may be compared to that of a narcotic."

51. "No knowledge can be obtained from revelation, intuition, or inspiration."

52. "We seem to diverge rather far on the role we assign to intuition. Your mystics rely on it to teach them how to solve the riddle of the universe; we believe that it cannot reveal to us anything but primitive instinctual impulses and attitudes ... worthless for orientation in the alien external world."

53. "Thus religion would be the universal obsessional neurosis of humanity ... If on the one hand religion brings with it obsessional limitations, which can only be compared to an individual obsessional neurosis, it comprises on the other hand a system of wish-illusions, incompatible with reality, such as we find in an isolated form only in Meynart's amentia, a state of blissful hallucinatory confusion."

54. "Religious intolerance ... was inevitably born with the belief in one God."

55. "Incidentally, why was it that none of all the pious ever discovered psychoanalysis? Why did it have to wait for a completely godless Jew?"

56. "Ruthless egotism is much more common among Gentiles than among Jews, and Jewish family life and intellectual life are on a higher plane." *'You seem to think the Jews are a superior people, then?'* "I think nowadays they are. When one thinks that 10 or 12% of the Nobel Prize winners are Jews and when one thinks of their other great achievements in science and in the arts, one had every reason to think them superior." (*Wortis*)

57. "I have never done anything malicious and cannot trace any temptation to do so, so I am not in the least proud of it. When I ask myself why I behave honorably, I have no answer. Why I — and incidentally my six children — have to be thoroughly decent human beings is quite incomprehensible to me."

58. *Dream*: "The scene is a mixture made up of a private sanatorium and several places. A manservant appears, to summon me to an inquiry. I know in the dream that something has been missed, and that the inquiry is taking place because I am suspected of having appropriated the lost article. Analysis shows that inquiry is to be taken in two senses; it includes the meaning of medical examination. Being conscious of my innocence and my position as consultant in this sanatorium, I calmly follow the manservant. We are received at the door by another manservant, who says, pointing to me, *'Have you brought him? Why, he is a respectable man'*. Thereupon, and unattended, I enter a great hall where there are many machines, which reminds me of an inferno with its hellish instruments of punishment. I see a colleague strapped to an appliance; he has every reason to be interested in my appearance, but he takes no notice of me. I understand that I may now go. Then I cannot find my hat, and cannot go after all."

59. "Ethics are remote from me. I do not trouble myself very much about good and evil, but I have found little that is *'good'* about human beings on the whole. In my experience most of them are trash, no matter whether they publicly subscribe to this or that ethical doctrine or to none at all. If we are to talk of ethics, I subscribe to a high ideal from which most of the human beings I have come across depart most lamentably."

60. "That men are divided into leaders and the led is but another manifestation of their inborn and irremediable inequality. Men should be at greater pains than heretofore to form a superior class of thinkers, unamenable to intimidation and fervent in the quest for truth, whose function it would be to guide the masses dependent on their lead."

61. "From an old man who greets in the Ruler the Hero of Culture" (Freud's inscription in book he gave to Italian dictator Benito Mussolini).

62. "Why do we, you and I and many another, protest so vehemently against war, instead of just accepting it as another of life's importunities." (*letter to Albert Einstein*)

63. In 1933, immediately following Hitler's rise to power in Germany, Hungarian psychoanalyst Sandor Ferenczi, a former disciple, wrote to Freud urging him to leave Austria while there was still time, to which he replied: "As to the immediate reason for your writing, the flight motif, I am glad to be able to tell you that I am not thinking of leaving Vienna. I am not mobile enough, and am too dependent on my treatment (*medical treatment for cancer of the jaw*) ...; furthermore, I do not want to leave my possessions here. Probably, however, I should stay even if I were in full health and youth ... It is not certain that the Hitler regime will master Austria too. That is possible, it is true, but everybody believes it will not attain the crudeness of brutality here that it has in Germany. There is no personal danger for me." (quoted in American psychiatrist Thomas S. Szasz's *Ideology and Insanity*)

64. "My dear Jung, promise me never to abandon the sexual theory. That is the most essential thing of all. You see, we must make a dogma of it, an unshakable bulwark." ... 'A bulwark — against what?' "Against the black tide of mud ... (*pause*) of occultism." (from Swiss psychiatrist Carl G. Jung's *Memories, Dreams and Reflections*. Jung joined the psychoanalytic movement in 1907 at the age of 32 and in 1912 founded his own school, *Analytical Psychology*. Their differences were personal as well as theoretical, of the latter a major one was Freud's emphasis on sexuality and aggressiveness in understanding human nature, whereas Jung zeroed in on ethics and religion. Jung died in 1961.)

65. "He (*Jung*), being a Christian and the son of a pastor, can only find his way to me against great inner resistances. His adherence is therefore all the more valuable. I was almost going to say it was his emergence on the scene that has removed from psychoanalysis the danger of becoming a Jewish national affair." (1908)

66. In 1910 an uninvited and infuriated Freud addressed a secret meeting called by dissident disciples to protest the growing power of Jung within the psychoanalytic circle: "Most of you are Jews and therefore you are incompetent to win friends for the new teaching. Jews must be content with the modest role of preparing the ground. It is essential that I should form ties in the world of general science. I am getting on in years and am weary of being perpetually attacked. We are all in danger." Then, seizing his coat by the lapels, he said: "They won't leave me a coat to my back. This Swiss will save us — will save me and all of you as well."

67. Freud and Jung lecture-toured America in 1909. "I haven't been able to sleep since I came to America. I continue to dream prostitutes." "Well, why don't you do something about it?" "But, I'm a married man."

68. 'Freud had a dream — I would not think it right to air the problem it involved. I interpreted it as best I could, but added that a great deal more could be said about it if he would supply me with some additional details from his private life. Freud's response to these words was a curious look — a look of the utmost suspicion. Then he said, "but I cannot risk my authority!" At that moment he lost it altogether. That sentence burned itself into my memory; and in it the end of our relationship was already fore-shadowed. Freud was placing personal authority above truth.' (*Jung*)

69. "Your reproach that I abuse psychoanalysis for the purpose of keeping my pupils in infantile dependency and therefore I myself am responsible for their infantile behavior toward me, as well as everything else that you base on this assumption, I won't judge, because all judgment concerning oneself is so difficult and doesn't carry conviction." (1912, letter to Jung)

70. "What Jung contributed to psychoanalysis was mysticism, which we can all dispense with."

71. "Does one know today with whom Columbus sailed when he discovered America?" (*referring to Jung*)

72. "Rank (*Austrian psychoanalyst Otto Rank*) was, so to speak, my secretary for fifteen years, and was closely associated with me and did very valuable work, practicing psychoanalysis in the way it should be done. Then he went another way and since then we have no longer had relations with each other ... I cannot go into the reasons why, because I have no right to reveal his personal life, but I can say one thing, because it is generally known: since leaving me Rank has been having periodic fits of depression, and in between, sort of manic phases — periods in which he does a great deal of work, and others in which he cannot do any at all. He had this tendency before, but now ... one could call him ill."

73. "I have made a pigmy great." (*Referring to Austrian psychiatrist Alfred Adler, a former disciple and founder of Individual Psychology*)

74. "I don't understand your sympathy for Adler. For a Jew-boy out of a Viennese suburb a death in Aberdeen is an unheard-of career in itself, and a proof of how far he had got on. The world really rewarded him richly for service in having contradicted psychoanalysis." (1937, letter to Austrian novelist Arnold Zweig, who in correspondence with Freud had expressed how he had been moved by Adler's death: quoted in American psychotherapist Erich Fromm's *Sigmund Freud's Mission*)

75. "I feel sure that Ellis (*Havelock Ellis, the English sexologist*) must have some sexual abnormality else he would never have devoted himself to the field of sex research. You might, of course, say the same of me, but I would answer that that is first of all nobody's business, and second of all it is not true."

76. "My illusions — apart from the fact that no penalty is imposed for not sharing them — are not, like religious ones, incapable of correction, they have no delusional character."

77. "The conceptions I have summarized here I first put forward only tentatively, but in the course of time they have won such a hold over me that I can no longer think in any other way."

78. "We possess the truth; I am as sure of it as fifteen years ago."

79 "Do you not know that I am the Devil? All my life I have had to play the Devil, in order that others would be able to build the most beautiful cathedral with the materials that I produced."

80. "Calling me a genius is the latest way people have of stating their criticism of me; first they call me a genius and then proceed to reject all my views. If they thought I was a genius, one should think they would not question my authority."

81. "The cost of Communism to intellectual freedom is too great. Communism means an intellectual dictatorship; it is not compatible with psychoanalysis because it is too dogmatic."

82. "Civilized life of today exerts an almost unbearable pressure which necessitates corrective measures. Does it seem too fantastic to expect psychoanalysis, in spite of the many difficulties it encounters, should be called upon to furnish this corrective agent?"

83. "A quack is a person who undertakes a treatment without possessing the knowledge and capacity required for it."



personal stories

My Own Experience

by JEANNE LINDSAY

In 1968 I was a senior at the University of Hartford in Connecticut. I went to a nearby psychiatric hospital called the Institute of Living once a week for therapy to help me cope with chronic, deepening depression. It was during this time that I began taking certain drugs called phenothiazines. I have been told that I became very spaced out, vacant, unable to concentrate, and that it was a miracle that I finished college in that condition.

My depression grew worse after final exams were over and my mother, frantic with worry, sought medical advice. It was decided by my family and their doctor that I would enter the Institute of Living. That was in June, 1968. I remember very little about this period, but one thing stands out: I felt happy that I had a woman psychiatrist. Her name was Ann Kazarian. I thought I would be able to talk things through with her in therapy.

Dr. Kazarian had other ideas. She was a firm believer in the physical approach: shock "treatments," cold packs, and heavy medication. We did have therapy sessions twice a week, but for her they were no more than an observation lab in which she would decide which frontal assault technique to try out next.

Ice Cold Sheets

During my first months there I was on a locked ward called Thompson II. I vaguely remember that I was put into cold packs nearly every day, sometimes two or three times a day.

A cold pack would work as follows: I was taken by several nurses or aides into a room which was barren except for a metal bed which was bolted to the floor. The bed had a rubber mattress. I was stripped of all clothing and then the nurses would wrap damp, ice cold sheets around each arm, leg, and then my body. When they were through, it was impossible for me to move any part of my body except my head. Then the door was closed and I was left alone. After three or four hours, someone would come and release me.

Even before I entered the hospital or saw a psychiatrist I was suffering. I felt that I must have done something terrible to have been singled out for such punishment while others around me seemed to be enjoying life. The cold packs intensified these feelings of isolation and punishment to an almost unbearable extreme. The agony that one goes through lying there alone hour after hour — cold, numb, completely immobile — is beyond description. A male patient later told me about the painful indignity that it was for him, a male, to be stripped and slowly bound by female nurses.

Alone In Our Terror

The cold packs were not all. Another method of dealing with patients who were severely depressed or otherwise unreachable was electroshock. On the mornings that I was to receive a shock treatment I was not allowed to have breakfast. Eventually a student nurse would give me an injection which I was told was a muscle relaxant. These were the most painful injections I have ever received. It took an incredibly long time for the syringe to be emptied, and it felt like salt and lemon juice was being squirted into my arm. Then the nurse would accompany me (and perhaps several others) through the tunnels to another part of the hospital where the shocks were given. Usually, about eight or nine people would be waiting on chairs and benches outside the door. We were all terrified, and we were each alone in our terror. I suppose we felt ashamed that this was happening to us. There was no feeling of comradeship among us and no one thought of trying to escape. We had learned early that if you did not cooperate, you made it worse for yourself. When my turn came, I would be taken alone into the shock room where there were four or five staff members waiting, including Dr. Enrique Delgado-Faurzan, who was in charge of "somatic therapy," as it was euphemistically called. There would also be a resident and a few student nurses, who were there to learn the technique, I suppose. I knew that the patients who had preceded me into the room were now lying, unconscious and violated, behind curtained partitions a few feet away.

There was some wiry apparatus which I always tried to ignore. I would be helped onto a high table and Delgado-Faurzan would inject my vein with sodium pentothal. A great roaring noise would overtake me and I was carried away into an ocean of darkness. For a moment all was quiet. Then, out of this darkness there would come an explosion, a jagged flash of lightning which entered my head from the right side and ripped through me like gunfire. The explosion was yellow and it gave off sparks and volts of blue and orange. It was a huge, shuddering, mind-slammng jolt. It was death and the end of the world all rolled into one. At the same time I could see an image of my brain. It was gray, but its blood vessels were bursting and a network of red ran throughout. There was an ugly cracking sound and I knew that I had died.

Rising Out Of Darkness

After a long time, I could hear a word. The word was "Jeanne." I didn't know what it meant but someone kept repeating it, directing it at me. I latched onto it as an infant latches onto a nipple for the first time, and in so doing I began rising out of the deepest darkness I have ever known. It kept on more insistently, more urgently, "Jeanne ... Jeanne ... Jeanne." Since it was the only thing offered I embraced it, feeling that it must somehow be mine. I opened my eyes to see a person sitting next to me repeating that word. Somehow I became aware that I was to go with her. Who was she? I walked with her and she kept talking, but I did not understand her or the words. At the end of our walk we came to a room I had left behind light-years before. It was dimly familiar. There were people there and I was helped to sit down. Sometimes these people spoke to me. When they spoke they used that word, "Jeanne," the same as the first person, the one who had brought me back. Gradually, I understood that Jeanne was my name, that it belonged to me, and that other people had different names of their own.

Some of those other people were Debbie and Mary and Bridget and Amy. Those were their names and they belonged to them, just like Jeanne belonged to me. I felt happy knowing this. Things made a little more sense now, although I still didn't understand who I was or where I was or how I had gotten there. Those things would take years.

In time, both my arms became so bruised from the pre-shock injections that they began giving them to me in the hips. When the same thing happened to my hips, they went back to the arms again.

Self Slipping Away

With each shock treatment, I felt more and more of myself slipping away. I couldn't remember things, particularly the immediate past, but eventually even the more distant past began to be erased. I was frightened by this. I thought, "If I don't know what I've done or where I've been, then who am I?" A person's memories are her identity. Take them away, and you take away her sense of self, the unbroken continuity and wholeness that life was meant to be.

I felt like I was being shocked back into the stone age of my mind. I had an eerie sensation that I had sprung onto the earth full-grown at the age of twenty-three with no past, no memories, and hence, no identity. My mind was as blank as a newborn baby's, but there was a difference: I wasn't newborn. I was twenty-three years old and people expected certain things of me, even if only in conversation. I learned to lie and pretend to remember things when I really had no idea of what people were talking about. If I had not done this, conversation with others would have been impossible. At best, it was already very difficult. Later, visitors would tell me that they were horrified by the extent of what I did not know about my own life.

A line kept floating through my head: *Oed' und leer das Meer*. "As empty and blank as the sea." I didn't know where these words came from but they seemed to fit my condition perfectly. As more and more of my past left me, less and less of the outside world made sense. Once I remember receiving a letter from my sister. She was revisiting the place where we had lived for a year three years ago. She told me which people she had seen, which places had changed ... and none of them meant anything to me. I remember staring at the page and thinking, "How many more shock treatments will it take before I forget how to read, and then language itself?"

It became very important to me that I at least know how many shock "treatments" I had had. Knowing that I couldn't trust my memory, I made a mark on a piece of paper after each "treatment." It was my way of maintaining a link with my lost self. When I left the Institute of Living there were forty marks. I later learned that I was off by one: I had had forty-one electroshock "treatments."

Everyone in the hospital was taking some sort of drugs. In my own case, I was taking Thorazine, Stelazine, Mellaril, Elavil, and Cogentin. I also drank a little cup of liquid twice a day which was supposed to reduce the dryness in my mouth caused by the other drugs — it didn't. Without drugs, I am basically an introvert with a tendency toward depression and being overweight. The drugs I was placed on magnified these tendencies a thousandfold. I had no interest in socializing or talking with anyone. Whereas previously I had been an avid reader, I now couldn't get through the simplest magazine article. It required too much effort and concentration.

Twilight Half-Life

Before I had entered the hospital I had had serious problems, but at least I had been alive. I had cared about things: about myself, my friends, politics, school, literature. Now, due to the drugs, I was a vegetable. I had only one interest in life and that was sleeping. If someone had told me that the world had been placed under one dictator, or that the United States was due to blow up in five minutes, I couldn't have cared less. I no longer saw any connection between the world and myself. Even if I had been able to see a connection, I was so drugged that I simply wouldn't have cared.

These drugs altered my mind and body into a strange twilight half-life in which reality was indistinguishable from nightmare. Some (but not all) of the effects I experienced were: weight gain, constant thirst, blurred vision, menstrual cessation, slowed thinking, lethargy, indifference, constipation, numbness, total urinary blockage, and abnormal skin flushing. Also during the period in which I was drugged, I had a fantastic number of dental cavities. My dentist and I couldn't figure it out. Yet, when I discontinued the drugs, my cavity rate dropped back to normal (about one a year).

The major thing I remember about my stay in the Institute of Living is fear. I have never in my life before or since lived in the grip of such fear. I think this was due to two main reasons. One was the drugs I was taking. They divorced me from myself: I felt completely out of touch with myself, as if I was no longer in control of my own life. The only outside activities I had any interest in were a few uncomplicated television programs and swimming, which I have always enjoyed. The drugs nearly paralyzed me. They robbed me of all motivation to do anything. As I mentioned earlier, they also increased my already strong tendency toward withdrawal. Many, many times I recall listening to the conversations of the other patients and feeling that I had something to contribute. But I never did because the drugs had slowed down my thought processes to such an extent that, by the time I had formulated what I wanted to say, the conversation had moved three paces ahead of me. In frustration, I would lapse back into myself, feeling that it just wasn't worth the trouble.

The second major reason for my fear was the Institute of Living itself. The whole place was structured, not to help the patients, but to wipe out "abnormal" behavior. I think I entered the place genuinely believing I would be helped. I had faith in the medical profession and in my enlightened society. I now realize that there is nothing "enlightened"

about our treatment of the "mentally ill." If anything, it has become more brutalizing with the advent of modern technology. The chains and shackles of the nineteenth century were dehumanizing, but at least they did not cause the irreversible death of brain cells.

Identifying With Oppressors

I once read an essay by Bruno Bettelheim about his experiences in a concentration camp. He said that under the conditions of extreme deprivation in the camp the prisoners, instead of striking or revolting against their oppressors, became very childlike and identified with their torturers, groveling for favors and trying to prove to the guards that they were "better than" the other prisoners. Exactly the same situation prevails in "mental hospitals." I mentioned earlier that I had no sympathy for the others who were receiving electroshock. When I was helped onto that table, I always hoped the staff would realize I was a cut above the other patients, that I was one of them (the staff) really. Many times I would watch with pleasure as another patient would be grappled to the floor and dragged into seclusion or given an injection. I felt pleased because it was happening to them and not me.

Now, if given a choice between jail and a mental hospital, I know that I would much rather be in jail. In prison the situation is clear-cut: you're there because you're being punished and the staff is under no obligation to maintain a pretense of liking you. In the Institute of Living I found out that there is no limit to the amount of torture that can be inflicted on people in the name of helping them. For the most part, they don't beat or kick patients any more. They don't have to. Although the major policy in mental hospitals is still one of punishment, there are now much more sophisticated techniques for forcing patients into submission. And if the patients resist, it's not because they have a valid objection but because "they don't understand that it's for their own good." This resistance will be taken as further proof of their insanity and will provide a legitimate reason for the application of even more force. This system is so consistently repressive that in time many of the patients come to *believe* in it.

Certainly people who have never been locked inside a psychiatric institution are fooled by the trappings of "medical legitimacy." If we were still physically beaten, it would be easier to prove that we had been mistreated. Since leaving the hospital, I have told many people about the barbarism of shock treatments. The general response has been, "Well, they must be of some value or the doctors wouldn't be giving them." That's one of the "miracles" of modern technology. Take away the chains and shackles, substitute electricity and a hypodermic needle and people believe in it. If it was discovered and invented by scientists, doctors, it must be good.

I read a book called *A Mind That Found Itself* by Clifford Beers. He was in the Institute of Living around the turn of the century and later wrote an account of his treatment. His experiences were horrible — beatings, straitjackets, filth — all the forms of physical and mental abuse available at that time. But there was something about this book that seemed innocent compared to my own experience. At least Clifford Beers knew right away who his enemy was. In 1906 the aides came up and kicked him in the groin. By 1968 overt violence was rarely used. Who needs to hit a patient when you've got electrically induced seizures to stun her into submission? Why bother with beatings when we have drugs which alter

the mind and body chemistry, keeping the person in a perpetual state of fear? Who needs straitjackets now that we have sheets which have been chilled in ice?

I remember a patient named Margaret who was severely depressed. She missed her children very much, but was allowed no visitors or phone calls. One day she received an upsetting letter from home concerning one of the children. She requested permission to make a phone call home. The request was denied. I remember how bitterly she cried. I felt that that phone call would have done a lot for her. By denying her any contact with the outside world, her doctor was increasing her feelings of isolation and deepening her pain.

There was a girl named Debbie who was in the Institute because of drugs. One morning she told me the story of how she had gotten there: she was addicted to "speed" and had stolen a prescription pad from her doctor's office. She went along for some time writing her own prescriptions until one day she entered a pharmacy which didn't have the brand she requested. Without telling her, the pharmacist made a phone call to the doctor to see if it was okay if he substituted something else. Within moments the police arrived and her father later negotiated to have her taken to a hospital instead of staying in jail. After telling me this story, she was taken away for a shock "treatment." A couple of hours later we found ourselves next to each other again and she began repeating the same story, detail for detail, with a complete lack of awareness that she had told it to me only a short time before. I looked at her closely and I saw that some light had been extinguished, never to be relit again.

Cremation Pills

I remember a woman named Marie. Her husband had been a survivor of Bergen-Belsen, and she had had a middle-class American upbringing. One morning about 10 o'clock we were sitting alone on the unit staring into space when her psychologist came striding into the room, quite red in the face. He demanded to know why she had refused her "medication" that morning. She responded by saying angrily, "I refuse to take any more of your cremation pills, Doctor." He became even angrier and repeated his demand, adding that if she didn't take the pills he would have her sent back down to a locked ward. She repeated the line about the "cremation pills." They went on like this for several minutes until finally he stomped out of the room in disgust and gave the order to have her moved down to Thompson II.

I think about Debbie and Marie and Margaret and all the others who were and are still suffering, and I wonder how I bear this pain. Do others know about these things, or is this burden mine alone? This wasn't Auschwitz, it was America, 1969, and it's still happening. Why do we allow it? At least the concentration camps are over, and we acknowledge that it was a holocaust. But what is happening to people in mental hospitals today is no less horrendous. And we are doing nothing about it.

I left the Institute of Living in October of 1969, sixteen months after entering. (I later found that my "recovery" coincided with the expiration of my insurance benefits.) It seemed like years had gone by. I was overweight, still heavily drugged, and vast areas of my memory had been erased. I had lost contact with my friends at the University and, anyway, I no longer remembered them. No one in the hospital prepared me for the prejudice I would face in returning to society or in trying to get a job. Since no one acknow-

ledged that I had any memory loss, I of course received no advice on how to deal with it. In the hospital I had been, to some extent, protected. But the outside world was overwhelming. I found it impossible to carry on a conversation on any level because, to begin with, I didn't know who I was supposed to "know" and who was supposed to be a stranger to me. Once I had established that (through clumsy, blundering questions which were a nightmare for me and for the person I was talking to), my ordeal still wasn't over. When I left the hospital I didn't know that Martin Luther King was dead, that there had been riots in the ghettos, or what the Chicago Seven was. I didn't know who the Beatles were or the Rolling Stones or the names of my friends or what I had done with my own past life. I was totally and completely defenseless, without any of the traditional knowledge or conversational tools that most of us take for granted. To take a person who has suffered as much brain damage as I had and put her with no preparation back into society was like putting a three-year-old in the middle of Times Square. It was terrifying. Not surprisingly, I reacted by withdrawing and trying to avoid people as much as possible.

Shortly after leaving the Institute, I was listening to the radio one day. The song "Puff the Magic Dragon" was playing. My mother came into the room and said absently, "That's one of the songs you used to play on your guitar." I couldn't have been more astounded if she had told me that I had taken a trip to mainland China: "But how could I have? I don't even know how to read music." She informed me that I had learned how — I had taken private lessons. Not only that, but I had enrolled in an introductory course in college and had done quite well. Still doubtful, I looked up the transcript of my grades from college and saw that it was true: I had received an A in something called Introduction to the Principles of Music. I remember none of this, nor any of the courses I saw listed on my transcript. It might as well have been a record of some stranger's life. I went into my room and looked into the bookcase. I took out *A Farewell to Arms* by Ernest Hemingway. I leafed through it. It was heavily underlined and my handwriting was in the margins.

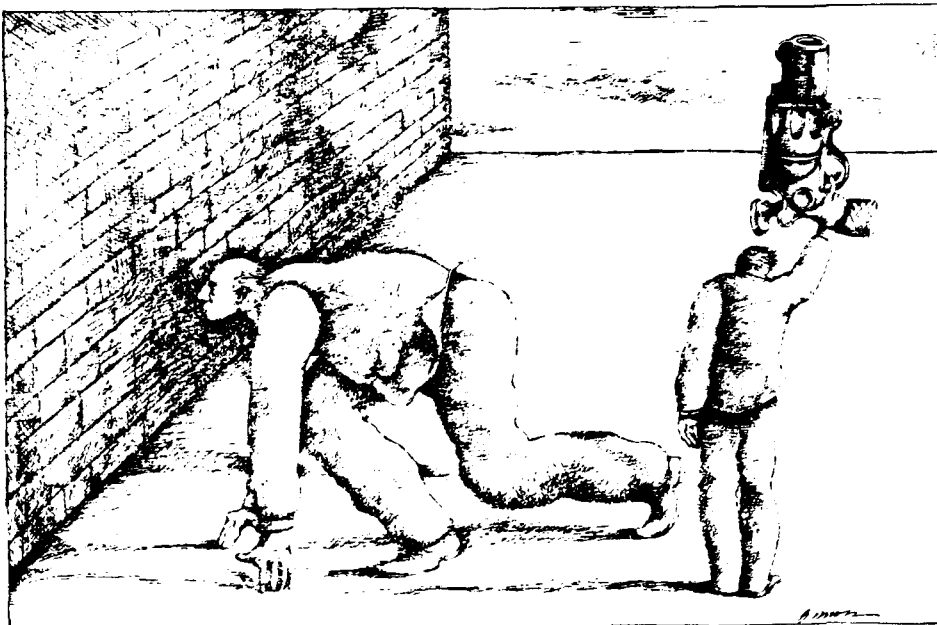
But just the other day I had told someone that I had never read Hemingway. There were lots more books. I must have liked literature because they were all by people like Kafka, Joyce, Rilke, Proust. Had I really read all these books? I must have, because my handwritten comments were all over the pages. But I didn't remember any of them. Only the named sounded vaguely familiar. I was impressed by what I had read, yet horrified at the magnitude of what I had lost. It seemed like such an overwhelming waste.

Hole In My Existence

During this period I was undergoing outpatient psychotherapy with Dr. Richard Bridburg, the Chief of Patient-Staff Services at the Institute of Living. Once, when I tried to tell him about the enormous problems I was facing due to my lack of memory (I was going to ask his advice), he became downright hostile and said that such a thing was impossible. He said that shock treatments cause memory loss only right after they are administered. In no uncertain terms, he pompously informed me that anything else I had forgotten was due to normal forgetting. This is simply not true. In my own case, I lost years, not weeks, of time. Besides, the difference between normal forgetting and the total erasure caused by electroshock is like the difference between dunking your big tow in the water and being drowned. I have never met anyone else who has "forgotten" where she went to college. But I realize that I was lucky. If I had been born ten years earlier, I might have had a lobotomy.

I had frequent nightmares about wandering into a hospital and not being able to find the exit door, about being burned by electrical wires, and paralyzed by injections of mind-altering drugs. It took a long, long time for me to accustom myself to the "real" world again. For many years I felt like there was a hole through the center of my existence and no one knew of it but me.

Reprinted from *Madness Network News*.



A Feminist Comes Undone

Anonymous

Twice in the past three years I've fallen apart — otherwise known in various interest groups, as depression, nervous breakdown, chemical imbalance, burnout, spiritual malaise, vitamin deficiency, etc. Whatever it is, it was damned painful, very confusing and lasted over six interminably long months each time.

Being considered "mentally ill" is very scary for anyone, but for a feminist it's a totally terrifying idea. At our best and strongest, we're suspicious and skeptical of the System and its agents (doctors) and institutions (psychiatry, psychology, mental hospitals). When at a low ebb of confidence and power, the danger seems overwhelming.

Of course, I'd done all the prescribed and politically correct reading on the subject b.c. (before crazy). *The Myth of Mental Illness*, *Asylums*, *Women and Madness*, *On Our Own*, *The Radical Therapist* and so on. But I was edged in the direction of conventional theory and therapy by my inability to make sense of feminist analysis of the issue (when I was in the middle of it) and by the apparent discomfort, lack of understanding or absence of interest of many feminists acquainted with my "condition". After many encounters with weirdos and quacks in my search for a counterculture "cure", I hit the mainstream literature. I found myself checking for, and finding, my symptoms; labelling or no labelling, I felt I now knew what was wrong with me.

Don't get me wrong. My closest friends were wonderful. Not primarily as feminists (a few of them were men), but as intimates who were worried and scared for me. But others less close, with whom I had worked, theorized and organized in different times, either ignored my absence, or made clumsy, insensitive attempts to fit my suffering into a feminist framework they could feel more comfortable with (but which further confused me). I even lost one woman "friend" totally — no explanation, no apology — just a total removal of support and presence. And

she was a person sworn to loyalty and love of other women, and specifically to me.

I'm not saying I was easy to be with. I was terribly scared, resentful, irrational and sometimes hysterical — and sometimes silent. I took no pleasure or interest in anything, was totally self-absorbed and physically and emotionally uncomfortable in just about any situation, bar sleep.

I had a horrible fear of being conspicuous, being seen as different. I felt "wrong" all the time. I understand that it was very difficult to accept and comprehend all this in a woman who is generally perceived as being vital, risk-taking, confident, hard-working, eloquent and skilled. I know that it is a morbid experience to keep company with someone who is talking about suicide a lot.

In addition, I found "functioning" people to be a painful reminder to me of the times when I was directed, useful, appreciated and one-of-them. I know they felt the resentment and disassociation.

But, with all my rational retrospective understanding of how hard it may have been for people to know how to help me through, I had/still have some bitterness, anger and disappointment that many didn't manage to do a better, kinder job of it. Maybe one has to go through it to know what can be supportive, or at least non-destructive, help. If that's the case, I want all feminists everywhere to listen to me on this:

It could happen to *you*, anytime, anyplace. I was one of the last people I (or others close to me) suspected would freak out in this way. But I know now that many, many more women than we think go through this ghastly experience in isolation and secrecy.

We owe it to ourselves, as human beings and as a movement, to do anything we can to ease the pain and threat of this "thing". And to help women reintegrate when they're ready. Just because a woman is no longer creative, fun to be with, stimulating and giving, is no reason to pass judgment, ignore or reject her. It's probably temporary, but with enough fuck-ups (example: lack of family support, hospitalization, destructive professional or not-so-professional intervention) at the wrong times, she may be permanently damaged by the experience.

I would ask that every woman out there take some responsibility in ensuring that a sister not feel guilty or unworthy because she is nonfunctional for a given time. It is an ugly thing to throw her into the system without monitoring or support just because you

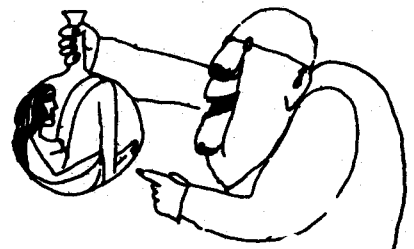
don't understand what's happening with her. She may not respond with instant recovery or obvious joy to your caring, but she needs it — for her self-love, for her protection and for her recovery. I know that for myself I was unable to spend even a minute alone, and this was a great strain on my intimates; twenty-four hours is a lot of time to delegate to the chosen few who are looking after their cabbage-doll-like friend, when the days run into months.

Please remember that it could be anyone, it could happen once for a month or for years at a time on a cyclical basis. And no, you can't screen your friends for depressive predispositions. I believe that you should be willing to do a whole lot of giving (without much return) for as long as it takes. Her inconvenience, frustration and confusion is far greater than yours.

A healthy movement of women must take care of its ailing members. We might need assistance from the establishment at times; counselling, medication, suggestions — but this should always be monitored, questioned and fully understood by those with enough marbles intact at a given time to do so.

I'm not signing my name to this, because I know that I am suspect and jeopardized in the real world of work and credibility if they have information of my vulnerability. I am dedicating this to my male partner because he, ironically, stuck closest to me and suffered in relative isolation as I did. Maybe women will take a part in changing this, along with the embarrassment, misinformation and loss associated with this topic.

But till then I'm SILENTLY AND SOMETIMES ACTIVELY SUPPORTING WOMEN WHO GO INTO THE ABYSS.



A Circumstance of Isolation

Anonymous

I was drugged for six years on lithium and a number of different anti-depressants. Finally I realized that I was being manipulated and not helped by a cynical family and a money-hungry psychiatric establishment. I got myself off of the drugs and away from both exploitative family and psychiatrists, and I'm now working to build a stable life, free from drug policing.

It occurs to me that there is a clear pattern which is a part of my experience. Many other people undoubtedly have been victimized by this pattern. During my six years as a drug victim, I met a number of these people in psychiatric office waiting rooms, group therapy sessions, and in institutional lock-ups.

Like many psychiatric drug victims, I have come originally from an enormously socially isolated circumstance. Very few friends or supportive social contacts. Solidarity with fellow-victims is hard to establish because our isolation prevents genuine communication. Anyway, I welcome the chance to communicate with others of similar concerns who read PHOENIX RISING. It's a chance to break the oppressive requirement that a person who has been through the "mental health meatgrinder" be forced to keep his past experiences to himself to protect basic employment and survival privileges.

I escaped from a very unhappy marriage breakup which was filled with acrimony, family in-law politics, threats of physical violence, lawyers, private detectives, and the destruction and theft of personal property. When the "dust" had lifted, I was completely alone, unemployed, and without the support of friends, family or parents.

My parents have always been emotionally unsupportive people. Both are pre-Depression-era orphans who were raised in desperate circumstances, without affection, social skills, or abilities to cultivate friends. These two orphans married each other and had children who became like their parents: socially and emotionally isolated people.

Many people come from such families. The wide-spread propaganda which alleges that families always raise and protect children without need for outside support is simply not true. Many children are raised unprotected. Many adult people who need help from their immediate family (i.e. from parents and siblings) do NOT get that

help. Instead, needy people are often shunted off to psychiatrists.

When my marriage ended, I needed a quiet place to live in, food to eat, a chance to recover from a period of incredible physical exhaustion. Had I gotten the recovery environment I needed, I could have gone through a period of rest and recovery and then continued to build a stable social and economic life for myself.

I didn't get what I needed.

My younger sister, who is an airline stewardess, had, at the time I needed help, recently read a book entitled MOODSWING. The book eulogizes lithium as a treatment for manic-depressive illness, and was written by a smart New York City psychiatrist named Ronald Fieve who used the book and the publicity surrounding it to build up the income and prestige of his New York City psychiatric consulting practice.

The entire "manic-depressive" concept is, of course, very sweet for money-hungry psychiatrists. If a patient agrees to be classified as a "manic-depressive", the psychiatrist has a repeat customer for virtually a lifetime. The need for lithium and periodic psychiatric supervision is announced as a lifetime need. The psychiatrist makes money no matter what the future brings. If the "patient" shows evidence of psychological balance and adjustment, lithium, other drugs, and visits to the psychiatrists are hailed as the saviours of the previously distressed person. Continued money paid to the psychiatrist and to drug manufacturers is, of course, prescribed. If the "patient" is unhappy or agitated (unhappiness and agitation occur in *everybody's* life, most often for obvious reasons — money problems, social relationships, etc.), MORE drugs and more psychiatric visits are prescribed. This means, of course, more money taken from the "patient" and given to the enormously prosperous psychiatric and pharmaceutical community.

It's a hustle.

Why, then, would any thinking person allow themselves to be victimized by all this? In my case, it was because my family insisted on it. Submitting myself to the "mental health establishment" was, supposedly, the price of family support. In fact, my family intended my being fed to the psychia-

trists and drug pushers as a *substitute* for family support. It was an excuse for them to avoid honest, open discussion about my overall circumstances, the part they had played historically in bringing it about, and the possibilities of material help they might give to bring about genuine changes and improvement in my life. It was also an excuse for them to avoid being prevailed upon to provide a quiet place for me to recuperate. Finally, my psychiatric "condition" was an excuse to discount and ignore (even to scorn) any analyses or complaints I might make regarding my situation.

Sending an unhappy family member to the psychiatrist gets negligent relatives off the hook. They don't have to help a needy relative, and they are given an excuse to ignore the basic needs the relative presents to them. The pattern was clear in my case, and must be similar for others. An isolated person in need of temporary help goes to his immediate family. The family looks for a reason not to help him, in order to avoid monetary expense, guilt feelings, and admission of past wrong treatment and support of the person in need.

The psychiatric establishment provides an "out" for a family unwilling to lend a helping hand.

A huge number of people are ordered to "get straightened out by a psychiatrist." An anxious, lonely, exhausted person who sees his family as his only ally then falls victim to the coming trap. The "new patient" obediently reports to the psychiatrist, as ordered by his family, tells his unhappy story, and is welcomed as a new customer in a familiar category. Few, if any, psychiatrists will analyze the motives and social situation of the "new patient" and reject the proposed relationship based on the fact that the person ordered by his family to visit a psychiatric office has no need for drugs or psychiatric contact.

In short, almost all people who go to a psychiatrist and announce that they are mentally ill are welcomed and agreed with. The psychiatrist is in business to earn money, and a new patient means new money. A long term patient means recurring money, usually in exchange for ridiculously little effort or thought.

The average psychiatric visit by a "manic-depressive" patient usually involves a one hour recitation of recent events by the patient. The psychiatrist punctuates the patient's comments with an occasional grunt or a thoughtful "Ummm-hmmm." The patient is NEVER TOLD that he or she had no further need of drugs or psychiatric

visits, particularly if the patient obviously has the means to pay for these further drugs and visits. An announcement of a patient's clean bill of health by the psychiatrist would, obviously, be bad for business. It would diminish the enormous incomes most psychiatrists take in.

If a patient is socially isolated (as I was), the family uses the person's "psychiatric status" as a reason to discourage the person from making new friends and forging new alliances. The family often keeps the person in continued isolation, away from outside counsel, and away from people who might be supportive of any attempt to get off of the drugs and away from the psychiatric establishment, and to start a new life.

In order for me to put a stop to the drugs and the psychiatrists, I had to separate myself from my family, who threatened to have me "locked up" when I voiced discontent with my situation. I escaped into a very lonely,

unsupportive, hostile world — the world of a frightened person who has no friends or money.

Now, I am slowly building a new life. I have almost no money, and am presently without employment. Even so, I am personally happy, and — without the drugs, et al — have a sense of personal peace which has been unfamiliar for many years.

The hostile family — greedy doctor syndrome is an old story. Nightmarish old age homes are filled by families who have dumped needy aged relatives using the "medical need" excuse, which is always supported by negligent but greedy doctors who profit from the family's attitude toward the needy relative. It is an enormously painful thing for a needy person to face up to the fact that he cannot depend on his family, and that they would willfully do terrible things to avoid helping him.

For many years, I could not bring myself to admit that my family was unwilling to give me the help I periodically needed. Nobody wants to believe

that his own mother and father and siblings would desert him in time of need. However, for many people, it is a fact which must be faced. The entire psychiatric establishment perpetrates its outrages largely because families submit their own relatives to be given up like sacrifices in an ancient pagan religion.

Family support of psychiatrists keeps them going.

It is often said that in time of severe crisis, one's family is always willing to give help, and that their help will be complete and adequate. Unfortunately, this is frequently not true. The huge community of people victimized by psychiatric druggings need access to means of survival/recovery from sources OTHER THAN immediate family. Peace of mind in times of crisis is impossible without basic access to safe, comfortable housing, clothing, and food. If these things are not available to distressed persons whose families refuse to help them, such persons become likely victims of psychiatric barracudas.

I'm Not Going to Die

As I write this, my head is pounding from anger, fear and anxiety. My colitis is acting up again as the stress in my life increases and I feel helpless to control it. My wife doesn't love or want me anymore — after 17 years. It really began perhaps four or five years ago. I just didn't want to recognize what was happening. My two children don't regard me as their father and don't want me around anymore.

Many years ago, before I was married, I suffered through a painful hell of a deep depression, anxiety and one suicide attempt. I spent time in hospital and went through the agony of shock treatment and medication. I'm still on medication — but not much. I lost out on my education and five years of life. But I made up my mind to recover and build a life for myself and anyone who wanted to share it with me. And that person had to be aware of who I was and where I had come from.

She did. And seemed to accept me.

Times were often tough. There was never much money, as the jobs I had never really paid very much. However, we survived, despite these things and occasional periods of depression and anxiety. Over the years, I completed a university degree and completed other subjects at community colleges, etc. And I landed a job, a fairly good job — after a year of unemployment (the firm I worked for went bankrupt).

Still, she suddenly wanted more than I could provide; and the children followed suit. She became cold and aloof — putting me through torment. I became increasingly tense and withdrawn. At the same time, there was a change at the place where I worked. I applied for the job as general manager. The job, however, went to someone imported from the United States.

Needless to say, dismissals became the order of the day. And, I began to sense harassment and knew that I was next. This only added to my feelings of isolation and depression. The axe finally fell late last summer. Given the poor state of the job market, it's not surprising that I have been unable to find another job yet. All those years of hard work and long hours down the drain. It was for nothing. In the final analysis, they didn't want me; just like I'm not wanted at home. Or for that matter, in society at large. I was thrown out like a rag.

No wonder I go from rage to the pits of despair. The bad thing is I can't do anything about it — try something and see what will happen.

My wife tells me our marriage has been one long "zilch." Maybe it has been. She says I'm like her father and her poor mother suffered all through the years with him.

Why didn't she leave then?

Why did she even marry me?

It's snowing and cold outside, adding to my feelings of loneliness and isolation. I have very little money left.

Maybe I am a failure, a "loser." Maybe my map through life has been charted wrong. I don't know.

During my last five months on the job, I was subjected to frequent episodes that can best be described as humiliating and degrading and I was put forward to the staff as an object of ridicule. Only two persons supported me — one was forced to quit and the other demoted and reprimanded.

Meanwhile, someone at work put sand in the gas tank of my car and ruined the motor. I got about 20 per cent of the repair costs back from the insurance company — the person(s) who did it got away. Clearly someone was out to get rid of me at all costs. And, the harder I tried to get a job, the more I became discouraged. Now, of course, I am getting a bad reference from that company.

I am pausing to take a deep breath . . .

Everything looks so dark and bleak. Things are happening that I can't control or even have a say, no — even think about.

I am being rejected. Being made to feel like I'm superfluous.

I don't want to die now. I've still got dreams and ambitions. I don't want it to end now, here, this way.

But I'm not giving up. I don't know yet what to do.

I'm not going to die.

By John Smith



the Book worm turns

Psychiatric Drugs; Hazards to the Brain

By Peter R. Breggin, M.D.
Springer
New York, 1983

Reviewed by BONNIE BURSTOW

Peter Breggin's latest book, *Psychiatric Drugs; Hazards to the Brain*, is a well-researched scholarly exposé similar in style and significance to his earlier book on electroshock. The book's focus is on the hardcore psychiatric drugs — the major tranquilizers and the antidepressants. The central hypotheses are:

1. The hardcore psychiatric drugs impede and do damage to various parts of the brain.
2. The brain damage in question is not a side-effect of the drugs; *the psychological states associated with this brain damage are, rather, the very 'therapeutic effects' which the psychiatrists are seeking.*

The second of these hypotheses — known generally as the brain-damaging hypothesis — is the issue with which the book begins. Arguing for it, Breggin cites experiment after experiment and report after report where the effects of the major tranquilizers and antidepressants are noted and applauded. Those effects are: a general subduing, apathy, emotional flatness, etc. The effects being applauded, Breggin hastens to point out, are *the very effects* associated with brain damage generally and with lobotomy in particular. Breggin quotes many professionals who admit this, openly referring to what they have achieved as a 'chemical lobotomy.' Breggin agrees with the description. The disagreement comes in when most professionals see causing brain damage (which induces emotional flatness, apathy, etc.) as a good thing; Breggin sees it as the *atrocious* which it is. Psychiatrists are attracted to this form of treatment, Breggin suggests, because it makes the inmate more manageable. It is unclear whether being manageable is in itself a good thing, but it is only too clear that being manageable *because one is so brain-damaged one is incapable of*

being anything else is far from good.

In the next section, Breggin explores the different types of brain damage associated with the major tranquilizers and the antidepressants. Beginning with the major tranquilizers, he cites experiment after experiment showing that these primarily impede processes within the extrapyramidal system of the brain (lower part of the brain) and secondarily impede processes in the middle brain. Interfering with lower brain processes causes not only parkinsonian reactions, which are reversible, but also such *irreversible* diseases as tardive dyskinesia. (Tardive dyskinesia is characterized by involuntary shaking, chewing motions, etc. — and can result in blindness and death). Impeding the middle brain is the source of the chemical lobotomy referred to earlier.

Turning to the antidepressants, Breggin cites experiments and reports which suggest that they are more neurotoxic than the major tranquilizers and generally do more serious brain damage. The main distinction is that the major tranquilizers impede and do more damage to the extrapyramidal system than the antidepressants, whereas the antidepressants impede and do more damage to the middle brain. Correspondingly, while the major tranquilizers are associated primarily with dyskinesias, the antidepressants:

1. more often lead to chemical lobotomy;
2. often result in organic brain syndrome and dementia.

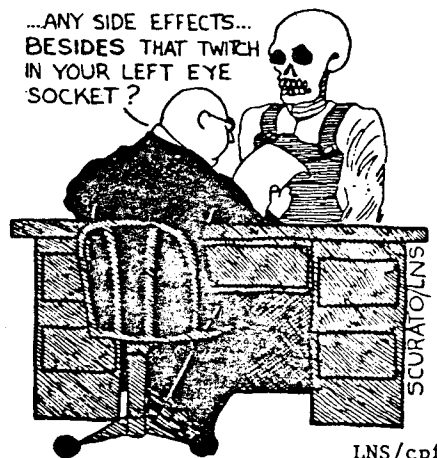
Neither drug, as Breggin points out, tranquilizes or alleviates depression. Both are experienced as extremely unpleasant, and, for the most part are not taken willingly.

Surprisingly, it is lithium — a close relative of the antidepressants — which Breggin singles out as potentially the

most dangerous. This is surprising because lithium is generally accepted as free of adverse effects. Breggin gives evidence that this drug is extremely toxic. Moreover, not only does it damage the brain, *lithium damages every cell in the body.*

The damage done by all these drugs, Breggin argues, is aggravated by the body's reaction to withdrawal and the psychiatrists' response to that reaction. The story Breggin tells is as follows: After being brain-damaged by drugs, the inmate is released from hospital. Not being able to function, s/he goes off the drugs. The systems which have been drastically impeded by the drugs try to correct themselves. The result is hyperactivity on the part of the systems and — for the person — very serious "symptoms." The doctor responds by readmitting the person and administering the same if not a higher dosage. A system is hereby established which is *inherently self-aggravating*. The person gets worse and worse.

A further aggravating factor which Breggin discusses is the *no-win approach of the psychiatrist*. The inmate is administered high doses of a brain-damaging drug. If the inmate becomes subdued, apathetic, and emotionally flat, the 'therapy' is considered a success and is continued, with progressively more brain damage ensuing. If the inmate is not subdued, apathetic, and flat s/he is deemed in need of more drugs, and so an increase in medica-



tion is administered, with still more brain damage developing. Correspondingly, if the inmate complains the drugs are making him worse, this complaint is seen as evidence of "psychotic thinking" — proof, that is, that *s/he is not yet stable and that an increase in dosage is in order*. In every case, the inmate loses. In every case, progressive brain damage occurs.

In the last chapter, Breggin protests strongly against the immorality of what is happening. He maintains that brain-damaging treatment like this simply should not be given without consent but that real consent is impossible in coercive institutions. He therefore asks for a stop to involuntary hospitalization in general. Breggin concludes with an indictment of the psychiatric profession and an endorsement of the self-help movement.

I highly recommend Peter Breggin's latest book. It is scholarly. It is comprehensive. It provides insight into how drugs work and how damage comes to be done. It is full of painstaking medical and sociological analyses. It argues logically and point-by-point to a conclusion and an indictment which, I think, cannot be reasonably denied.

This is not to say the book has no flaws. It is often turgid and dry — and it is sadly in need of diagrams. A more fundamental flaw is its approach to the minor tranquilizers. In trying to distinguish the major tranquilizers from the minor, Breggin ends up understating the dangerousness of the minor tranquilizers and minimizing the doctors' complicity in minor tranquilizer addiction. Finally, while revealing some devastating truths about lithium, Breggin neither mentions nor deals with facts which do support his contention that lithium has no effect whatever on so-called 'manic' symptoms.

I feel the book's assets still far, far outweigh its deficits. I would not recommend it for anyone who wants a quick overview — let alone light entertainment. But it is a fantastic resource for those really trying to come to terms with the hardcore psychiatric drugs and/or committed to combatting this most accepted and pervasive of psychiatric assaults.

Margaret Fraser House

301 Broadview Avenue
Toronto, Ont. M4M 2G8

Margaret Fraser House is a 10 bed home for women with mental health problems. It is one of several new group homes opening throughout Metro Toronto.

The purpose of Margaret's is to provide a stepping stone towards independent community living. Some of the residents will have been hospitalized for long periods and others will not have had safe or stable living situations. The length of stay at the house is six months.

While at Margaret's the women will re-learn such basic living skills as cooking, budgeting, and using public transportation. Many will also be involved in outside programs at hospital outpatient centres, community centres, or vocational rehabilitation programs.

The house will be staffed 24 hours a day by nine staff members. Margaret's will be working closely with Woodgreen Community Centre, which provides two of the staff. Their focus is to provide living skills programming to the women during the day and to assist the women leaving Margaret's in finding suitable longterm accommodation.

The staff at Margaret's operates as a collective. This means there is no "boss" or director, but that all staff participate equally in duties and in decision-making.

Margaret's has a Board of Directors made up of representatives of many eastend agencies and individuals from the community interested in mental health.

Margaret's is funded by the Ministry of Health and will be working closely with the Ministry in an on-going evaluation of the program.

12th Annual Conference in Colorado

This year's 12th Annual International Conference For Human Rights and Against Psychiatric Oppression will be held at the University of Southern Colorado in Pueblo, Colorado, about 120 miles south of Denver. The Conference runs four days, June 1-5. The registration fee is \$75, which covers your room and all meals. Child care will be provided. As in previous conferences, only people who are psychiatric inmates, ex-inmates and supporters endorsed by an ex-psychiatric inmate group are eligible to attend. The Women Psychiatric Inmates Liberation Front in Denver is hosting the Conference. Please make a special effort to attend this important conference. People are asked to donate whatever they can to help subsidize travel, or other basic expenses of those who can not afford the full cost. To register or make a donation, please send a cheque or money order payable to: '12th Annual Conference Committee' and mail to: *12th Annual Conference Committee, P.O. Box 61307, Denver, Colo. 80206*. For more Conference info, write to this address or call: (303) 393-7026. The Conference Committee needs your support now to make it a success. THANK YOU.

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FAY HONEY KNOPP AND OTHERS

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Anti-Drug Book Now Available

A new and outstanding book on psychiatric drugs was just published last year. It's titled *Psychiatric Drugs: Hazards to the Brain* by Dr. Peter R. Breggin (Springer, 1983). The book sells for \$15, about \$8 less than the list price, and it's available at: SCM Book Room, 333 Bloor St. W. (ph: 979-9624). Breggin's book documents the many brain-damaging effects of the 'major tranquilizers' and antidepressants. (See review of this alarming and revealing book in the Spring 1984 issue of *Phoenix Rising*.)

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*“We want a few mad people.
See where the sane ones have
landed us!”*

—George Bernard Shaw