Understanding and Ending ECT

A Feminist Perspective

BONNIE BURSTOW

Il s'agit ici de repenser la thérapie des électrochocs comme une violence faite aux femmes. On dit qu'ils endommagent cerveau, q'ils sont un moyen de renforcer les rôles sexuels, et qu'ils torturent. L'auteure demande aux mouvements des femmes de mettre fin à ces pratiques. Elle donne des indications pour redéfinir l'électrochoc et pour en parler dans leurs conférences, leurs livres et leurs déclarations des comme d'une violence faite aux femmes.

It may initially seem strange discussing ECT or electroshock in a journal issue devoted to violence against women. After all, is not ECT a standard psychiatric treatment? Indeed, it is. It is despite the fact that since its inception in fascist Italy, there have been mammoth concerns about it. Significantly, objections and qualms were immediately voiced by both recipients and professionals. As Leonard Frank documents, no sooner did the first jolt of electricity surge through the head of the first ECT victim than the victim bolted upright, screaming in horror, "Non una seconda! Mortificare!" (Not again, it will kill me) (8). "When I saw the patient's reaction, I thought to myself, this should be abolished," ECT's inventor acknowledged (see Frank 11). Since this horrific beginning, the questioning and the protests have continued. Researchers such as Peter Breggin (1979, 1991, 1997) have alarmed people with findings that establish damage. Throughout North America and Europe, shock survivors and their allies routinely demonstrate against the treatment and submit deputations on the harm done. Throughout all this protest, as evidenced in Ontario Coalition to Stop Electroshock (1984a, 1984b) and Breggin (1997), sexism is repeatedly raised. And yet not only is ECT continuing, but as MindFreedom shows, it is on the rise. Moreover, it continues to be theorized as treatment.

The purpose of this article to reach past the commonplace understanding of ECT as treatment to reveal ECT as state-sponsored violence against women—violence, moreover, which must be stopped. The bulk of the article explores ECT as violence and the gendered nature of it. The article culminates in a discussion of the role of the women's movement in ending this violence.

Technically, What is ECT?

ECT is procedure that consists of passing sufficient electricity through the head (100-190 volts) to produce a grand mal seizure. In unilateral or modified shock, both electrodes are placed on one side of the head; in bilateral or unmodified shock, one electrode is placed on each side (see Frank; the Electro-convulsive Therapy Review Committee; Breggin 1997).

Electroshock as Damage: Scientific Evidence of a Crime

As early as the 1950s, animal experiments established that ECT causes brain damage. For example, in a definitive double blind study (Hartelius), a pathologist examined the slides of the brains of cats—half of which had received electroshock. Significantly, on the basis of observable brain damage (cell death and hemorrhages), he was able to identify accurately which animals had been administered shock.

To cite relevant research on human beings, Weinberger found more cerebral atrophy in the brains of "schizophrenics" who have had ECT than those that have not. And in a CT (computed tomography scan) study, Calloway found a correlation between frontal lobe atrophy and ECT.

Memory loss, intellectual impairment, and the creation of neuropathology are standard and well documented. An experimental study by Templer, Ruff, and Armstrong establishes that ECT causes permanent memory loss and general intellectual impairment. On the basis of a thorough literature review—including seizure studies, autopsy studies, and studies of memory loss and intellec-

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tual impairment—Templer and Veleber concluded that ECT causes permanent brain pathology. Also on the basis of an extensive literature review, Peter Breggin (1998: 27) concluded, "ECT causes severe and irreversible brain neuropathology including cell death. It can wipe out vast amounts of retrograde memory while producing permanent cognitive dysfunction." In line with the research, neurologist Sidney Samant redefined ECT as "brain damage produced by electrical means" (cited in Breggin 1991: 184).

While minimizing the damage done, ECT promoters defend the use of ECT on the basis of its alleged effectiveness in alleviating depression and preventing suicide. And yet electroshock has no such special efficacy. In a rigorous double blind study, Lambourne and Gill found that a month after shock and simulated shock, shocked patients had not improved more than non-shocked. They concluded that shock does not produce a superior therapeutic effect and that its alleged effectiveness is due to placebo. Correspondingly, all the research on electroshock and suicide—for example, Black and Winokur—tell the same story: ECT has no effect on the suicide rate. Breggin concludes, "after more than fifty years there is no meaningful evidence that this dangerous treatment has any beneficial effect" (1991: 207).

Effective in Doing What?

The long standing discrepancy between claims of effectiveness and research findings raises the question of whether or not psychiatrists' impression of effectiveness rests on something other than lowering depression and preventing suicide. Psychiatrist Peter Breggin attributes the impression to ECT's ability to control behaviour via fear and punishment (1991: 212). Psychiatry's historic use of terror and torture lends support to Breggin's position. Consider, in this regard, such torturous procedures as repetitively dunking a patient in ice water (for further details, see Szasz; Frank). Is the terror inspired by the passing of electric current through the brain an improvement over the shock of being immersed in ice water?" asks one psychiatric survivor (see Grobe 103).

Breggin (1979, 1991) suggests a complementary rationale on the part of psychiatry: A good part of what is impressing the shock doctors, he suggests, is precisely the controlled behaviour, memory loss, and intellectual impairment arising from brain damage. He also maintains that shock doctors are aware that brain damage is operant.

There is considerable merit to these claims. Shock doctors have been known to make statements that show that they are counting on memory loss. For example, at a review board hearing which I attended as an expert witness, a psychiatrist seeking authorization to force ECT on a woman who was not eating took the patient's lawyer aside and told the lawyer that shock would solve the problem, for after shock, the woman would not remember why she was not eating and so would likely resume eating. Additionally, there is reason to believe that to varying degrees both psychiatrists who administer electroshock and leading shock promoters are aware of damage beyond memory loss and are even counting on that additional damage. Significant, in this regard, is the following statement by Abraham Meyerson—a psychiatrist pivotal in popularizing the use of ECT:

> I believe there have to be organic changes or organic disturbances in the physiology of the brain for the cure to take place. These people have for the time being at any rate more intelligence than they can handle ... and the reduction of intelligence is an important factor in the curative process. (cited in Breggin 1979: 142-143)

Shocking Statistics

It is impossible to look at statements such as Myerson's without getting a sense that *some people's* intelligence is being treated as expendable. A look at shock statistics quickly reveals *which people.* Throughout the history of ECT, one statistic remains constant: Women are subjected to electroshock two to three times as often as men. To cite as examples statistics from different eras and locations, a 1974 study of electroshock in Massachusetts reported in Grosser revealed that 69 per cent of those shocked were women. By the same token, figures released by the Ministry of Health (Weitz) show that for the year 1999-2000 in Ontario, 71 per cent of the patients given ECT in provincial psychiatric institutions were women; and 75 per cent of the total electroshock administered was administered to women. Another telling statistic is that approximately 95 per cent of all shock doctors are male (see Grobe).

Factor in these statistics, and a frighteningly anti-woman picture of ECT emerges: Overwhelmingly, it is women's brains and lives that are being violated. Overwhelmingly, it is women's brains, memory, and intellectual functioning that are seen as dispensable. Insofar as people are being terrorized and controlled, overwhelmingly, those people are women. And almost all the people making the determinations and wreaking the damage are men.

Now as survivor Carla McKague states, psychiatrists who promote shock typically defend the ratio by pointing out that shock is most commonly given for depression and that women are depressed approximately two to three times more often than men (Burstow 1994). However, as has already been shown, electroshock has no special efficacy in relieving depression. Moreover, as the Electroconvulsive Therapy Review Committee found, women are electroshocked two to three times as often as men irrespective of diagnosis.

Women Survivors Speak Out

Damage, Impairment, and Their Impact

Damage to the brain, impairment of memory and other cognitive functions, and the dismal effects on the women's lives is a common theme in women survivors' testimony. Significantly, all women shock recipients discussed in an article on women electroshocked in the Bay area (Warren) thought that the purpose of electroshock was to erase memory. Correspondingly, all women shock survivors I interviewed in a video recorded in 1994, all women shock survivors who testified in front of the Toronto Board of Health (Phoenix Rising Collective, 1984), and all but one woman survivor who testified in the 1984 hearings at Toronto City Hall (Ontario Coalition to Stop Electroshock 1984a) spoke at length about their difficulty navigating the world because of electroshock-induced damage (Burstow 1994). Women testified that the damage was extensive, that much of it was permanent, and that it had wreaked enormous havoc in their lives. Problems typically listed by women include: not being able to remember family, friends, or conversations; no longer being able to hold down meaningful jobs; a sense of diminishment. To quote one survivor to give you a sense of the extent of the injury:

> *I was a trained classical pianist... Well, the piano's in my house, but ... it just sits there. I don't have that kind of ability any longer.... None of these things stay in my memory. People come up to me ... and they tell me about things we've done. I don't know who they are. I don't know what they're talking about.... Mostly what I had was ... modified shock, and it was seen as effective. By "effective", I know that it is meant that they diminish the person. They certainly diminished me.... I work as a payroll clerk for the Public Works Department. I write little figures, and that's about all.... And it's the direct result of the treatment.* (Phoenix Rising Collective 20A-21A)

Electroshock as Assault and Trauma Within the Context of Parens Patriae

Repeatedly, women's testimonies connote a sense of the entire electroshock process as an assault—being strapped down, being herded into the room, one's head being incased in a band, being unable to breathe, being rendered unconscious, being brain-damaged. In this regard, one woman in a study by British researcher Lucy Johnstone reports, "I feel like I've been gotten at, bashed, as if my brain has been abused;" and another reports, "it can feel like a brutal assault on who you are" (46). Many women explicitly identify the process as torture. In my video on women survivors, the shock survivor, Sue, at once names ECT as torture and directly indicts the state, saying:

> *All the therapy in the world is not going to erase the scars of being dragged into a room, having a band on your head, and having your brains fried. People say there's no torture in Canada. That's pure bullshit. And excuse my language. There is torture being paid for by the Ministry of Health.* (Burstow 1994)

In line with survivor depictions, Johnstone identifies ECT-induced trauma in all the women shock survivors interviewed in her study. The trauma, however, is more extensive than even Johnstone suggests. Testimony by shock survivors typically lays bear extreme states of terror, the feeling of being powerless, the sense of being humiliated and degraded, the subjective sense of annihilation, of dying. Why did I have "to die 36 times?" asks a shock survivor at a recent hearing in Toronto (Electroshock Panel). "Your heart's a muscle, and your lung's a muscle, and all of your muscles stop," points out shock survivor Connie Neil, "and each time, you feel like you are dying, and then they shoot electricity through your head, and then you don't know anything" (Burstow 1994).

Feelings of humiliation and degradation are equally evident in survivor testimony, and as with the sense of death and doom, they are tied to the assault, to the sense of being purposefully mistreated. "I felt like an animal;" and "they strip you of your self-worth," state survivors (cited in Baldwin and Froede 185). "I felt as if I was a non-person," objects a woman in the Johnstone study (49).

Similarly, the women typically express a sense of having no control, of being powerless. For example, a woman at a public hearing testified, "I never felt so helpless in all my life" (cited in Baldwin and Froede 185). The sense of helplessness joins with the sense of diminishment in wom-

en's depiction of themselves as being infantilized (see, for example, Baldwin and Froede 184-185).

Terror, humiliation, and sense of helplessness, significantly, stem at once from the damaging and terrorizing treatment and from the larger objective context of what British researcher Erving Goffman calls a "total institution"—an institution which controls all aspects of life. In such an institution, choice has little meaning regardless of what rights a person may technically have—the supposed right to refuse treatment, for example. With the psychiatric institution and its authority figures additionally authorized by the state—moreover granted *parens patriae* by the state—both practically and psychologically, the inmate has little room to maneuver. The shock victim is constituted as powerless child who knows that she will not be heard while presiding male emerges as all powerful parent who knows what is best and can enforce it. Note, in this regard, Velma's compelling description:

> Every time I saw him coming down the hall, I'd shake with fear.... I'd say, "I can't ... take it any more. I don't think this is doing me any good. I feel worse." And he'd walk down the hall a little way and put his arm on my shoulder and say, "Come on now, lassie, you know you're going to do it." (cited in Burstow and Weitz 1988: 202-204)

As with all or almost all trauma, the low sense esteem and the sense of powerless continue even after the woman's objective situation changes (see, for example, Burstow 1994) So does the fear. Indeed, "the biggest thing," explains Connie Neil, "is the business about the terror and the violence. This just doesn't go away" (Burstow 1994).

ECT as Punishment, as Control of Women

While not all women who experience electroshock as assault see it as punishment, most do. In this respect, Connie Neil states, "It was meant to be punishment" (Burstow 1994). And women report wondering what they did wrong to deserve such punishment (see Johnstone 49).

Punishment and control likewise go hand in hand. Women after woman have testified that the real purpose of the electroshock was social control. Cognitive impairment or memory loss is frequently identified as the means. The rationale is: What cannot be remembered, cannot be acted on (see in particular Warren; Funk; and Ontario Coalition to Stop Electroshock 1984a). Correspondingly, if people are so impaired that they cannot function, behaviour seen as undesirable may be altered (see, in this regard, Funk; ;Ontario Coalition to Stop Electroshock 1984a). Even more commonly, women testify to being kept in line via fear of ECT.

> *There was always the fear ... that you are going to appear a little outside the norm," says shock survivor Connie Neil. "You must not be anything that is outside the norm because ... if you are, you will be taken to a hospital, you will be strapped down, and you will be given electroshock.* (Ontario Coalition to Stop Electroshock, 1984a: 90)

Connie makes the point even more forcefully in my video:

> *All I did was have a baby. And look at what they did to me. Now if I really did something, what would they do to me next? So you be very very careful. You be very very quiet.... You fit in. You play a role.* (Burstow 1994)

ECT is effective in the way abuse is always effective—by inspiring fear of further violation. Additionally, a vicious cycle sets in, with ECT used to stop women from complaining about the effects of ECT. Significantly, many women have testified that when they spoke of the treatments making them worse, they were chastised and warned that continued complaints would be interpreted as illness and result in further "treatment". Not surprisingly, women in turn reported protecting themselves by obeying (see, for example, Funk). What is also telling, women psychiatric survivors who have not been shocked describe the very witnessing of shock in the institution as both traumatizing and an ever-present threat (see Ontario Coalition to Stop Electroshock 1984a: 161 ff.).

Add all this together, and what emerges is a formidable and comprehensive method of social control. The fact that such control is primarily exercised over women would raise the question of gender role enforcement even if women's own testimony did not suggest it. Women's testimony, however, blatantly suggests it. Women have testified to ECT being used to control their sexuality (see Blackbridge and Gilhooly 45-50). Being controlled as a wife figures particularly centrally—generally with the psychiatrist seeking this control, sometimes with the husband tricked into cooperating, sometimes with him actively instigating.

The story of British Columbia's Wendy Funk is a case in point. In 1989, states Wendy, the following conversation transpired between her husband and her doctor:

> "Can't you tell her to ... spend more time at home?" Dr. King asked.
>
> "I try but she doesn't listen to me," Dan joked.
>
> "So you can't control your wife's behaviour?" Dr. King asked. (Funk 15)

Dr. King "explained" to Wendy that her "problem" arose from neglecting her house and being consumed by "feminist-type thinking" (48). Locked in a ward, with Dan urging cooperation, and her doctor pushing ECT and threatening to ship her far away if she refused, Wendy consented

and was shocked. Even though profound amnesia resulted, the psychiatrist later pressured for further ECT, telling her, "You really should have ECT for the sake of your family if nothing else. Making Dan worry about you so much is not a good thing for a wife to do" (91). Patriarchal enforcement of stereotypical wife and mother behaviour is evident.

The same patriarchal control is evident in other stories. "Why don't you care for your baby? Why don't you care for your husband? Why don't you smarten up?" Connie was asked before the electrical assaults began (quoted from Ontario Coalition to Stop Electroshock 1984a: 87). Women saw shock's purpose as "fixing" the marriage with "fixing" *them* as the route.

In some cases, women receive ECT as a result of their husband signing the consent form. Taking the word of the doctors, some husbands sign without any idea that damage is being done. Others, however, are aware of and even counting on the damage (see Warren).

In the Carolyn Warren study, significantly, many husbands openly expressed satisfaction with the memory loss. To quote Warren, "Mr. Karr commented on his wife's long-term memory loss as proof of her successful cure by ECT.... These husbands used their wives' memory loss to establish their own definitions of past situations in the marital relationship" (294).

The combination of husband plus medical establishment plus threat of further ECT is formidable in its ability to control women. Once again, Warren is instructive. Women told Warren that they refrained from expressing any kind of problems to their husbands, "for fear of reprisal in the form of ECT" (296). Broad ways in which husbands are implicated in this medical-marital web of control of women include: signing for consent, pressuring wives to consent, suggesting shock, acting as a spy for the shock doctor, advising the doctor of "bad behaviour", and threatening to report noncompliance (see Warren; Funk; Burstow; Ontario Coalition to Stop Electroshock 1984a).

Women in Special Jeopardy

Sadly, severely violated women are in special jeopardy of being subjected to this injurious treatment. As I have shown, women routinely end up in psychiatric institutions precisely because of violence against women (Burstow 1992, 1994). Indeed, the majority of the 19 psychiatrized women I interviewed for the 1994 video have an extensive background of violation. Once incarcerated, violated women are at serious risk of ECT not only because they are frequently depressed, but because they commonly cope in the traumatized ways that psychiatry theorizes as dangerous—cutting themselves, starving themselves (see Burstow 1992). Correspondingly, if they are electroshocked, retraumatization occurs. As such, ECT constitutes a special threat to the well-being of violated women and is one of the ways in which the violence against women is compounded.

Women giving birth are also in special jeopardy. Significantly, the vast majority of the women who testified in 1984 at Toronto City Hall stated that were given shock just after the birth of a child. Peer below the surface, and an alarming truth presents itself: Utterly natural though post-partum depression is, ECT is being used to "cure" it.

The group in most jeopardy is elderly women. While young women were in highest jeopardy years ago, elderly women are now the primary target. Note, for 1999-2000, as shown in Don Weitz, 52 per cent of the total electroshock administered in Ontario was administered to *women over 60.* With brains being more fragile the older people are, damage is likewise greater.

Why the Women's Movement(s) Should Take Up This Issue

To date, despite the ongoing work of some feminists, the issue of electroshock has not been taken up broadly by the women's movement(s). However, if we in the women's movement were to take up this issue in a concerted way, we could make a huge difference given our numbers, our knowledge of the patriarchy, our experience organizing against violence against women, our organizational strengths, our comparative credibility, our ability to put forward what would be seen as a new message, a new analysis. What is equally important, it falls to us to take up this issue, for as this article has demonstrated, regardless of intention or perception, ECT constitutes state-sponsored violence against women. Indeed, it is state-sponsored violence against our most vulnerable sisters. Moreover, it is an ever present danger to those who have already been violated, whether that violation be childhood sexual abuse, battery, or adult rape.

What the Women's Movement(S) Could Do

A beginning as well as an ongoing task would be educating others in the movement. As long as most feminists think of ECT as a treatment that unfortunately, "some people" might need, we will get nowhere. It is important that the issue of electroshock be included in all general conferences, discussion papers, special issues of journals, and books dealing with violence against women, with the point drawn home that ECT is violence and that whatever else women need, no one needs to be violated. Correspondingly, it is important that the issue of choice be tackled head on and that ECT be theorized politically and strategically: that is, not as treatment amenable to choice but an act of violence in a web of violence committed both by a total institution authorized by the state and by patriarchal society more generally.

Whenever a relatively new area is taken up, it is easy to assume that the identical structural dynamics that apply to other issues apply to this one. Indeed, I have heard feminists who know little about ECT claim that working class women and women of colour are in greater jeopardy of electroshock. As demonstrated in Breggin (1997) and numerous other sources, the reality is markedly different. The primary target is middle-class white women. While is it important to start theorizing why this is the case and theorize it with an anti-racist and anti-capitalist awareness, it is essential that we educate with this reality in mind.

Feminists organizations, of course, are best positioned to educate the general pubic about electroshock as a feminist issue. And just as we have insisted on our own naming with other issues, we would need to do so here. We are also in the best position to approach/pressure government with respect to the role of gender, though the task is not simple. To date the gender dynamics have never been taken seriously by those in power. Indeed, the statistics themselves are routinely ignored or trivialized. What we are up against is psychiatry's contention that women get electroshock two to three times as often as men because women are depressed two to three times as much as men. Pushing a feminist analysis would involve deconstructing and taking the ground out from under such rationales.

Raising awareness of the special jeopardy of women who are older, women giving birth, and women otherwise violated (including previous psychiatric violation) is crucial. By the same token, while it is important to press for psychiatry-free services generally, such advocacy is especially critical for these women. Elderly women place a particular demand upon us, for they almost never step into a public arena to give testimony, and so their voices are never heard.

We might also be conducting our own research into ECT and gender. This means applying for funding and setting up projects. In the interest of research and activism, additionally, it would be important to force governments who longer do so (e.g., Ontario) to maintain an up-to-date data base on ECT which includes a breakdown by gender and age. The absence of such statistics was an impediment in writing this article and would impede the ongoing work.

A further change that is important is conscientiously incorporating statements about ending electroshock into organizational mandates and statements about ending violence against women. An eventual next step would be mobilizing to include electroshock as a prohibited violence in international conventions against violence against women.

Learning from the past and not repeating mistakes is a "must." Perhaps the single biggest mistake of ECT abolitionists has been to make governmental investigation into shock the object of our lobbying. At various points, governments throughout the world, including Ontario and Quebec, have conducted investigations into the use of shock, generally at the behest of activists. The result was predictable: The press were initially excited and provided coverage. Time ticked by while the committee went about its research. The press lost interest and electroshock rapidly became a non-issue. When the report was finally released (see, for example, Electro-convulsive Therapy Review Committee), it provided no hard-hitting recommendations and utterly sidestepped the issue of gender. Moreover, for the most part, the recommendations were not acted on. What compounds the injury, for decades afterward, no one could interest the press anew, for they felt that they had already done justice to the ECT question. In the 1980s I, along with my colleagues in the Ontario Coalition to Stop Electroshock, made precisely that mistake, and the issue of electroshock in Ontario and most of Canada continues to be off the table

as a result. The lesson to be learned from our mistake is: Despite the initial "high" that getting a foot in the door brings, the surest way to kill an issue and to squander momentum is to either ask for or agree to a study. While without question, we need to do our own feminist research into electroshock, it is action—not inquiry—that should be demanded. And whatever else we demand in addition—feminist help for shock victims, restitution—we should be demanding total abolition.

That said, one transitional/accompanying goal is critical—removing state funding for ECT. The point is that the state should not in the business of funding anything even remotely approaching brain-damage. Moreover, cutting off state funding would dramatically reduce the number of victims. Other goals might also be considered, though we would have to do our analyses carefully and be convinced that they move in direction of abolition.

In ending, I would suggest that ECT activism is an area where coalition politics is both possible and optimal. As I have discussed elsewhere, obvious allies are the people who have been battling it out in the trenches all these years—psychiatric survivors, antipsychiatry activists, and radical professionals (see Burstow 2005). While, of course, different constituencies would need to continue to work in their own separate spheres, joint events, statements, and interlocking campaigns could be entertained. Things to keep in mind in all such coalition work is the centrality of survivors and their stories, the legitimacy of survivors' mistrust, the obligation which power differences place upon us, and the critical need to maintain a feminist analysis.

Bonnie Burstow is a faculty member in the Department of Adult Education and Couselling Psychology at Ontario Institute for Studies in Education of the University of Toronto. She was co-chair of the Ontario Coalition to Stop Electroshock. She is an academic, a feminist psychotherapist, an activist, and a novelist. Her works include: The House on Lippincott *(2006),* Radical Feminist Therapy: Working in the Context of Violence *(1992); and* Shrink-Resistant: The Struggle Against Psychiatry *in Canada (with D. Weitz 1988)*

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Heather Hicks is a practicing artist with a Bachelor of Fine Arts from Queen's University and an ISP post-graduate diploma from the Toronto School of Art. She has a polyamorous relationship to creative methods and materials. This is expressed in multi/interdisciplinary practice through the use of painting, drawing, printmaking, sculpture and poetry. Her installations take form in a variety of spaces and scales: from her small, hand-bound bookworks, to large format pieces which meld architecture, image and text. Her poetry and imagery has been published in Zhush *and* Misunderstandings Magazine. *Heather has also been teaching creative arts and bookmaking programs to children and adults for the past nine years. "Evasive Maneuvers" is a series of mixed media drawings that forms a narrative through text and image. Each original images measures 3" x 4".*