



phoenix RISING

THE VOICE OF THE PSYCHIATRIZED

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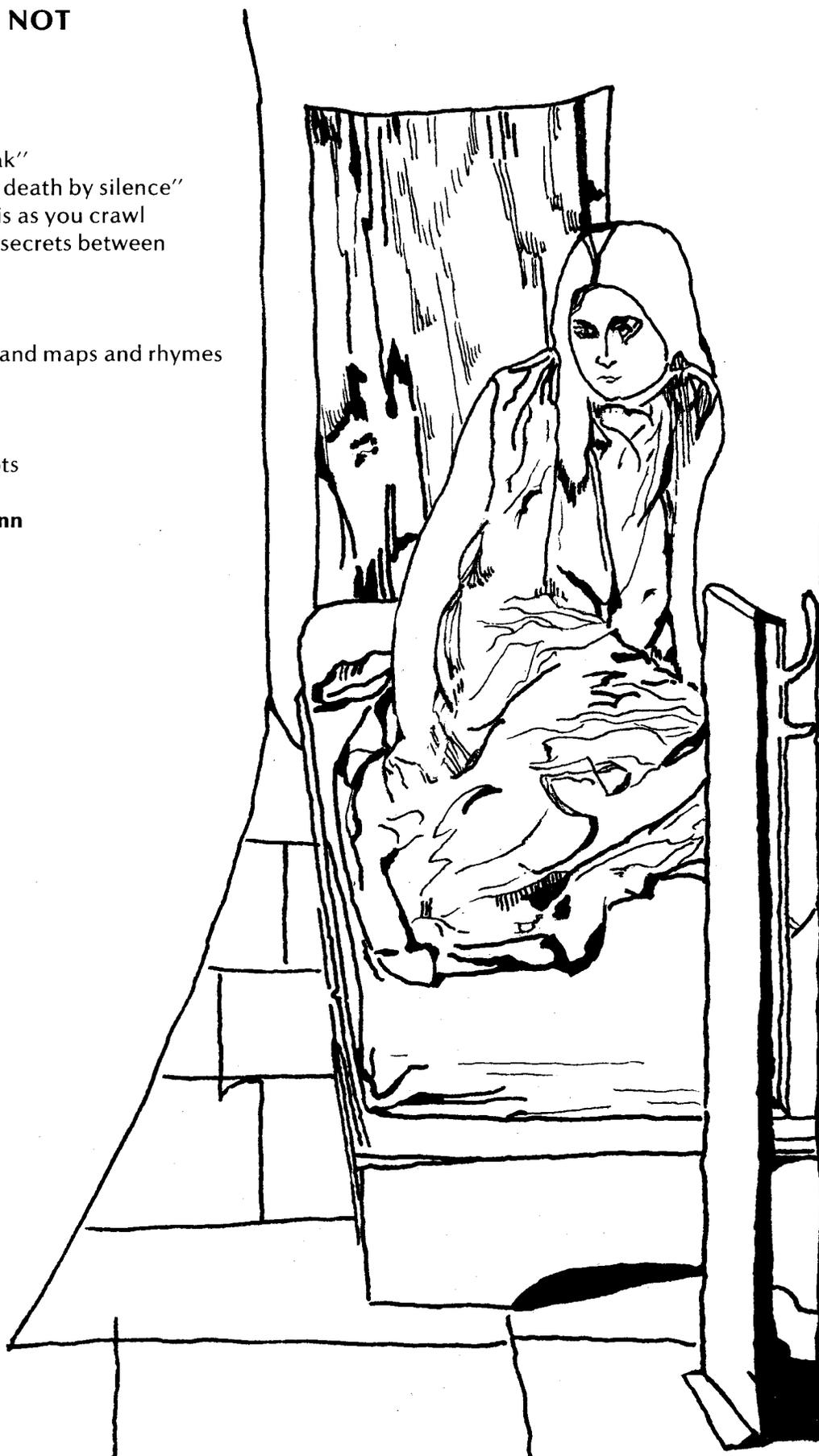
Retrospective:

- > Inmate Deaths
- > Survival Stories
- > Psychiatry Under Attack

FORGET US NOT

He
calls you
Afraid
Saying "Speak"
Saying "Fear death by silence"
Saying all of this as you crawl
Clutching your secrets between
Clean
Green
Walls
Where colours and maps and rhymes
fall
like petals of
crazed
forget-me-nots

Nira Fleischmann



Nira 1/04

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**PSYCHIATRY
KILLS**

EDITORIAL

How do people get locked up in psychiatric institutions? What happens to us when we are locked up? What happens when we get out? What about those who don't? What lies have we been told? What lies are told about us?

Phoenix Rising has been working on answering these questions since its inception in 1980.

The articles, poems and personal stories reprinted in this retrospective issue all appeared originally in **Phoenix Rising**. All were written by ex-psychiatric inmates. They were chosen because they say loudly and clearly that we are **not alone, and not at fault** for what we've been through.

Isolation, panic, rage, confusion and misery are not personality flaws or mental illnesses, but products of living in our society. Let's look at, and learn from, our common experience. We must take back our strength and dignity if we are to fight for people's right to be free from psychiatric oppression.

Guest Editorial

by Carla McKague

One of my proudest boasts is that I was a member of the first editorial collective of **Phoenix Rising**. In early 1980 on the strength of \$5,400 from Ontario's interchurch funding council, PLURA, and the dedication of our five original collective members, **Phoenix Rising** made its debut, and Canadian psychiatry hasn't been quite the same since.

For the first time, there was a publication in which our side of the story was told, in which such crucial issues as psychiatric inmate deaths, the appalling treatment provided in psychiatric institutions, and the denial of civil liberties to people labeled "crazy" were explored by those who knew them best—those who had inhabited the institutions and worn the labels. And people listened. From the beginning, our subscribers included not only other psychiatricized people across Canada and the rest of the world, but also "mental health" professionals, lawyers and government officials.

One incident stands out in memory. A friend of mine had attended a meeting at the Clarke Institute of Psychiatry at which a psychiatrist was asked why it wasn't easier to get people committed and treated. His answer? "It used to be easier, but now when we do that, **Phoenix Rising** gets on our backs." I can't imagine a higher compliment to our effectiveness and influence.

At first **Phoenix Rising** concentrated on Ontario and mainly on Toronto; now it is a national resource. The first issue was 28 pages long, hand-typed and modest in format; recent issues have been up to three times that size, with an appearance to rival that of many mass-circulation magazines. It has explored in depth the permanent damage caused by institutional psychiatry and the medical model of mental disorder. It has provided accurate, reliable information on psychiatric drugs. It has published gripping first-hand testimony of the experience of being psychiatricized, and made available poetry, fiction and art created by survivors of psychiatry.

In short, **Phoenix Rising** has grown up just as its parents hoped it would. And, as one of those parents, I want to wish it many more years of printing material of the quality, importance and relevance of what is contained in this retrospective issue.



phoenix rising

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The opinions of the editorial collective are expressed in the editorial and unsigned articles. Other articles, columns and letters to the editor express the views of the writer. We will not accept any advertising which in any way supports forced drugging, electroshock, involuntary confinement, or psychiatry's medical model of mental illness. *Phoenix Rising* reserves the right to edit material submitted. Material should be submitted typed and double-spaced. Persons wishing to have material returned must enclose stamped, self-addressed envelope. *Phoenix Rising* is published quarterly by: ON OUR OWN, Box 7251, Station A, Toronto, Ontario, Canada M5W 1X9. Telephone: (416) 699-3194, Second class postage No. 5342. Copyright 1986 ON OUR OWN. Winter Issue. ISSN 0710-1457.

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Phoenix Rising assumes that any correspondence sent to us may be printed in our letters section unless otherwise specified. Please tell us if you would like your name withheld if your letter is printed.

HARD times

Dear Editorial Collective:

I would like to express my sincere thanks to Bonnie Burstow for her comprehensive article on Oak Ridge. Although we have tried to do justice to this blight posing as a "hospital," I don't think it is possible to do so! Bonnie made a good point in commenting on the prejudices even within the group labeled "psychiatric patients." We must surmount these. Is it not enough that we are in the same hell? Do we have to create other hells within those already created for us by the system?

I would also like to thank all of you for your support, patience and understanding for a new-comer to the movement against psychiatry.

I have been very busy trying to find my way around a new "psychiatric" facility—not a simple matter. Once again I find myself treated like a leper. After seven years of being moved around from hospital to hospital I should be used to it, but the feeling of degradation has almost overwhelmed me. And once again, I have had to gather myself together for yet another fight.

My departure from Oak Ridge was rather hurried for very obvious reasons, none to do with what was best for me. On the day I left, HARD was to celebrate its first year of existence, and had just won the battle for the right to meet as a body. It was very sound politically from the administration's point of view to remove me on that day. However, they have failed to silence me completely.

The problems encountered in hospitals are universal. New faces, new doctors and nurses, but the attitudes and beliefs are basically the same. "We know what is best for you"; "Let us be the judge of that"; and all the usual platitudes. To quote my new psychiatrist, "I can do anything I want." Pity the poor patient who cannot defend himself.

I would like to state that I am definitely opposed to ECT, having been a victim of it in the late 1950s without the benefit of sleep-inducing drugs. Another way to control "rebels." I feel so strongly against it that if my release depended on having it, I would forever remain incarcerated. How can I express it more vehemently?

I will close this letter with this thought: as long as we accept psychiatric "help," we, the oppressed, are contributing to our own oppression. *The rulers* will maintain themselves at all costs. For us, the cost includes our tears, our doubts, and our fear that what we feel is wrong.

Denis R. McCullough
Humane Awareness with Respect
and Dignity (HARD)
North Bay, Ontario

Imprisoned by migraine

Dear Friends at *Phoenix Rising*:

Recently, a young single mother shared her experience with me. She had fallen victim to a severe bout of migraine. When her doctor recommended a brief hospitalization period for further investigation and treatment, she found herself in a ward with other women who were extremely depressed. She asked to be discharged, only to be told that she needed her doctor's approval. She made a super-human effort to convince her keepers that her migraine had disappeared.

A shopping-pass was offered to her, and as she prepared to leave, she jokingly suggested that since she felt so much better, perhaps she would just go home while she was out. The ominous answer came back loud and clear. "On no you won't—if you don't return to the hospital, the police will bring you back." Any doubts she may have had about her state of imprisonment were quickly and frighteningly dispelled at that moment. It was only the fact that she was strong enough, and aware enough, to continue to pretend that her migraine had left her, that eventually released her from that psychiatric ward.

Another powerful anecdote which I have now added to my lecture circuit on the need for the abolition of prisons *and of psychiatric hospitals*.
Claire Culhane
for: Prisoners' Rights Groups
(PRG)
Vancouver, British Columbia

Torture at St. Thomas

Dear Editors:

I am very happy to see the problems and issues discussed in your magazine finally being addressed.

I am originally from Windsor, Ontario, and was first incarcerated in the Ontario Hospital in St. Thomas two weeks before my fourteenth birthday, in 1964. My introduction to the place was being put in seclusion and having my head shaved bald. Then I was dragged to the ward office, where my arms were placed in an arm-bar position up behind my back and my nose was pinched so I'd have to open my mouth to breathe. When I opened my mouth, the goons poured Epsom salts down my throat. This was to

make me shit all over myself in the "Pokey," or seclusion room, to which I was then returned. My clothes were torn from my body.

The seclusion room had no drinking water and no toilet. You had to deposit your excrement on the floor. There was a steam radiator and a window covered with shutters made of heavy steel mesh. The windows were generally kept open between the shutters, and the patient couldn't close them. As you were kept naked, you had to run in circles and do calisthenics to keep warm on winter nights. But sometimes they sealed the room up tight and turned the heat up all the way; with no water to satisfy your thirst, the drugs that parched your throat added to the torture. At best you might be able to lap the urine off the floor.

I'll swear affidavits to anything I say on this subject, and will assume legal responsibility. I was in St. Thomas till I was eighteen years old, and since then I have been in Oak Ridge, Penetang, eight times, on remands and involuntary committals from prisons and jails. I've served one penitentiary term in the US, and I'm finishing my second pen bit in Canada. I've also served a reformatory term in Ontario. However, I must say the penitentiary and reformatory never held a candle to the hardship I've experienced in mental institutions. And this began when I was fourteen years old, so penitentiaries are like water off a duck's back.

Sincerely yours,
Alton McCorquodale
William Head Institute
Victoria, British Columbia



Correction Notices

We really goofed in our last "Maggie's Bag" (pg. 5). Plaudits were piled on the wrong group in asking our readers to "speak up and speak out" about the offensive ads from Canada Homes. All the credit for the initial protest against those ads should in fact go to the Whitby Patient Government, and to Karen Walker, who complained on their behalf. We sincerely apologize, and hereby congratulate this newly-formed, independent and active patient group for their fine work in advocating patients' rights from within Whitby Psychiatric Hospital.

We would also like to apologize to Kali Grower, whose name we misspelled in the table of contents and (twice!) on pg. 34. Sorry about that.

Celebrate



It's our birthday.

Don't miss our
15th anniversary issue.

January, 1987



Phoenix Pheather

This time, the Pheather is presented with much gratitude and many tears. Don Weitz is leaving his full-time job at *Phoenix Rising*. If we can find anything good about this, it's that he will still remain as a consultant and a friend. Don needs more time: to pursue his research and writing; to help set up a hassle-free crisis centre for our brothers and sisters; and to further the goals of the Antipsychiatry Movement, as he is uniquely qualified to do. And he deserves that time as much as he needs it.

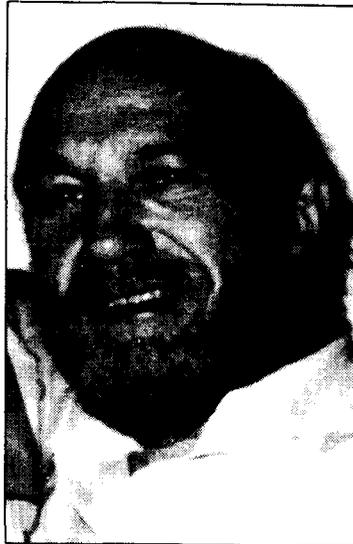
Don has been a one-man Movement in Canada. Together with a handful of other courageous people, he initiated ON OUR OWN. Since then, he has acted as the group's coordinator, raised money for it at flea markets, and started *Phoenix Rising*. Against all odds, he cajoled, pleaded, raged, loved, demonstrated and tenaciously increased the awareness of Canada's public, and legislators, of the psychiatric inmate's plight. He made us stand up for our rights, congratulated us on our victories, large and small, and encouraged us in times of defeat.

Don, we cannot possibly thank you enough. We can only try to maintain the force of your anger, compassion and integrity. As usual, someone else can always say it better; we proudly present excerpts from some of the many testimonial letters received:

It is largely because of your dedication, your personal efforts and the work of the people you have profoundly influenced that issues of human and civil rights of people labeled "mental patients" have become important to the society at large, and that great advances are now being made in ensuring and practising those rights.

—Carla McKague, Advocacy Resource Centre for the Handicapped (ARCH), Toronto, ON

Special Phoenix Pheather to Don Weitz



Don Weitz

Your passionate analysis made it more difficult for lawyers like me to be blinded by the narrow perspective of the law, although I'm sure that you feel we still need help.

—David R. Draper, Parkdale Community Legal Services, Toronto, ON

I know that with your last breath you will work to abolish psychiatry.

—Don Johnson, Mabel White Group, Buffalo, NY

The light of God's love for His/Her most forsaken and needy children in this world shines through your life with great beauty.

—Ruth Morris, Society of Friends, Toronto, ON

A guarantee that *Phoenix Rising* will continue to grow and continue to spread the truth (ghastly as it is at times) will be our best tribute to Don for his own loving contribution.

—Claire Culhane, Prisoner's Rights Group (PRG) Vancouver, BC

I know your vision and attention is always turned on what is yet to be accomplished for present and former psychiatric inmates, and that you will approach your exciting new projects in the same way as you always have—with the same uncompromising high values.

—Harry Beatty, ARCH, Toronto, ON

Don, I dearly love you. You are so committed, so reliable, so passionate, so divinely furious, so enthusiastic, so joyful, so sensitive, so loyal, such a dear friend. I know in my heart that we will always be very close, and that we will always shit-disturb together.

—Bonnie Burstow, The Ontario Coalition to Stop Electroschock, Toronto, ON

Your contributions to your adopted country are too numerous to count. We hope you will continue to attack the enemies of freedom and that your voice will never be stilled.

—Allen Markman and the APAPA staff, Association for the Preservation of Psychiatric Artifacts, New York, NY

Just thinking about you always makes me feel good. If I had to sum it up in one word, that word would be integrity: being true to yourself, you can hardly be false to anyone else.

—Leonard Roy Frank, San Francisco, CA

We shock-knockers salute you.

—Marilyn Rice, New York, NY

As Bonnie summed it up:

For once, Don Weitz, you're not going to be able to interrupt! You're just going to have to sit there and take it while the rest of us say what should have been said a long time ago.



Turkey Tail

The Turkey Tail should be firmly pinned to the butt of Dr. Sheila Cantor, a Winnipeg psychiatrist who claims that schizophrenia can be treated with nicotine. Cantor bases this unlikely conclusion on her observation that the people she treats tend to be more alert if they smoke. Although she admits that the exact mode of action is not known, she offers by way of explanation that nicotine acts as a stimulant, helping to compensate for malfunctions in the involuntary nervous system that cause schizophrenia.

Such bargain-basement logic clouds the reality that life on the wards is boring. There's nothing to do. No wonder an inmate seems more alert and in a better frame of mind upon being offered a free smoke.

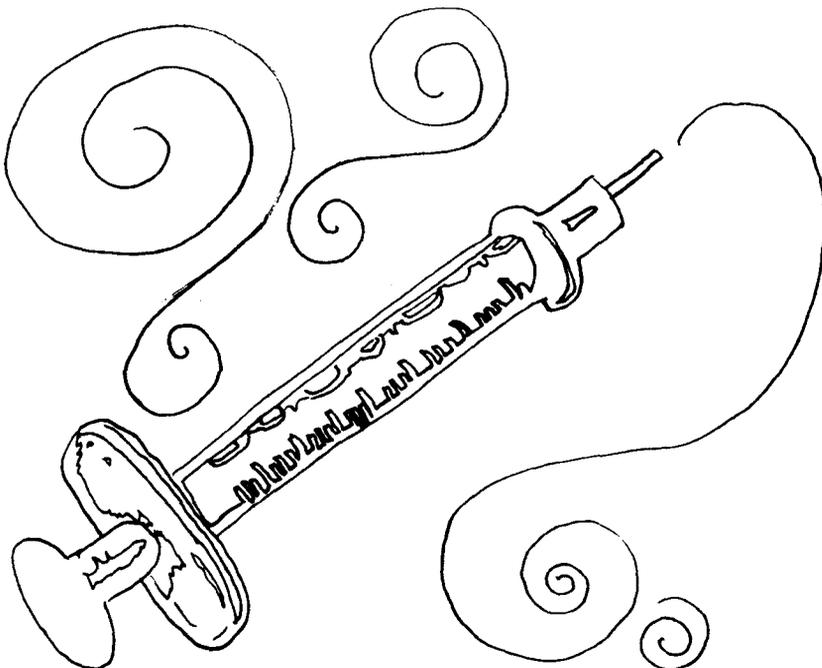
Dr. Cantor takes a normal human reaction and imposes on it an absurd medical analysis. The result: a new treatment for schizophrenia. (Imagine the government-funded research projects: which brands of cigarettes are most therapeutic? What about filtered vs unfiltered?

How effective are cigars and pipes?)

Nothing to flick your bic about, you may say; maybe we'll all get free cigarettes. But psychiatrists have always preferred the most invasive methods of treatment possible. Dr. Cantor's laughable conclusions provide the perfect smoke-screen for a plan to inject schizophrenics with nicotine. Witness her statement that "I wish someone would do some research into the use of purified nicotine in treating patients."

Cantor seems unaware that the method by which a drug is administered has an effect on its action. Her ignorance of basic pharmacology reinforces one's suspicion that psychiatrists don't go to medical school. Swallowing nicotine or applying tobacco preparations to open wounds results in acute poisoning. Symptoms include nausea, vomiting, violent diarrhoea, convulsions, paralysis and respiratory arrest. Do we need another drug with the side effect of sudden death?

Perhaps when Dr. Cantor's patients stop breathing, she will know it's time to butt out.



Phoenix Rising Retrospective



(Vol. 5 No.1; from *Still Sane*, by Persimmon Blackbridge and Sheila Gilhooly: Press Gang, 1985)



SCHIZOPHRENIA — Exploding

by Don Weitz

Schizophrenia is psychiatry's equivalent of leprosy. Millions of people have been stigmatized and invalidated by being labeled schizophrenic. Schizophrenia is a very strange disease, since it has no specific cause, no definite signs or symptoms, no predictable course or outcome, and no cure.

In the 1800s, the observation that pellagra (a neurological disorder caused by vitamin deficiency) and general paresis (syphilis of the brain) caused "mental symptoms" suggested to psychiatrists that there must be many other types of "mental illness" producing such symptoms. New, non-medical disturbances were pathologized as types or symptoms of mental illness: compulsions, obsessive-compulsive neurosis, hypochondria, depression, mania, manic-depressive psychosis, and even homosexuality and masturbation insanity (the latter two are no longer classified as diseases by the American Psychiatric Association). Virtually any kind of "irrational" or "abnormal" behaviour was automatically assumed to be caused by a brain disease. These mental illnesses were not discovered—they were *invented*. Schizophrenia is no exception.

In the early 1970s, the United Nations' World Health Organization somehow managed to get a group of psychiatrists from nine countries to agree on fifteen diagnostic criteria or psychopathological characteristics of schizophrenia. A base sample of 306 patients was found to exhibit these symptoms, listed from most to least common: lack of insight, auditory hallucinations, visual hallucinations, ideas of reference, delusions of reference, suspiciousness, flatness of affect,

voices speak to patient, delusional mood, inadequate description, delusions of persecution, unwillingness to cooperate, thought alienation, thoughts spoken aloud, and delusions of control.

Most of these terms are so vague they can mean almost anything, which is typical of psychiatric jargon. For example, what does "lack of insight" (into what? into whom?) really mean? What is "inadequate description"? What does "unwillingness to cooperate" specifically refer to?

In 1974, the National Institute of Mental Health (a prestigious US government agency) honestly admitted in an editorial that "it is not possible to validate a diagnosis of schizophrenia." But this has not stopped psychiatrists from diagnosing people with it.

Metrazol convulsive therapy, insulin coma and sub-coma therapy, electroshock, hydrotherapy, lobotomy or psychosurgery, megavitamin therapy and various types of psychotherapy and drug therapy have all been used to "treat" schizophrenia, with little or no success.

Psychologists Theodore Sarbin and James Mancuso rightly point out in *Schizophrenia: Medical Diagnosis or Moral Verdict* that "unwanted behaviour" has been cast into the medical-disease model of schizophrenia. But medicine was never meant to explain "norm-violating" behaviour. The disease model of schizophrenia has been used to justify denying people their freedom and legal rights by locking them up and forcibly "treating" them.

The classic 1973 study by Rosenhan clearly and dramatically ex-

posed the subjectivity and bias inherent in psychiatric judgement. Eight "normal" people—a psychiatrist, three psychologists, a graduate student in psychology, a pediatrician, a painter and a housewife, posed as psychiatric patients. The eight presented themselves at various psychiatric institutions on the east and west coasts of the United States, telling the admitting psychiatrists that they were hearing voices, and giving truthful accounts of their family histories. All were diagnosed schizophrenic, and promptly admitted. Most were released within four weeks with a diagnosis of schizophrenia in remission. One was kept on a locked ward for 52 days. Many were drugged. Rosenhan concluded that "It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals."

As many presently incarcerated and former psychiatric inmates know all too well, the power to label and treat people against their will is the power to oppress and stigmatize them—usually for life.

It's important to realize how easily psychiatrists and other mental health professionals can be influenced by social or political factors in making their diagnoses. In a study by Braginsky and Braginsky (summarized by Sarbin and Mancuso), professional staff members were asked to diagnose various psychiatric inmates on the basis of what they said during videotaped interviews. Some inmates voiced "New Left" political views, some openly criticized staff, and some praised staff. Those who criticized staff were typically judged as more "pathological" than those who didn't; the "New Left" inmates

the Myth

were also judged sicker than those who didn't express this ideology. The most spectacular change in professional judgement occurred when one "very disturbed mental patient was suddenly perceived as . . . normal" after he praised the staff.

Sarbin and Mancuso raise important questions that remain unanswered by research: "How do strange, illogical or uncommon associations handicap people? How do they result in getting people into hospital? Why does overgeneralization lead to *faulty* conclusions and why are faulty conclusions labeled *delusions*? Everyone overgeneralizes. Everyone draws faulty conclusions, but not everyone is judged schizophrenic."

As Thomas Szasz has asserted, "Psychiatry creates schizophrenia . . . if there is no psychiatry, there can be no schizophrenia." Schizophrenia is a dangerous myth masquerading as a disease. Doctors who treat myths are charlatans.

Schizophrenia has been used by psychiatry to incarcerate and forcibly treat people who have not committed criminal acts; to manipulate and control people and deprive them of their rights; to invalidate legitimate political dissent by medicalizing it; to discredit poor people by labeling them sick, pathological, or deviant; and to deceive the public into believing that strange, non-conformist conduct or unpredictable outbursts of anger are symptoms of mental illness and dangerousness.

The concept of schizophrenia must be exposed and challenged for what it is: an unethical attempt to socially control, punish and invalidate non-conformist behaviour.

(Vol. 3 No. 3)



Nira Fleischmann





The Tardive Dyskinesia Epidemic

by Don Weitz

The many "side effects" of the major tranquilizers, also known as "antipsychotic" drugs, neuroleptics and phenothiazines, have reached epidemic proportions. The most serious and widespread "side effect" is tardive dyskinesia (TD), a disorder of the central nervous system caused by such drugs as Thorazine (chlorpromazine), Stelazine, Mellaril, Moditen (also known as Modecate and, in the US, as Prolixin). "Antiparkinsonian" drugs like Cogentin and Artane, almost always administered with major tranquilizers to disguise their effects, aggravate the disorder. TD indicates brain damage and is generally permanent: treatment is limited to temporarily masking its symptoms. It is safe to assume that hundreds of thousands of people in North America are currently suffering from this disorder; it is estimated that as many as half the people given major tranquilizers develop TD.

Tardive means "late-appearing" and dyskinesia means "abnormal muscular movement." TD was first identified and described in the early 1960s, shortly after Thorazine-type drugs were introduced in psychiatric institutions. But the medical/psychiatric profession has largely ignored its existence.

TD is a grotesque and disfiguring disorder. As described by J. Horowitz in a 1978 journal called *Human Behavior*, "The symptoms . . . include slow, rhythmic and involuntary movements of the face and limbs; cheek-puffing; lip-smacking or lip-pursing; chomping of the tongue or repeated tongue thrusts in a 'fly-catcher' movement; occasional stiffening of the neck and arms, difficulty in swallowing or speaking; in severe cases, rotation of the ankles or toes, or wrist and finger movements. . . ." Serious respiratory problems and persistent vomiting or retching have also been reported as indications of TD. People with any of these bizarre symp-

toms are extremely vulnerable to being socially ostracized.

Symptoms usually appear within six months to two years after the start of "treatment" with major tranquilizers, but have been known to appear within three weeks of continuous drug use. Some people suddenly develop the disorder a few days after the drug is stopped.

Your likelihood of developing TD increases with increased dosage and duration of "antipsychotic" druging. You are also at high risk if you get long-acting injections of the drugs or have bad muscle reactions to them, or if you already have brain damage or neurological problems. Women appear to be more susceptible than men.

Of course, the best way not to get TD is never to take major tranquilli-

zers. The second-best way is to take as low a dosage of them, and for as short a time, as possible. But if you are taking them now and want to stop, you should do so gradually, under the supervision of a physician if possible. "Cold turkey" withdrawal from these drugs can be very dangerous.

Although TD results in permanent brain damage unless it is detected in its earliest stage and the use of all major tranquilizers immediately discontinued, the American Psychiatric Association has minimized its seriousness: ". . . an alarmist view is unwarranted, especially since many cases are detected early and improve spontaneously."

Most doctors prescribing major tranquilizers don't bother telling their patients about TD and other dangerous effects. It's time they did, so that people can decide whether they want to play Russian Roulette with brain-damaging psychiatric drugs.

(Vol. 3 No. 2: Phoenix Pharmacy)

The non-compliant schizophrenic.

A better way to help this patient develop a new outlook.

IMAP FORTE

Psychiatry's Reign of Error

Dr. Lee Coleman: In practising psychiatry, I saw the things that were being done to patients—the effects of the drugging and labels—and I came to conclude that this was not helping people.

When a medical doctor examines a patient and decides the patient's problem is not a stomach ulcer but stomach cancer, he can prove his diagnosis with real scientific evidence—a tissue specimen that he mounts on a slide. Hematologists can show you a blood sample. Psychiatrists don't have anything like that—only what they see or what they hear, filtered through their own subjective impressions. The reason psychiatrists cannot contribute anything of value to the court is that they don't have methods to do what the court thinks they can do: they cannot measure people's minds or intentions. They cannot tell whether someone will be dangerous in the future. Psychiatrists are supposed to tell us whether a person knew what they did, and whether they knew it was wrong, whether they had the capacity to conform their conduct—which is a fancy way of saying: did they act with free will? Can you imagine? Free will is a philosophical question, a metaphysical question. The idea that psychiatrists can help us with the question of free will is absolutely absurd, yet that's what they are expected to do.

The theory of the insanity defence says that there are certain people who are legally insane and therefore we must not blame them because they are not morally guilty. They didn't know what they were doing, therefore we shouldn't punish them. We should treat them. But in fact, they are being punished. When you get locked up in a state mental hospital, that is every bit as much punishment as being locked up in a

prison, because a mental hospital *is* a prison, and what they do to you there is punishment. When they force-drug you, that is punishment; in some ways it's worse than being in prison, because of the permanent damage the drugs can do.

Allen Markman: You're one of a handful of psychiatrists totally opposed to any form of involuntary or coercive psychiatry, and you also advocate the abolition of all force and fraud in psychiatry. Aren't there any justifications in your mind for locking a person up in a psychiatric facility against their will?

Medicalizing is
the bread and butter
of psychiatry.

Coleman: No, I don't think there are. Now, that doesn't mean society doesn't have the right to lock somebody up. I just think we have to be more honest in recognizing that the mental health system is acting as a backup system for jails and prisons—a backup social control system.

Most people believe that a person who has a psychotic breakdown may be violent. There's no evidence that people who have breakdowns are any more violent than anybody else. The answer is education.

If people haven't broken the law, we should not have the right to incarcerate them or drug them. I consider forced drugging to be chemical rape. It's an outrageous practice that helps nobody. I think that if we did not have the power to lock up any mental patients we would help more people.

Psychiatrists are the only medical doctors in the mental health field, so they're convincing a lot of people that "schizophrenia" and "manic depression" are biochemical, and therefore the best treatments are pills. Can you imagine any other business in America where you can force the customer against their will to take your service, and then bill them for it? That's what psychiatry can do.

All physical treatments in psychiatry—all the way back to bleedings, the incredible variety of toxic substances, lobotomy, up to phenothiazines, lithium, shock treatment—have one thing in common: they create a new disability. They damage the body. Shock treatment is the classic example. We cause a brain injury using electricity, with all the classic effects: memory loss, confusion, inability to retain new information, learning disability. Then, because the person isn't crying for a few weeks, because the brain injury keeps them from remembering what they were crying about—we say the patient has been treated.

Do not expect psychiatry to blow the whistle on itself. Psychiatry is fighting desperately. Imagine what it would mean if people were to recognize that there was only a very, very tiny percentage of mental problems that have any relation to any medical issues. If we recognized how phony all of this medicalizing was, how phony the role of psychiatry is in the courts, and the link with the state and the power, psychiatry would shrink to a tiny vestige of what it is now. You know that psychiatry is going to fight to the bitter end to stop that from happening. Medicalizing is the bread and butter of psychiatry.

(Vol. 5 No. 4, courtesy of Allen Markman, WBAI radio, New York)



Psychiatric Treatment and Your Right to Decide

by Carla McKague

Being found Incompetent

Usually the person who decides whether you are competent will be the doctor who wants to treat you. What he or she has to decide is whether you have the capacity to understand the information given to you and make a logical decision based on it. (There will probably be a strong temptation to find you competent if you agree with the doctor's proposal and incompetent if you disagree.)

Asserting your Right to Decide

Know the law in your province or territory, and what your rights are. If you think there is a danger that at some time in the future you will be found incompetent, make sure your wishes are known *now*. Go to a lawyer or legal clinic and ask to have a formal declaration drawn up stating that if you are ever found incompetent, you do not wish to have a particular treatment or treatments authorized on your behalf. If possible, get a statement from a psychiatrist that at the time of making this declaration you *are*

legally competent to make such a decision.

Arrange with the lawyer that if and when you are declared incompetent, he or she will approach the hospital on your behalf and argue that the person giving the substituted consent is bound by your wishes. If possible, discuss your wishes in advance with the person who would be authorized to decide for you.

If you are found incompetent, consider getting legal help to challenge that finding in court. Make it clear to your doctor that you know the legal requirements concerning information and voluntariness, and that if the doctor does not comply you will consult a lawyer. If the doctor refuses to give you information or attempts to coerce you into agreeing to treatment, get legal help immediately.

If none of this works, then continue to refuse firmly, preferably in the presence of witnesses. It is unwise to resist physically, as in some places the law allows the doctor to use drugs to "restrain" you. (Vol. 3 No. 3: Rights and Wrongs)

Coroner Claims Tranquillizers Cause Inmate Deaths

In the late 1970s, Dr. Federick Zugibe, Coroner of Rockland County in New York State, published alarming research showing that the major tranquillizers, even at "therapeutic" doses, were a major cause of death among psychiatric inmates.

After performing autopsies on 203 inmates who died in two state mental institutions while on tranquillizers, Dr. Zugibe, along with six independent pathologists, discovered that the tranquillizers frequently suppress the gag or cough reflex. As a result, undigested food or vomit gets stuck in the lungs, esophagus or windpipe, causing internal choking or strangling.

Hundreds, if not thousands of people have strangled to death while receiving major tranquillizers. Dr. Zugibe found "aspiration of food and vomitous materials" in 30 percent of the autopsy cases studied. He also found evidence that major tranquillizers can mask pain and other symptoms of physical disease — another contributing factor in inmate deaths. The mysterious "sudden unexplained death" phenomenon reported in psychiatric literature since the 1950s was becoming less mysterious.

New York's psychiatric establishment immediately tried to fire Zugibe for the heresy of publicly stating that psychiatric drugs can cause death by internal strangulation.

(Vol. 3 No. 1: What's Happening)

P. 208

It
was
Xaffery
lying there
in the gutter
I wanted to
pick him up
dust him off
shake him clean
but he told me
"Lie down here beside me"
I did
and he showed me
where Vega
was.

J. Toews

(Vol. 5 No.4)

THE HOLE IN MY HEAD

You asked me to
return to teaching.
You said that
"the youth of today need
guidance."
You opened a hole in my head
and poured in
chlorpromazine, fluphenazine,
haldol, stelazine,
saying,
"these will help you
to help us."

The hole in my head
where my brain used to be
is now empty.

If I am to be
your insulin,
you salvation,
your apostle,
show me that
the system that drove me
insane
is prepared to look at
its own insanity.

Al Todd
(Vol. 5 No. 1)

Shock and the Law

by Carla McKague

A person has the right to suffer pain by refusing painkillers, even to die by refusing life-saving treatment, but not to remain depressed by refusing electroshock or anti-depressants.

In Ontario, in theory, the voluntary or "informal" psychiatric patient retains all the rights she would have had as an out-patient; she may accept or refuse any form of treatment. In practice, the situation is not so simple. Once a person admits herself to the hospital, she may at any time be made an involuntary patient upon the doctor's completing a form stating that she meets the criteria for committal. It is not unusual for a refusal of treatment to quickly lead to committal.

A psychiatric ward is an inherently coercive setting, and it is very difficult for a patient to make a truly voluntary and informed choice about whether to have any treatment. The typical voluntary patient for whom electroshock is suggested is likely to be a woman suffering from severe depression: listless, apathetic, uncritical of her doctor, aware that she is liable to the additional stigma of committal if she does not cooperate, and very susceptible to persuasion or intimidation by staff, and often by family. I do not mean to suggest that a psychiatric patient is *by definition* incapable of making a voluntary decision, but only that special care must be taken to ensure that the choice is truly voluntary and informed. Persuasion or coercion by staff and family is generally not ill-

intentioned; on the contrary, it is usually based on a sincere belief that electroshock will alleviate the patient's distress and restore her mental well-being. Nonetheless, coercion it is, and it therefore invalidates the consent.

Electroshock can be ordered over the refusal of a competent patient in a hearing of which she gets two days' notice, at which she is probably not represented by counsel, without access to her clinical records, in the absence of any properly admitted evidence supporting the application, and in the absence of any chance for the patient or her counsel to test the doctors' evidence by cross-examination. I believe this falls far short of being in accordance with the principles of fundamental justice.
(Vol. 5 No. 2-3)



ECT

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 practised 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 seared
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 propaganda
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 buy it.
I've seen the disasters, the mistakes.

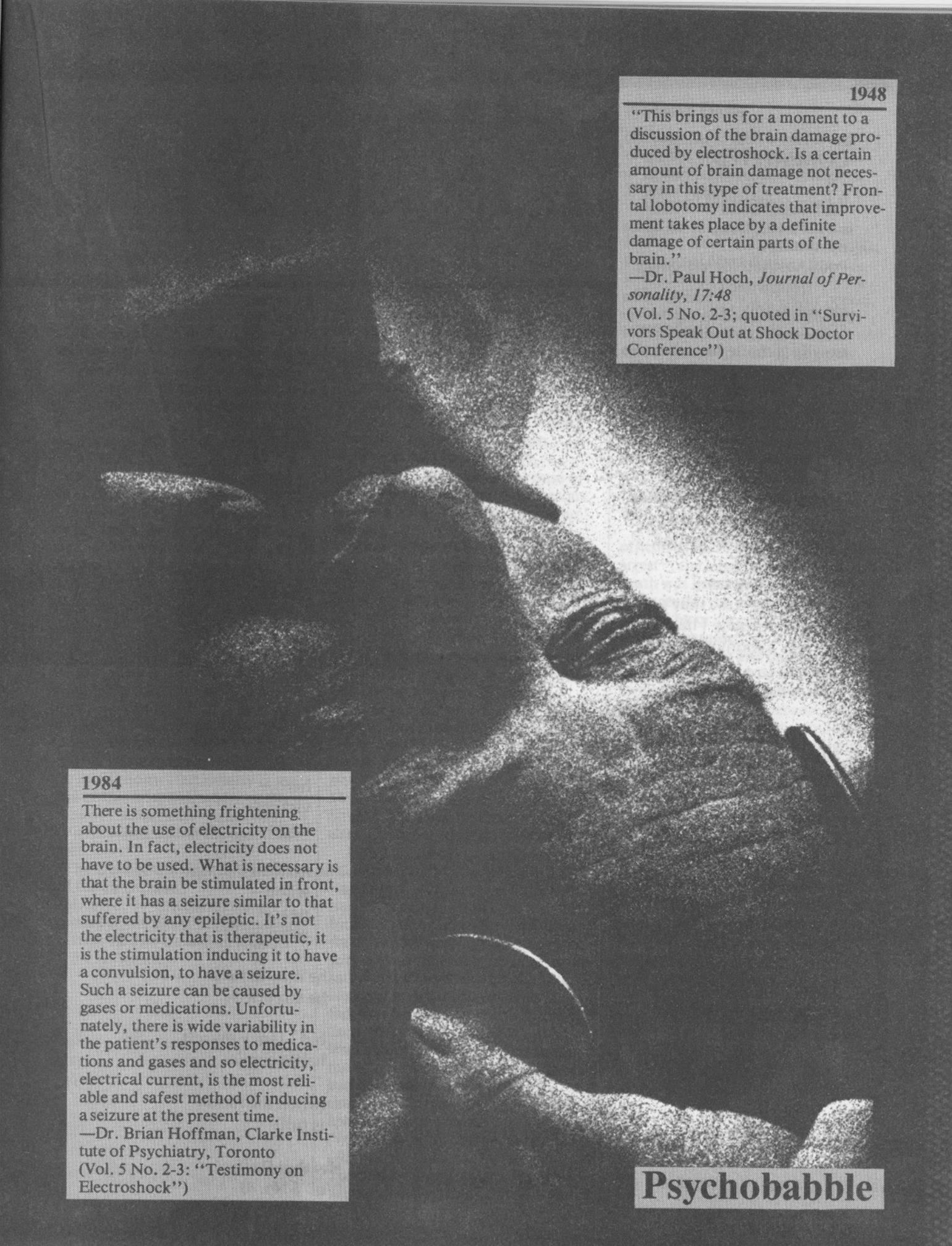
I call it electrocution.

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.

Nira Fleischmann

(Vol. 4 No. 3-4)



1948

“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 improvement takes place by a definite damage of certain parts of the brain.”

—Dr. Paul Hoch, *Journal of Personality*, 17:48

(Vol. 5 No. 2-3; quoted in “Survivors Speak Out at Shock Doctor Conference”)

1984

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.

—Dr. Brian Hoffman, Clarke Institute of Psychiatry, Toronto
(Vol. 5 No. 2-3: “Testimony on Electroshock”)

Psychobabble



COMMITTED

If I am committed to —

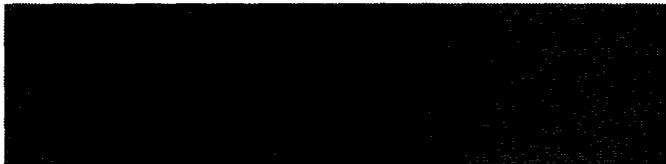
Becoming
Poet/Aesthete/or Visionary
(renowned)

He will surely say:
"Oh, by the way, that's my
ex-wife. I made her what she
is. We're still close friends."

If I am committed to —

The Loony Bin
(fading unknown
into plaster whitewashed
brick wearing one-size-
fits-all-loonies striped
pyjamas —),

He will surely say:
"Oh, by the way, that's my ex-wife.
You can see why I had to divorce her.
She was a loony that one."



If I am committed to —

Suicide
(infamous)
(drowning in various calculated
liquids, guaranteed to wash down
243 peppermint sedatives: pomegranate
nectar, unwhipped whipping cream,
one Tequila Sunrise, unsweetened
blackberry tea, sacramental
ammonia —)

He will surely say:
"Oh, by the way, that (was) my ex-wife.
I guess she couldn't bear the thought
of living without me."

He will surely say anything
to make himself seem
hero —
victim —
lover —

instead of
wimp —
nazi —
pimp —

he may in fact
be streetwise

but I fancy myself
half a genius

(when the moon
is full).

Heather Duff
(Vol. 5 No. 4)



Anonymous

On the morning of May 4, 1985, a nineteen-year-old woman was found dead in Riviere-des-Prairies Hospital. She was naked in a bathtub without any water. When the hospital would not give the woman's mother any information about the death, she sought help from Madeleine Girard (a former president of the Parents' Association, which has been fighting against abuses at Riviere-des-Prairies), who got her a legal-aid lawyer.

The lawyer obtained an autopsy report from the hospital, which stated that the woman was part of a group of people whose cause of death could not be established with certainty. He then asked the Quebec Coroner to conduct an inquest into the death, writing that "The circumstances of this death appear to be quite mysterious. No one can tell when (she) was seen alive for the last time. . . . Could she have been forgotten? . . . Many other questions remain unanswered regarding the security of the patients in psychiatric institutions. Particularly in the case of this hospital, where twelve cases of 'suspicious' death have been recorded within the past three years. . . ."

The Quebec Coroner refused the call for an inquest. (Vol. 5 No. 4: "Medieval torture exposed to the light"; information courtesy of *The Canadian Human Rights Advocate*)

Aldo Alviani

Aldo Alviani died a tragic and unnecessary death when he was only nineteen. On June 23, 1980, while a "patient" in Toronto's Queen Street Mental Health Centre, Alviani died after a massive dose of Haldol—one of the most dangerous and powerful of all "antipsychotic" drugs.

Many people believe that Alviani was killed by the Queen Street staff's excessive reliance on psychiatric drugs. Big (over six feet and around 240 pounds), Italian, and poor, with a record of psychiatric incarcerations, Alviani was an easy target for psychiatric drug control. On the night of June 21, he was arrested twice. The police laid no charges, but took him to Humber Memorial Hospital. It is clear from the events that followed that psychiatric staff, both at Humber Memorial Hospital and at Queen Street Mental Health Centre, had already labeled Alviani "difficult."

Upon his admission to Humber Memorial, staff judged him to be "agitated" and gave him a tranquilizer. The next morning, he was transferred to Queen Street, where staff promptly started drugging him with several times the "maximum safe dosage" of Haldol, as well as Nozinan and Valium, despite the fact that he was already tranquilized. They did no blood or urine tests before or during the drugging, though they suspected that Alviani had been using street drugs. The cause of death was said to be "therapeutic misadventure."

(Vol. 1 No. 3, Vol. 1 No. 4)

(Alviani's body was shipped to Toronto Western Hospital before he was pronounced dead.)

Norman Davis

Norman Davis died from forced drugging, or prescribed overdoses of dangerous psychiatric drugs, at 27 years of age.

A few hours after Davis was admitted to Queen Street Mental Health Centre on December 4, 1981, psychiatrist Mark Lowery prescribed 24 ml of paraldehyde to be administered over a 24-hour period, in addition to a moderate dose of Nozinan. However, the medical chart showed that 32 ml of paraldehyde was actually administered: a nurse misread the doctor's order. Around four p.m. on December 6, another inmate found Davis lying unconscious and dead-white in bed; he immediately called a nurse. Davis was rushed to Toronto Western Hospital, where he was pronounced dead.

The jury's verdict was that the official cause of death was "cardiac arrest"; the means or mechanism of death was listed as "unknown." Apparently, the jury was unimpressed by or simply unaware of the fact that paraldehyde is a very potent, unstable and dangerous drug. In fact, the drug has been medically discredited; it's rarely been used in the past decade. When administered alone or in combination with other drugs, paraldehyde frequently causes serious medical complications, including death. (Vol. 3 No. 1 "Norman Davis: Another Unnecessary Drug Death" by Don Weitz)



Andrew Zamora

Andrew Zamora died on August 17 1981, at the age of seventeen.

Labeled as having an "acute paranoid disorder," he was taken to South Beach Psychiatric Center, New York, and drugged with Navane. On August 16, he got a shot of Thorazine for "aggressiveness and threatening action towards the staff," and was put in a bednet restraint for several hours.

On August 17 Zamora was again put in restraint and given massive doses of Serentil and Benadryl. At four p.m., still in restraint, he was "agitated, yelling," and "a danger to himself and others," according to therapy aide. At 4:30, it was noted by another aide that his face and nails were blue and his pupils dilated; he had foam around his mouth; and he had no pulse. A failed attempt was made to revive him with CPR: the suction machine from the treatment room would not work, and the "crash cart" was located on another floor and had to be brought down. Two safety officers got a second suction machine, but the physician had to remove its tubing for use as a tourniquet to tie around Zamora's arm. The crash cart had no tourniquet, and the doctor needed one immediately. Zamora was pronounced dead between 4:45 and five p.m., a victim of too-rapid "neuroleptization" and too-slow resuscitation.

The medical examiner's office had little difficulty in pinpointing the cause of death: myocarditis, an inflammation of the heart muscle. Zamora's parents insist that he was violently allergic to all phenothiazines and other major tranquilizers, and that the myocarditis was a result of the drugging. They are suing the state.

Penny Rosenbaum

Penny Rosenbaum's final admission to Queen Street Mental Health Centre (her ninth in seven years) occurred on June 16, 1983. Penny was 23 years old. She was diagnosed as suffering from "schizophrenia" and "mild mental retardation." On July 30, she died.

According to the coroner's jury verdict, the cause of death was "inhalation of stomach fluid due to fecal impaction." Psychiatrist Eric Zarins said that on the day she died, he diagnosed Penny as suffering from the "flu."

Dr. Edward Sellers, a psychopharmacologist at the Addiction Research Foundation, said it was possible that two of the three drugs administered to her "might have been partly responsible for her condition." The drugs were Haldol and Thorazine, common "antipsychotic" drugs, together with the anti-parkinsonian drug Benzotropine, used to prevent the other drugs' "side effects." Both Haldol and Thorazine can cause constipation and suppress the gag reflex, thereby permitting a person to choke on her or his vomit.

(Vol. 4 No. 3-4: "Death at Queen Street" by Hugh Tapping)

Patricia Ellerton

Patricia Ellerton died in August 1981 at the Queen Street Mental Health Centre, apparently from an overdose of Nozinan. She was 37.

Ellerton was described by the hospital physician responsible for her physical health as "a whiny kind of patient constantly seeking attention," and by a nurse as a person well-liked by her fellow inmates. Only one physician, Dr. Gerard Lippert, was on duty to take care of 600 inmates the morning she died. He said that he did not go directly to Ellerton when he was paged because no emergency call was made to him. When he finally heard that it was an emergency, he ran across a parking lot and up to the fifth floor of another building to her room, where he found her dead.

Because she had been refusing food, Lippert concluded that her death was caused by "self-induced anorexia." When her body was examined by a pathologist, however, he found her lungs congested and partially collapsed—common in deaths due to drug overdoses.

No account of the non-narcotic medicines in the medicine room was being kept, so it was impossible to check whether Ellerton had been given an accidental overdose by nursing staff. She was found to have ten times as much Nozinan in her body as she should have.

(Vol. 2 No. 4)



Pablo Martinez

Pablo Martinez, a 27-year-old inmate at Manhattan Psychiatric Centre, New York, died on December 26, 1981. The press reported that two security guards sat on him while two others placed a strait-jacket on him backwards, so that his arms were folded behind him. They left him on the floor, and soon a nurse noticed blood coming out of his mouth. He died at Metropolitan Hospital after a doctor at Manhattan State refused to try to resuscitate him. The hospital has attributed his death to "falling" and "struggling," while the death certificate described his injuries as "bleeding in the neck and spinal canal, contusions of the spinal cord and bruises of the head, chest, arms and legs." The Commission on Quality of Care found that he died from "undue force" consisting of "asphyxia by compression of the neck while being restrained." Dr. Michael Ford, head of the Manhattan Psychiatric Centre, called the findings "overstated" and added that the Manhattan District Attorney's office found no reason to take criminal action.

Anthony Ruggeri

On August 16, 1979, three days after Anthony Ruggeri, 24, was admitted to South Beach and labeled "manic depressive, manic type," he was transferred to the Intensive Care Unit.

He had been given Haldol and lithium, but then his doctor had stopped all medication on learning that he had a history of "drug abuse," to rule out the possibility of "drug-induced psychosis." By August 20 Ruggeri "appeared asymptomatic and free of any psychotic behaviour." But on August 22 the chief of service returned from vacation, decided Ruggeri was still crazy after all, and ordered Prolixin six times a day for ten days, starting on August 24. Ruggeri got his first two shots on August 24, but then the treating psychiatrist decided to discontinue the chief's order. Later that day, Ruggeri was given paraldehyde, a powerful sedative.

On the morning of August 26, staff found him in bed sweating profusely and having trouble breathing.

He appeared to be having a seizure, according to the two nurses on duty. The senior staff nurse found that his pulse and respiration rate were high. He was found by the psychiatric resident on duty to be "agitated, hyperventilating, demanding, manipulative, verbally abusive at times." The resident gave him a placebo.

That afternoon Ruggeri was put in seclusion for "agitation." At four p.m. he was put in a straitjacket. It was extremely hot that day, and the air conditioning was not working. By evening, he was so soaked with sweat that the strait-jacket was removed, and he was forcibly taken to the shower by two staff members. Refusing to cooperate, he was placed in a posey restraint which was then tied to a chair. The chair, with Ruggeri in it, was placed in the shower. The staff noted that his colour became ashen. While the nurse went to get the blood-pressure cuff, he became unconscious. Attempts at resuscitation were unsuccessful. He was pronounced dead at 9:10.

Judith Singer

Judith Singer died on October 16, 1980 in the Intensive Care Unit at South Beach. She was nineteen years old. She had been physically restrained and forcibly drugged with Haldol, sodium amytal, Thorazine, Cogentin and lithium since her admission to hospital on October 10. On the day of her death, she arrived at ICU still straitjacketed and tied to a wheelchair in a posey restraint. The wheelchair was tied to a pole in the ICU dayroom. Since she was in restraint, the nurse had to defer checking her vital signs. Singer attempted to refuse her medication. It was noted that she was "agitated" and pale. A doctor was called, and couldn't find her pulse. CPR was begun and she was transferred at once to nearby Staten Island Hospital emergency room, where she was shortly pronounced dead. The autopsy, performed by the New York City Medical Examiner's Office, listed the cause of death as "manic depressive psychosis with exhaustion."

(Vol. 3 No. 4, Vol. 4 No. 1: "Death by Psychiatry" courtesy of Allen Markman)





DON QUIXOTE

The inmates went to the park
to hear the jazz concert;
deep black shadows hung
over the grass and the
sun — sinking lower and lower —
was a thief with his
pockets full.

The inmates did not sit
in the trees but walked
here and there, like pigeons,
dreaming of sleeping
with full bellies,
under the eaves of a church,
where the air is free,
where they could awake
to the sound of bells.

As the sun slipped
down the sky, the trumpet wailed,
the windmills whirled
on the popcorn-seller's
buggy.

And like Don Quixote,
one stood up, fighting
with his own shadows,
talking to himself:

unsocialized behaviour,
noted, recorded;
not alive, electric,
dangerous to others.
Sit down. Sit down.
*Do you want everyone
to know
we're crazy?*

And as the trumpet
wailed to the bloody sky,
it sliced out the heart
of this one,

both mad, riding their madness,
Don Quixote —
his great white horse.

While the others dreamt
of sleeping like pigeons
under the eaves of a church
waking to the sound of bells,
with their bellies full.

Madness, not enough, never
enough madness,
charging like a great white horse . . .

They went back to the ward
early because of him,
this one
nattering at him,
angry . . .

He did not notice:
Sharp was his pulse,
for he had ridden hard.

Donna Lennick

(Vol. 4 No. 1)



Jean Skov

The real beginning of my story was an undiagnosed pinched nerve. The end result was tardive dyskinesia—caused by long and useless “treatment.”

My family doctor had prescribed Mellaril when I first went to him for help for muscular tremors. Within six months I became severely depressed. It became a tremendous effort to do the slightest thing. I didn't know that the major tranquilizers could produce this effect.

When I asked my doctor why I was feeling this way, he said he couldn't understand, but suggested I get away from whatever was stressing me and go the hospital. In June of 1980, I admitted myself to Peel Memorial Hospital and became an “in-and-out” patient for the next three years.

On the ward, my purse and everything was taken from me and I had to take all my clothes off. They had to look for drugs, so a nurse did an internal and a rectal examination. I felt like a criminal and still feel that way.

The first six months in hospital was just about the worst experience in my life . . . the whole thrust of a psychiatric institution is to make you feel like a nobody. I was put on Moditen. It was so powerful that my system couldn't take it, and I started breaking out in a rash. Then they put me on an antihistamine. At the same time I was on Sinequan and chloral hydrate. Even with that, I couldn't sleep. I questioned the doctor about the medications, and he said that a little knowledge was a dangerous thing.

I had a hemorrhoid condition before I went into the hospital. While I was there, I was bleeding so badly at times that in the morning my clothes would be soaked in blood. I was examined and they gave me Metamucil. That helped. I was told that if the condition continued I would have to have an operation. The point is they assumed it was just hemorrhoids and didn't examine me any further. What had happened was an inflammation of the large intestine. Consequently, I was in terrible pain until I got out.

In 1982, Dr. Faux suggested ECT treatments “for depression.” I remember that when I was asked to sign the consent papers for the treatments, I was willing to try anything. I received seventeen ECT treatments but within a month the depression was back. Toward the end of these treatments I developed convulsions. They started before I got out of the shock room. I was awake, convulsing and hardly able to breathe. My spine was bending back; I was panting and sweating. And a nurse was scolding me, saying, “You can stop that right now.” I went in at eight o'clock in the morning and it wasn't until six o'clock in the evening that I was able to get out of bed. I was having convulsions during that whole period of time, shaking and bending backwards. It was horrible. According to a compendium I read later, Reserpine was not to be given during ECT treatments. Reserpine was one of the drugs they gave me for my “high blood pressure.” My pressure was low-normal! While on this drug, I convulsed regularly. I would shake all over and sometimes pass out. For the last three months before my release, I was also getting Inderol for



heart problems, as well as Sinequan, Halcion and Librium.

I was diagnosed with everything: “schizophrenia,” “depression,” “manic-depression,” “mania,” “anxiety,” “psychosis.” All I ever really suffered from was muscle tremors caused by the undiagnosed pinched nerve in my back. But I am sure the psychiatric labels are still on my record.

Soon after I left the hospital, I went to a neurosurgeon for the pain my back and throughout my body. He said it was caused by the tardive dyskinesia. The pain is still with me—in my jaw, my neck, down my back and in my feet.

Sometimes my jaw will clench for about five minutes and I just scream with the pain. This is diminishing, but my jaw is very stiff. I haven't got a tooth in my mouth now. My jaw twisted sideways and my dentures pressed against the teeth I had—I've lost about eight in the last year. My oral surgeon has no doubt that this is caused by the dyskinesia.

Most people are very kind. The people I see regularly couldn't have been kinder. But the children—they stare, they stare, and you feel like crawling into a corner.

I take no medication now.

I think an organization like ON OUR OWN was all I ever needed. Take your experience of depression and use it to help other people. Walking in another person's moccasins for a day gives you the ability to turn your experience outward in a productive, joyful, positive way. That's all I needed—a place where I could express myself. I want to express my anger in a way that will benefit someone else.

(Vol. 5 No. 4)

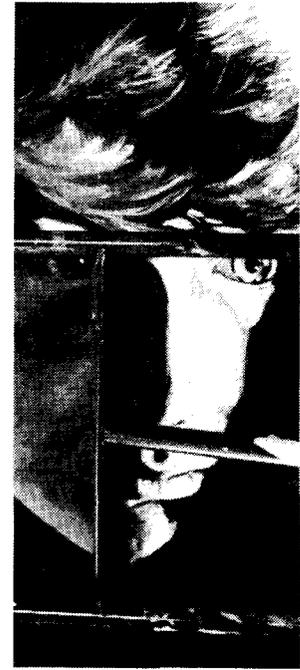


Emmerson Bonnar

In 1963, a nineteen-year-old New Brunswick youth fumbled an effort to steal a woman's purse; a comic tug-of-war on the street soon brought the police. Caught in the act, Emmerson Bonnar was charged with attempted robbery under the Criminal Code of Canada. Bonnar had no criminal record, and at his first court appearance he told the magistrate that he intended to plead guilty, that he did not wish to be represented by a lawyer (there was no legal aid in New Brunswick then), and that he simply wanted to get it over with. The magistrate accepted his plea and adjourned sentencing for two weeks in order to obtain a pre-sentence report. This is the report (generally ordered when dealing with a young offender with little or no criminal record) which assists a judge in making the most appropriate disposition.

The magistrate didn't question Bonnar's intellectual or mental capacity when accepting his plea of guilt. But during the two-week adjournment, Bonnar was examined for approximately one hour by a psychiatrist who had treated him previously as an outpatient (Bonnar had been on psychiatric drugs intermittently for several years and has also been treated for emotional problems).

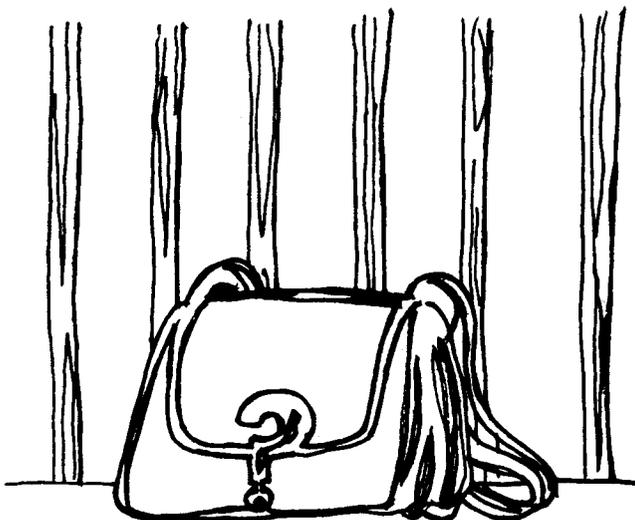
The sentencing hearing should have been routine: the judge would have heard from the psychiatrist and probably read the report, which would undoubtedly have included statements from other members of the community. Considering Bonnar's age, the fact that he had no criminal record, and the fact that the attempted theft had been bungled, with no injuries inflicted, the harshest possible sentence would probably have been about 30 days in jail. In all likelihood he would have received a suspended sentence with probation.



What actually happened has become a much-publicized example of questionable justice, and unquestionable personal tragedy. At the hearing, psychiatrist Robert Gregory gave evidence based on his one-hour observation of Bonnar. He asserted that IQ test results showed the defendant was probably "borderline retarded" or a "moron." When asked by the magistrate whether Bonnar could instruct a lawyer, he said "probably not." The pre-sentence hearing was evidently turning into a fitness-to-stand-trial hearing. Bonnar was not asked by the magistrate whether he wished to obtain a lawyer; he was not even asked whether he wished to cross-examine the witness, or had any closing comments to make before the judge passed sentence. Instead, the magistrate, after hearing five minutes of evidence from the psychiatrist, struck out Bonnar's "guilty" plea, declared that in his opinion Bonnar was unfit, and placed him under a Lieutenant Governor's Warrant.

Under authority of the Warrant, Bonnar was committed to a provincial hospital for the criminally insane in Campbellton, New Brunswick, where he spent the next seventeen years, until pressure from the Canadian Association for the Mentally Retarded and the CBC "Ombudsman" program led to his release. For the first seven years, there was not even a review of his detention; after that Bonnar was rubber-stamped unfit from review to review, until he was finally released. While incarcerated, he received no therapy that could be described as improving his well-being. Like many other inmates, he was involved in an intensive drug therapy program, and over the years he became increasingly withdrawn and uncommunicative.

(Vol. 5 No. 2-3: "Seventeen Years Behind Bars for Trying to Steal a Purse" by Harvey Savage)-



Anonymous

My first experience with dehospitalization home placement was a disaster, as was my second (and last), after which I was considered incorrigible, and they were unwilling to recommend me to any other placement.

The first boarding house was owned and managed by an elderly couple who were trying to supplement their retirement income by accepting referrals from the hospital. There were two of us: myself and another man. Our shared accommodation was in the basement. Money for room and board was provided by a social service agency, along with a small allowance given to us for personal expenses. Meals consisted of cold, lumpy porridge with powdered milk for breakfast, Kraft Dinner and Koolaid for lunch, and boiled white rice with the occasional hot dog for supper. On Sundays (the owners') extra meat or leftovers would be served.

The washroom was in the main part of the house, which was upstairs, and when the owners were out or the house was locked, it was unavailable. Bathing was restricted, and the rest of the house was off-limits. Since the monthly personal allowance was about 30 dollars, most outside activities, including transportation and movies, were out of the question.

When there was an argument between my roommate and the owners, he would be locked out of the house and would spend time wandering the neighborhood, missing his meals until the owners returned or decided to let him in. I remained for three weeks before complaining to the social worker. A city inspector was sent to investigate and found the basement of the house unsuitable for human occupation, and we were relocated. I was sent to a group home and was warned that this was to be my last chance.

The group home housed 25 to 30 ex-psychiatric inmates, with four to eight in a room. There was a ten o'clock curfew. Any meals missed were forfeited, and my schedule had to conform to the routine of the house. I was not interested in upsetting the regimen of the house and was willing to miss an occasional meal for my personal freedom; if I was away and couldn't or didn't want to return by five for supper, then I was willing to go hungry. They didn't see it that way.

I had trouble accepting that a grown man should be in by ten o'clock. I missed the curfew every night I was there. And they seemed suspicious when I didn't have any medication to declare. (The medication was kept in a locked cupboard and dispensed to the people in the house.) After the third night they complained about me to the hospital and I was out. According to them, the system was infallible, and I just didn't fit. In the three days I was there, I witnessed fights between other members of the house as well as swapping and dealing in street and prescription drugs.

Both of these houses were sponsored and used by government social services agencies. Both were, in my opinion, inadequate and unsuited for the services they were intended to provide. (Vol. 3 No. 2: "Boarding Houses Are Not the Answer" by Robbyn Grant)



Nira Fleischmann

July 17: The nightmare—reality. Simple. No puzzle after all. Because *nothing ever fits*. Just billions of pieces of different colours and contours, and in the end, just different landscapes of disintegration.

There's really *nothing* to hold on to. All the reaching upward has been a mockery. And it's *malicious* laughter after all is said and done.

I pass Suzanne's room as guards, nurses and doctors are forcing a tube down her throat, deeper and deeper, until it reaches her stomach and they feed her—for her own good. Salvation in a plastic bag, a tube, a hideous turquoise solution. She doesn't utter a sound. And a certain grace surrounds her there, on that bed where they've caught her, captive of leather belts and tangled bedsheets. She doesn't scream. She doesn't try to fight them. There is no fear, and I walk away strengthened. Ankles and arms pinned down, she's stripped their almighty power with a defiant peace. And eyes that see beyond the hellish geography of these rooms and walls. (Vol. 5 No. 4)

Nira, who edited the issue in which this excerpt appeared, died of respiratory collapse on January 1, 1985. She is sadly missed.

**David Reville**

January 23. Punishment isn't called punishment, of course, but it operates just like you'd expect, the restriction of liberty in some kind of relation to the severity of the offence. It almost always starts with a demotion in Grouping. Grouping is the status structure of the patients. Group 1 means you remain on the ward, probably in pyjamas. Group 2 entitles you to get dressed (yippee) and move around the hospital accompanied by an attendant. You might even get to work on a work gang or go to the Occupational Therapy workshop. On Group 3 you can walk around the building unaccompanied, and Group 4 opens the grounds to you. At opposite ends of the scale are "Special Observation"—you are watched more or less carefully for a while after a suicide attempt—and "Town Parole," an instructive term meaning that you may go into the city. Anyway, for inappropriate behaviour, you lose a group or two, returning to pyjamas for particularly heinous crimes. If you are really beyond the pale, you are put into the Old Hospital, Rockwood, Home of the Chronic and Defective.

I have made a decision to be Quiet and Cooperative. I've seen the results of non-cooperation and I don't think that my case history would be greatly improved by the inclusion of a medical report reciting the contusions, abrasions, fractures and concussions sustained resisting transfer. So I think I'll just plaster a smile on my face and sit here clutching my exercise book and wait.

A wall-eyed man beckons to me. "Cmere," he rasps, and I realize with one of those terrible jolts of comprehension that this is the ward supervisor. I wonder briefly if he's been given the job after 40 years' faithful service as a patient. And that's the last wondering I do for a while. I turn off completely, unable to absorb further jolts. And it's some time before I return to conjecture: it's not happening; this is a hallucination (maybe I *am* crazy); I'm tripping out on something; it's a Rod Serling/Vincent Price low-budget 3-D reject. But now there is a heavy steel bolt through my temple, expanding and contracting, driving sharp spikes deep into my head and I'm grateful that I can get lost in the pain until I eventually lose consciousness.

When I peer out through trembling eyelids I can make out three figures standing around the end of my bed. A deep but female voice says, "You'd better watch this one—suicidal." Then they move away and I hear a raucous laugh and a sharp slapping sound. I fall asleep again.

January 30. The doctor comes on the ward once a week for an hour. That works out to 1.2 minutes per patient. I wonder where the Department of Health enshrines *that* statistic.

February 18. In a way it's legitimate enough. *We are* political prisoners, all of us. We have dared to challenge mythology. Foolish of us, I guess, especially those of us who had a choice. Most of us didn't know we were challenging, most of us couldn't help it. Old Zack over there, he certainly didn't intend to outlive all of his people, and he doesn't shit himself on purpose. But there he is, alone, old, vague, incontinent. You can't have embarrassing people like him around. Lock them up, get them out of the way, there is room for only some kinds of social failure.

March 9. It shouldn't be possible to be an oddball here but I am. This hospital is filled with poor people. The middle-class contingent could meet comfortably in a phone booth. So I must be here accidentally. (Hey fellas, this is all a big misunderstanding. If you'll just unlock the door . . .) All my power systems are temporarily out of order or I'd never be here. I'm getting a rare opportunity; I'm seeing how *my* people deal with slow learners. If you fail to learn how to behave in the correct unobtrusive way and you have already committed the horrible crime of being poor, you will surely be thrown in jail—this one or the other next door (Kingston Penitentiary). If you are given the choice—you won't be—take the one next door. You might learn something useful, welding or safe-cracking, and you'll have a better idea of when you're getting out. And people will hold their mouths a little differently when you tell them your previous address. After all, you will have been considered worthy of *some* kind of legal process, unlike us who do our indefinite time without having had our day in court.

So, a word of warning—you can trust me—take care about the family you get born into. Then, if you safely make it into the middle class, don't piss all your relatives off. Best of all, get yourself a private psychiatrist and pay him *all* your money. When the white coats come to get you, he'll intercede on your behalf. Because he'll suspect that you held some of that loot back.

I say to Chuck, "You got town parole, why don't you split?" and he says, "Sure, and what do I do when I run out of pills?" and I see how cleverly they've got it worked out; if the system doesn't keep you then the dope will. And the hell of it is I don't think there's anything very wrong with Chuck. They just never let him try to handle his problems—keep him so stoned-out he could never learn to cope.

May 8. I'm an elevator. A hundred technologists designed and assembled me. My program was faultless. A million fingers pressed my Up button. But I didn't work. Turn off the Muzak, press Alarm, call the mechanic. But everything checks out. The two built-in responses—Door Open, Door Close—fail. The light at the top of the shaft is on but the elevator isn't seeking it. The Down button was programmed out at the start. What could be wrong? The elevator had been going Up as directed, the door opened and closed at the appropriate times, the maintenance was on schedule. Why is the program being rejected? Confusing. There is only one thing to do. Get that elevator out of service. A machine doesn't work? It could be a threat to the entire system. Get rid of it. I am taken out of the shaft and junked. I lie in a heap, wires trailing. I hum softly, despite my lack of power source.

(Vol. 2 No. 1 "Don't Spyhole Me")

David Reville is a Member of Provincial Parliament, living in Toronto.



David Reville



David Revilla

Carole Stubbs

I was married when I'd just turned seventeen, and by the time I was 21 I was in university and had had four children. Well, it's self-explanatory—I was pretty worn out. I wasn't well, and then I had a miscarriage. Stupid me, I went right back to school after the miscarriage! I collapsed—that was about it.

So I landed in a psychiatric ward, where I was given about 86 shock treatments within three months. I was given regressive therapy, which put me back to the level of a five- or six-year-old. Sometimes I had three shock treatments a day. And then, I really didn't feel the shock treatments did me any good. I lost my memory for that whole period—the time in the hospital and also the time just before—about a year and a half altogether, I guess. Once I was allowed to go home to visit—it was Christmas, so I got to come for dinner. I walked in and I saw these four little boys and I said, "My, what lovely boys! Whose boys are they?" They were my own boys and I didn't even know them.

I guess they discussed the therapy with my husband but, like me, he was really quite ignorant of psychiatry and accepted everything. I have since asked him who gave permission for me to have all those shock treatments, and he said he doesn't know whether he was formally asked, or whether he signed anything. He doesn't remember; he didn't see any significance in it.

It was if they were saying, "This is what we have to do, we're going to do this for her," and we just said, "Yes, yes, yes" to everything.

I don't think the shock treatment worked, and I'll tell you why. I lived in a blanket of fear—I couldn't get away from it. I think that not to know what you're afraid of is a hard burden to bear, because you don't know what to grab at—you don't know what's going to comfort you. If you know the fear, you can do something to get away from it.

(Vol. 5 No. 1: "A Case of Knowing Yourself" by Coreen Gilligan and Patricia Urquhart.)

Carole is the coordinator of ON OUR OWN in Toronto.



Carole Stubbs

Barbara Wish

I'm from Denver, Colorado. I'm a survivor of incest and rape and beatings by my family. I want to protest the locking away, drugging, shock torture and silencing, in psychiatric institutions that patriarchal psychiatry calls "hospitals," of women and children who are survivors of this kind of assault. I'm here to say that women surviving rape have a right to their rage. And you'll have to kill me to silence my rage! I don't want psychiatry to label and control my rage by calling it "rape syndrome," by victimizing me and all women over and over again, by assaulting me with its language of oppression. I want my language and myself and my body back.

I am privileged as a white woman. I know that I don't even comprehend what Chicano, Asian, native, black, all women of colour go through as victims of this white, male oppression.

I am an alcoholic. Alcoholics and drug addicts are drugged by psychiatry and are addicted further. . . . What does that say about our government and our society, when a person is trying to recover from addiction and is injected with sanctioned drugs in the name of treatment?

I'm a lesbian. I was locked up for being "latently homosexual." My male doctor assured me that I must be going through my homosexual stage, but that I was heterosexual and okay and normal and legal and fit to go back to my nuclear family. I'm here to say that violence against lesbians by psychiatry must be assaulted the way I and other lesbian women have been assaulted. We must fight back and demand our rights to define our own sexuality on our own terms.

I celebrate my survival from assault at an early age. I celebrate my rage. I celebrate being a lesbian. I celebrate being an incest survivor. I celebrate my freedom from therapists, psychiatrists, and all mental health professionals today. I join with other ex-inmates to express our rage at what psychiatry has done and is doing to a large population that is hidden and ignored and not talked about.

Two thirds of all mental patients are women. I celebrate today with my sister ex-inmates, and celebrate women's rage, pain and determination never again to give up our lives and our souls and bodies to the genocide of psychiatry.

(Vol. 5 No. 1: "Interviews with Ex-Psychiatric Women", courtesy of Allen Markman, WBAI radio, New York)

Connie Neil

I work as a payroll clerk for the Public Works Department. I write little figures, and that's about all I am really confident of doing at this point. And that's a *direct* result of the treatment. 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 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.

Connie is still working as a payroll clerk in Toronto.

Shirley Johnson

I'm a shock therapy victim; a survivor who 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. We are here testifying as survivors of shock, but there are many who don't survive. The pain and hardship it causes cannot be justified. There are alternatives, and we must look at those alternatives.

Shirley is working in a holistic therapy centre in Hamilton, Ontario.

Janet Gotkin

Between 1961 and 1971 I had over 100 shock treatments, some with anesthesia, some without, in public hospitals and private institutions. I never signed a consent form and was never told what the procedures would consist of or what lasting, debilitating effects I might endure. I have large, unpredictable blank spots in my life history—empty spaces I cannot fill.

Janet is an antipsychiatry activist in the US.

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." Medicine generally has a rational, scientific basis. The theoretical basis of shock—the supposed benefit of grand mal seizures—is totally discredited. Ask the Epilepsy Association about just what good seizures do. . . .

**Leonard Roy Frank**

Twenty-two years ago there began for me the most horrible and painful experience of my life. It was the start of a series of 50 insulin comas and 35 electroshocks. According to my psychiatric records, I was "withdrawn," "secretive" and "negativistic," and had "piercing eyes," "religious preoccupations," and "food idiosyncracies" (I was a vegetarian). I was pronounced "paranoid schizophrenic, severe and chronic" and, under court order and against my will, given the shock "treatment" series. The major effect of the shock therapy was the obliteration of my memory of two years of my life. It also rendered permanently vague the memory of my entire earlier life. I was 30 years old at the time.

Leonard is the author of The History of Shock Treatment.

(Vol. 4 No. 3-4: "Testimony On Electroshock", Vol. 5 No. 2-3: "Survivors Speak Out at Shock Doctor Conference")



THORAZINE

For Dr. Bob Miller

I'm funny and flat today, yesterday's tea.
These pills have caught up.
(They're doing the job.)
They've stripped the me out of its husk,
they've pounded it down like veal.
However can it re-form now?

I'd rather have giggles and tears,
champagne and razor blades than
This, whatever it is.
I'd rather be deadened by
unmade beds and dust and noise and
blue death in a plastic bag
than be overrun by these under-the-skin buzzies
without even caring to scratch.

What risk? what disaster averted
makes up for the soul,
ripped out, Comet-cleansed and
replaced sanitized,
without even the taste of the past on
my brain's tongue, its tears, smiles,
and dreads, even?
Not one, good doctor.

Better be found dead in bed
with feeling
than waked prematurely,
sitting in this cold clean room,
my Christian-silly smile pasted on
upside down.

Bobbie Jean Smith

(Vol. 5 No. 1)

THE SEASON OF PEACHES

There is something about the eyes
of old women who have been shocked too many times
like bruised blotches on overripe fruit
ringed like elephants' knees
eyes that look as though they have been
pummeled forever
by many fists
the shocks tell women to make meals
and to do the laundry
and to bake peach pies
some women don't need the shocks
baking comes naturally to them
for the unnatural ones
their husbands sign the consent forms
because they savour the taste of peach pie
how many women have you seen with the bruised
eyes?
who makes your pies for you?
what would happen if they stopped?

Cynthia Ingle

(Vol. 6 No. 1)

getting culture

they troop us from a grouphouse to a play
 little ducklings two by two
 the social workers fresh from college heading a
 delinquent and derelict procession
 along dupont up to the tarragon theatre for a
 torpid play about the untorrid life of a
 provincially straitjacketed woman
 translated from the french and written by a man
 a play coming at us from many removes

i sit down front row smack centre knees rubbing the stage
 beside doug the skinny many-weathered grizzled
 bootlegger
 who's got the lack-of-wine-bad-shakes
 it's his very first play

and in a very early scene the girl's brother
 snatches her doll stabs it and she
 all-of-a-sudden SCREAMS right-at-us
 jolting doug skyhigh off his chair and into that
 emphysemic cement-mixer rattle in his chest
 and he gasps real loud
 NO WONDER MY NERVES ARE BAD

it's a play as long as life is short and every bit as
 absurd with no intermission so that many
 kidneys are at high tide and a million nicotined cells
 are calling for help so doug clammers up clumsy cowboy
 boots
 stumbling coughing wheezing clattering through the small
 theatre's full house, and eclipses the spotlight
 momentarily
 and announces by way of explanation
 I HAVE NEVER BEEN SO BORED IN MY LIFE

finally it ends she dies and outside
 i ask doug what he thinks of his very first play
 and he says, "they'll never get me to another one. i feel
 like i been dragged through an asshole and fed farts for
 a week."

it was the finest theatrical
 criticism i've ever heard.

bud osborn

(Vol. 4 No. 1)

SHOCK WAVES

Shock Survivor Speaks Out Against ECT Report

Dear Mr. Minister:
I am an electroshock victim who contributed my views and experiences to the Electroconvulsive Therapy (ECT) Review Committee.

Although I was a voluntary patient, I belong to the international coalition of ex-patient groups working to end involuntary psychiatric treatment of any kind and to ban ECT.

It was clear from the start, when public hearings were denied, that the examination of this so-called therapy would probably be a farce, and the might of the medical industry would prevail, as it usually does. Most of the people appointed to the committee are psychiatric professionals and lawyers who have a great deal to gain from the use of ECT, and a clear conflict of interest.

It doesn't take a genius to figure out that pumping electricity through someone's brain to cause a grand mal seizure could hardly be good for that person. The effects of a severe blow to the head include amnesia, disorientation and brain damage. My own experience and the anguished stories of hundreds of thousands of others show the devastating effects of ECT.

The report states that some

patients felt ECT helped them, but this is misleading. First, some people actually like the effects of brain damage, just as an alcoholic likes to damage himself with alcohol—it takes away the need for personal responsibility. Second, people suffering from brain damage often deny the damage and pretend. It took me some fourteen years to admit that I am damaged as a result of the seven ECT treatments I received. Incidentally, I was totally deceived into signing for these so-called treatments. I was told it was "sleep therapy." I asked the doctor what that was, and he said, "you just sleep a little while." He didn't tell me about electricity, memory loss or anything else I should know for informed consent. It destroyed my life!

I urge you to find this report valid to the extent that it shows what shameless measures highly educated professional people have used to protect this barbaric "therapy." Psychiatrists have the highest suicide rate among professionals, and *not one* has submitted to their own, supposedly life-saving electroconvulsive therapy!

Dennis F. Nester
Scottsdale, Arizona

Stop Reclassification of Machines

The Food and Drug Administration (FDA), a branch of the US government, is on the verge of reclassifying electroshock machines from Class III (unsafe) to Class II (safe). This is mainly because of intensive political lobbying by the pro-shock American Psychiatric Association (APA).

Some shock survivors and ex-inmate groups in the US are trying to stop the FDA from declaring shock machines safe. Their tactic is to convince the FDA to conduct independent CT scans on the brains of shock survivors, who are confident these multi-dimensional x-rays of the brain will conclusively

Resolution to Abolish Electroshock

WHEREAS the psychiatric procedure known as electroshock (ECT) *always* causes brain damage, including permanent memory loss, many other serious intellectual impairments and great suffering;
WHEREAS electroshock as a "medical treatment" has never been proved to be "safe and effective" or "lifesaving";
WHEREAS the recent report of the Ontario Government's Electroconvulsive Therapy Review Committee, and the committee's members, show a blatant, medical/pro-shock bias and irresponsibly minimize the brain damage and other serious impairments resulting from electroshock; and
WHEREAS electroshock is, in fact, a brainwashing technique and a form of cruel and unusual punishment that cannot be justified on medical, scientific, ethical or humanitarian grounds;
THEREFORE BE IT RESOLVED
THAT the Ontario NDP demand the immediate abolition of electroshock in Ontario;
THAT the Ontario NDP draft an amendment to the Mental Health Act which will specifically prohibit the use of electroshock on any person for whatever reason in Ontario;
THAT in drafting this amendment, the Ontario NDP or one of its committees consult with the Ontario Coalition to Stop Electro-

shock and other self-help/advocacy groups of former psychiatric inmates and shock survivors; and
THAT the Ontario NDP instruct its leader, Mr. Bob Rae, to immediately inform Health Minister Murray Elston and Premier David Peterson of this resolution.

This resolution is endorsed by the Ontario Coalition to Stop Electroshock, which includes ON OUR OWN, Phoenix Rising, the Disabled Women's Network (DAWN), the Toronto Rape Crisis Centre and Humane Awareness with Respect and Dignity (an inmates' rights group). It was passed by the Riverdale Riding Association of the Ontario New Democratic Party at a meeting on March 25 1986, in Toronto, but was unfortunately not considered during the Ontario NDP's June 1986 policy convention.

At its last Board of Directors' meeting, held in Ottawa on October 25-26, the Canadian Legal Advocacy, Information and Research Association of the Disabled (CLAIR) also took an official position demanding the abolition of shock in Canada.

We urge our readers to speak out against electroshock. For more information, please contact Bonnie Burstow at (416) 536-4120 or Don Weitz at (416) 461-7909 in Toronto, or write to the Ontario Coalition to Stop Electroshock, Box 7251, Station A, Toronto, ON M5W 1X9. Thank you!

show that they have brain damage, and that the shock procedure is unsafe.

The Committee for Truth in Psychiatry, an antipsychiatry/ex-inmate group in Washington DC, is urging shock survivors to sign a petition authorizing the FDA to do a CT scan of their brains (as with any x-ray, the procedure is painless). If the FDA accepts your

petition, it will pay all your travel costs to Washington DC (if you are Canadian). More than 80 US shock survivors have already mailed in petitions.

If you would like a free copy of the petition, please write to the *Committee for Truth in Psychiatry*, c/o Linda Andre, 13 St. Mark's Place No. 7F, New York, NY 10003.

Cattle Prods as Behaviour Mod

Community and Social Services Minister John Sweeney has said that electric shocks with cattle prods are the only way to treat some developmentally handicapped children and adults in provincial institutions. The prods are currently used on inmates as a behavioural modification technique.

In response to vocal protests by rights activists, politicians, lawyers and social workers, Sweeney has limited their use to one provincial

institution. Cedar Springs, in Blenheim, is now the only treatment centre in Ontario that has official government sanction to zap inmates with cattle prods.

NDP social services critic Richard Johnston sums up his objections: "When we talk about these kinds of methods being used against political prisoners in some regimes we call it a terrible abuse of human rights, and yet here, with our retarded inmates, we call this necessary therapy."

One treatment centre with a government licence to practise torture is one too many.



Mass Murderers in White Coats

Psychiatric Genocide in Nazi Germany and the United States

— A Book by Lenny Lapon —

Lenny Lapon's recent book documents the mass murder of mental patients in Germany. The research material in this book documents psychiatric injustices and killings and contains information of interest and importance to all who are concerned about the oppression of psychiatric inmates and "mental patients."

The book sells for \$10.25 (US), including postage and packaging.

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The Anti-Psychiatry Bibliography and Resource Guide

by K. Portland Frank

Woodcut Illustrations



The Anti-Psychiatry Bibliography — Still an important source list for those interested in investigating — or avoiding — the failings of our present mental health system. Included are over one thousand annotations of books, periodicals and audio-visual materials relating to anti-psychiatry, introductory essays outlining major trends within the movement and a resource directory for North America and Europe.

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Rights and Wrongs

The "Eve" Case

The Supreme Court of Canada ruled on October 23, 1986 that no one, including the courts themselves, has the power to approve the sterilization, for contraceptive purposes, of any person who does not give her or his own consent to the operation. This is the final word from the courts in the case of "Eve," whose mother applied in 1979 to have the court in Prince Edward Island approve a tubal ligation on her daughter, who is developmentally handicapped. Eve is in her early 30s and lives in a group home.

All nine Supreme Court Justices agreed on this judgement, which confirms the decision of Mr. Justice Melvin McQuaid of the PEI Supreme Court—who ruled that he could not authorize Eve's mother to consent to the surgery. His ruling had been overturned by three Appeal Court judges in 1980, two of whom ruled that Eve should have a hysterectomy, rather than a tubal ligation. The case was heard by the Supreme Court of Canada in June, 1985. The Consumer Advocacy Committee of the Canadian Association for Community Living intervened in the case. The judgement corresponds very closely to the arguments made by the CAC through its counsel.

Reviewing the powers that can be exercised by the guardian of an adult under Ontario's *Mental Health Act*, and the extent to which regulations under the *Hospitals Act* might provide a basis for legitimate consent to a non-therapeutic operation on another person, Mr. Justice La Forest, (who wrote the reasons for the judgement) concluded that no law could

give a person authority to deprive another of "a basic right involving an individual's physical integrity."

Justice La Forest then traced the history of the ancient jurisdiction called *parens patriae*, whereby a Sovereign had wardship over his subjects. *Parens patriae* has been invoked by courts to empower them to make orders for the "care of individuals who cannot take care of themselves." There is no question that today's superior courts still have such power; the only uncertainty has been what is meant by "care."

It was Justice La Forest's feeling that such care must be "confined to doing what is necessary for the benefit and protection of persons under disability," like Eve, and that "The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction."

Despite this decision, provincial legislatures can still enact statutes that might permit sterilization without consent of the individual and without real medical necessity, but Justice La Forest warns that "the actions of the legislature will then, of course, be subject to the scrutiny of the courts under the *Canadian Charter of Rights and Freedoms* and otherwise." The judgement does

not go into the likely impact of the *Charter* on the sterilization question, since the court did not need to rely on any provisions of the *Charter* to reach its conclusion.

The judgement's closing words were to the effect that, in any proceedings in court involving questions about forced sterilization of a person with a mental handicap, "it is essential that the mentally incompetent have independent representation."

by Orville Endicot

Riviere-des-Prairies Atrocities

Reports of atrocities committed by staff on inmates of Montreal's Riviere-des-Prairies psychiatric hospital have been examined by a government-appointed Commission of Inquiry chaired by lawyer Richard Shadley, which submitted its final report last spring to Quebec's Minister of Health and Social Services, Therese Lavoie-Roux.

The abuses, documented in 191 affidavits filed last year, were publicly exposed first in the *Canadian Human Rights Advocate's* summer and fall 1985 issues, and then in our December 1985 issue ("Medieval tortures exposed to the light").

Lavoie-Roux accepted all seventeen recommendations except the most important one, which calls for placing Riviere-des-Prairies under government trusteeship. Other recommendations include:

- dividing the hospital into two parts, one for psychiatric patients and one for developmentally handicapped people
- evaluating the needs of residents and developing appropriate individual program plans, including plans for moving into the community
- adopting a code of ethics that would ensure respect for patients and their property, and accessibility of services
- creating the position of Ombudsman for the residents

Wrongful Imprisonment

Linda Armstrong, charged with mischief in 1982 for falling asleep in a closet in the lobby of a Campbell River hotel, was locked up for ten months in an institution for the criminally insane—the police knew that she had mental problems. Just moments before her case was to have been heard by the BC Supreme Court, the BC government agreed to pay her \$1,000, plus legal costs. Her lawyer, Gerald Green, commented, "the freedom of mental patients who are detained unlawfully isn't worth much."

Excerpted with permission from the *Canadian Human Rights Advocate*, May 1986.

- revising hospital rules on the use of isolation cells and restraints

The Quebec media, and especially the press, have responded to these reasonable and long-overdue demands in a patronizing and sometimes vicious manner. Hospital staff and administrators have been contemptuous of the commission. Quebec psychiatrists actually tried to stop the commission's hearings last fall.

According to the May 1986 issue of the *Human Rights Advocate*, the Canadian Mental Health Association (CMHA) showed no "interest or concern" at any time during the year-long inquiry. "Evidence of people being locked in isolation cells for days or weeks, people being tied to chairs and toilets for hours, the denial of the right to consent, the locking up of large numbers of people labeled mentally retarded in psychiatric hospitals for fifteen or more years, the lack of programs or activities—none of these abuses stirred a response in the CMHA."

To add insult to injury, both Dr. Giles Lorties and Jean-Yves Desbiens, the former and current presidents of the Quebec CMHA, "pub-

licly attacked the efforts of groups fighting to end the abuses at the institution. . . . The CMHA showed itself to be part of the problem."

This non-response to psychiatric abuses is nothing new for the CMHA, which presumes to advocate for reforms and patients' rights in the "mental health" system in Canada, but has never taken a public stand against any psychiatric institution, procedure or torture.

To make sure Quebec acts on all the recommendations in the Shadley Commission's report, we urge our readers to write strong letters of support, including support of trusteeship, to *Therese Lavoie-Roux, Minister, Health and Social Services, Quebec City, Quebec*. Also, ask for a free copy of the full report, or a summary listing the recommendations.

Advocacy Ontario

A proposal to create an organization called Advocacy Ontario was discussed at an August 1986 meeting of the Advocacy Resource Centre for the Handicapped (ARCH). Present at the meeting were several members of Concerned Friends of Ontario Citizens in Care Facilities, the group that drafted the proposal. Written by Trish Spindell, Harry Beatty and Sherill Carden, it has been sent to Ontario's Attorney-General, Ian Scott.

Advocacy Ontario would coordinate and administer advocacy services/programs in Ontario, which currently include a group of Adult Protective Service Workers (APSW) advocating for Ontario's developmentally handicapped; the Advocacy Centre for the Elderly (ACE); and twelve Psychiatric Patient Advocates (PPAs) in provincial psychiatric institutions. (PPAs report to the Ministry of Health while working in Ministry-controlled institutions; this amounts to a serious conflict of interest.)

The purpose of Advocacy

Ontario would be to promote respect for the rights, freedoms and collective and individual dignity of its clients; ensure that their legal and human rights were enhanced and protected and assist them to exercise those rights without interference; give them easier access to individualized, integrated, community-based services; provide the advice they need about alternatives to guardianship and conservatorship; and protect them from abuse.

Sixty percent of the 23-member board would be "consumers." The board would report to the Attorney-General, and/or to a standing committee of the legislature. The provincial office would have about fifteen staff members (including three lawyers), who would develop policy, educate the public, and do training, research and program evaluation. Fifteen new PPAs would be hired to work province-wide. Regional offices would do direct advocacy and promote lay advocates, working both in the community and in institutions. The program would be phased in over the next two years.

On the one hand, Advocacy Ontario might provide more effective and efficient advocacy by requiring advocates to work together, making them all accountable to the Attorney-General (and/or to the legislature), and promoting grassroots interests and issues as the result of a majority of board members being "consumers."

On the other hand, psychiatric inmates' and ex-inmates' interests might get lost in the shuffle of other groups; "consumers" risk being intimidated by professionals and government officials on the board; and there is no assurance that clients would be hired as lay advocates.

ON OUR OWN officially endorses the Advocacy Ontario proposal, but would like to see more victims of the health system included on its board.

In Brief

Last February, ON OUR OWN presented a brief to the Ontario government at a hearing on Bill 7, an act to amend laws that violate the *Canadian Charter of Rights and Freedoms*. The most hard-hitting recommendation was that the Mental Health Act be repealed. Short of this, it was recommended that: incompetence to refuse psychiatric treatment be decided by a court; regional review boards be abolished; psychiatric inmates be presumed competent; the right to refuse treatment be guaranteed; involuntary commitment be prohibited; the five-day assessment be abolished; a person be guaranteed automatic right of court review of involuntary committal within 24 hours of admission; due process be guaranteed inmates transferred to any in-

stitution; a person have the right to unrestricted access to her or his own medical/psychiatric records; a royal commission of inquiry into psychiatric abuses, violations of inmates' rights and alternatives to psychiatric institutions and interventions be established; minimum wage be guaranteed in sheltered workshops, industrial therapy and vocational rehabilitation programs; and people in sheltered workshops be recognized as employees in the *Workers' Compensation Act* and the *Occupational Health and Safety Act*.

Copies of the brief are available for \$2.00, including mailing and copying charges, from ON OUR OWN, Box 7251, Station A, Toronto Ontario M5W 1X9.

Charter

... and involuntary treatment of persons who pose no danger to themselves or others—and that criteria by which the decision is made to detain or discharge an involuntary patient are not specified.

VCLAS has a solid track record for initiatives in fighting human rights abuses against people with psychiatric disabilities and other marginalized groups, and can be contacted at 257 East 11th Avenue, Vancouver BC V5T 1C4. Legal Aid or the Attorney-General's office can provide you with a list of Canadian community legal clinics or advocacy groups.

Abstracted with permission from the Canadian Human Rights Advocate, August 1986.

Sexual Abuse

The College of Physicians and Surgeons of Ontario's Discipline Committee has charged two Ontario psychiatrists with having sex with their female patients. One has been found not guilty, and the other guilty of professional misconduct or "sexual impropriety with a patient." Unfortunately, their names have not been disclosed.

According to the College's March 1986 *Interim Report*, the first case involves a psychiatrist alleged to be "incompetent" and "guilty of professional misconduct" under the *Health Disciplines Act*. The Discipline Committee heard evidence from one of the psychiatrist's female patients and three witnesses who know her. From November 1976 to April 1978, the psychiatrist had a sexual relationship with the patient. The sexual encounters frequently occurred in the psychiatrist's home, where "they went to bed and had intercourse."

As the relationship deteriorated, the woman felt more and more confused and angry and wanted to talk about it, but the psychiatrist refused.

The College ruled the psychiatrist not guilty despite consistently damaging evidence from this woman and other witnesses, and the psychiatrist's poor record-keeping (two entries about this patient in nineteen months).

The second case, recorded in the June 1986 *Interim Report*, involves a psychiatrist charged with having a sexual relationship with a seventeen-year-old woman, previously a virgin. The psychiatrist faced charges of failure to maintain professional standards; failure to maintain medical records; "sexual impropriety with a patient"; and "disgraceful, dishonourable or unprofessional conduct."

In October 1974, the woman was referred to the psychiatrist, who had "fourteen years of experience and special expertise in adolescent psychiatry." Soon after the first week of therapy, the psychiatrist "became affectionate—stroking her arms, touching her hair, pressing his knees and legs against hers, causing her at first to be nervous and edgy . . ." In May 1975, he

invited his young patient to his farm, where he had sexual intercourse with her. She "became more depressed" and started taking Valium. Six months later, he told her he wanted to end the relationship, urging her to leave her parents' home and move into her own apartment, which she did. He then resumed having intercourse with her, in her apartment. In February 1976 the woman overdosed, whereupon he referred her to another psychiatrist. By March, he had stopped having sex with her.

The woman testified that the sexual relationship "had not been good and had affected her relationships with her family and with men, and that she had not had any good relationships since then . . . she had a lot of depression and anger." Two other psychiatrists, testifying in defence of the accused, claimed he suffered from a "bi-polar affective disorder," was "depressed" and "burned out," and had been in therapy for the last ten years.

The Discipline Committee noted that the "illicit sexual relationship" the psychiatrist had had with his patient had "undermined" the therapy.

It further concluded that he was guilty of professional misconduct for "sexual impropriety" and of failing to maintain professional standards. His licence to practise was revoked for one year. He has appealed the College's decision to the Divisional Court.

These two cases are only the tip of the iceberg—many other psychiatrists sexually abusing their patients are never charged or punished. (See "Psychiatric Malpractice," Vol. 5 No. 1 and "Two psychiatrists penalized for sexual misconduct," Vol. 5 No. 2-3.)

Minimum Wage for Disabled

Last May, Ontario Labour Minister William Wrye announced in the legislature that disabled people working in sheltered workshops and "other rehabilitation settings" should be paid the minimum wage. Currently these people, some of whom are psychiatric inmates and ex-inmates, make as little as 25 or 50 cents per hour. Section 24 of the *Employment Standards Act* legalizes this economic exploitation of disabled people, thus violating the *Canadian Charter of Rights and Freedoms*. Wrye said the government plans to repeal Section 24.

Although this is good news, we doubt that all people in sheltered workshops will in fact be paid minimum wage. The government will probably rule that people being assessed or trained in workshops and rehabilitation programs should be paid less, regardless of the work they do.

We urge our readers to write to *The Honourable William Wrye, Ministry of Labour, 400 University Avenue, Toronto, ON M7A 1T7* or phone (416) 965-4101, specifying that *everyone* working in sheltered workshops and rehabilitation programs in Ontario should be paid not less than the minimum wage. We'd also appreciate receiving a copy of your letter, if you write. Thank you.

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US Courts Restrict Forced Drugging

Two high-level court decisions, one in New York State, the other in Arizona, limit the right of institutions to forcibly administer psychiatric drugs to inmates. But both contain loopholes that still permit forced drugging under some circumstances.

The New York case came before the state's highest court as the result of a suit launched by three inmates who had been forcibly drugged at Harlem Valley Psychiatric Centre. The unanimous decision, brought down in June 1986, supports the right of involuntary patients to refuse neuroleptic ("anti-psychotic") drugs, but does not address the issue of forcible administration of other mind-disabling drugs, such as lithium and the anti-depressants. As well, inmates can still be drugged against their will if a judge rules that they are incompetent (unable to make treatment decisions), and/or dangerous to themselves or others.

The Arizona decision came about as the result of a suit brought by Larry Wayne Large, who had been sentenced to seven years for burglary and theft, and was later diagnosed as suffering from "schizoaffective paranoid behaviour" and forcibly drugged with Navane, Thorazine, Cogentin, Symmetrel, Artane and Benadryl. Large was initially refused a hearing on whether his right to due process had been violated, but was able to persuade a higher court to allow him to challenge that refusal.

The majority of the Arizona Supreme Court ruled that the lower court had to grant Large his hearing under the guidelines that "forcible

medication with dangerous drugs should be limited to specific emergencies under procedural safeguards" or as part of a "treatment plan." One of the justices, saying the majority opinion didn't go far enough, declared that prisoners ought to have "the absolute right to refuse the forcible administration of dangerous drugs as a form of treatment."

Only four states in the US require a "separate judicial hearing" allowing forced treatment: New York, Massachusetts, Oklahoma and Colorado. In Canada, no such hearing is required, although some provinces, such as Ontario, require a hearing by a review board (whose decision can be appealed to a district court) when an inmate refuses drugs, electroshock or other "treatment." (See Vol. 5 No. 2-3.)

The two US decisions are significant in that the court system is recognizing that routinely used psychiatric drugs are dangerous.

Lethal Sedative

A new benzodiazepine called Midazolam (manufactured by Roche) is being sold in the US as a sedative for "short diagnostic or endoscopic procedures, sedation before general anesthesia . . . and as the hypnotic drug in balanced anesthesia regimens."

Midazolam's adverse effects include hypotension (low blood pressure), anterograde amnesia (loss of memory of events occurring shortly after being injected with the drug), and difficulty in, or stoppage of, breathing! Be warned.

Pill-pushing Doc

Adam Gawenda, an Ontario doctor from Windsor, has been found guilty of "professional misconduct," in particular for overprescribing minor tranquillizers and sleeping pills, as a result of which many of his patients became addicted. According to the June 1986 *Interim Report* of the College of Physicians and Surgeons of Ontario, the College's Discipline Committee heard strong evidence to support charges of failure to maintain medical records and failure to maintain professional standards.

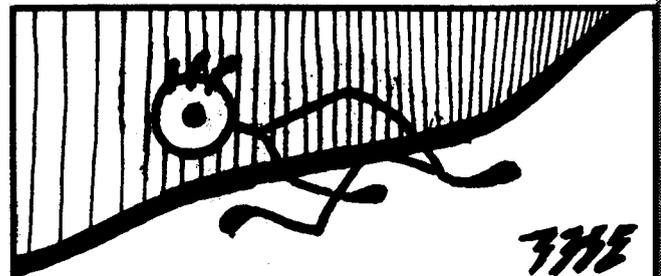
In 1983, a College inspector had found Gawenda to be in a "dishevelled state," his office filthy. In November of that year, Gawenda told the College that he planned to retire, and "voluntarily surrendered his prescribing and purchasing privileges for all types of narcotic and controlled drugs." But he continued to write prescriptions.

The Registrar warned him that he could face serious charges. The College Inspector was sent to Gawenda's office again in February 1984. It was still filthy, and the graffiti on the walls in-

cluded such phrases as "Downs & Ups Clinic," "This guy is a quack" and "Roamin' Hands."

The inspector paid Gawenda a third visit in February 1985, found that he had failed to take any corrective action, and seized some of his records. The Discipline Committee found that Gawenda had prescribed large quantities of Valium, Halcion, Zoroxalon, Neuleptil, Flurazepan, Oxazepam and Placidyl during a six-month period, and that office visits were too frequent, "varying from one . . . to as many as six . . . per month. It was apparent that these patients had developed a dependence on one or more of the drugs . . ."

Finally, after two years of investigations, Gawenda's licence to practise was revoked. The College's long delay in charging and convicting Gawenda is inexcusable, but not surprising. For more evidence of psychiatric pill-pushing, see "A Story of Valium Addiction," Vol. 5 No. 1, and *Dr. Caligari's Psychiatric Drugs* (NAPA, 1984).



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Drug Info

To Dr. A. J. Liston
Assistant Deputy Minister
Health Protection Branch
Health and Welfare Canada
Ottawa, Ontario K1A 0L2

In supporting the request made by *Phoenix Rising* (Volume 5, No. 4, p. 45) that your department "prepare and distribute a consumer-oriented statement about tardive dyskinesia and the neuroleptic drugs—for all Canadians," we would suggest the following addendum:

That all Canadians be perceived to include all prisoners detained at every level of incarceration, provincial and federal. And furthermore, that the responsibility rest solely with the respective administrations to ensure that those who are unable to read and/or comprehend the statement have it fully explained to them, in the presence of a friend, relative or accountably-concerned third party.

We insist on this procedure on the basis of our considerable experience with the manner in which the physical and psychological needs of prisoners, young and old, are cruelly exploited.

We look forward to your response to this request.

Claire Culhane
for: Prisoners' Rights Group
(PRG)
Vancouver, BC

Liston replied that the Health Protection Branch has "gone on record as supporting the voluntary programs instituted by the Canadian Pharmaceutical Association in developing Supplementary Medications (SIMs) . . . patient information handouts on drugs which can be most useful in providing basic information to the consumer," and that one of these would deal with neuroleptics.

He also referred Culhane's letter to Rheal J. LeBlanc,

Commissioner of Correctional Service Canada, who wrote that inmates in prison health care centres also have access to SIMs, and that "every patient should receive information about the medications he is taking; however the depth of information that would benefit the patient and not hinder his therapy must be left to the judgement of the physician." LeBlanc added: "We concur that Canadian citizens including the prison population have the right to adequate counselling about the medications they are receiving."

Brain Damage Epidemic

Brain damage caused by neuroleptics or "major tranquilizers" was discussed at a July 1986 meeting of the World Mental Health Congress in Brighton, England. Clinical psychologist David Hill asserted that over 25 million people have already suffered irreversible brain damage, including tardive dyskinesia (TD), due to these drugs. He urged that governments force multinational drug manufacturers to take such drugs as Thorazine and

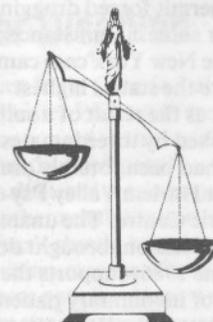
Stelazine off the market. Psychiatrist Farrukh Hussain added, "It is criminal not to tell patients of the risks. Informed consent is a must. We should give honest, clear advice."

But most psychiatrists and other doctors still don't fully inform patients about TD and other serious drug risks. Moreover, the inherent coerciveness of psychiatric wards makes true "informed consent" impossible.

What is CLAIR?

The Canadian Legal Advocacy, Information and Research Association of the Disabled (CLAIR) is a national voluntary organization established in 1982. As the name implies, CLAIR supports advocacy, provides information and promotes research on legal issues of importance to disabled Canadians.

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MAD NEWS



Yvonne Marie

Justice for the Allan Memorial Victims

by Kali Grower

For two years now, members of the Ontario Coalition to Stop Electroshock have been writing to the Prime Minister and to Health and Justice Ministers to ask for reparations for the victims of brainwashing experiments conducted at Montreal's Allan Memorial Hospital in the fifties and sixties. (See "A Psychiatric Holocaust," Vol. 6 No. 1.) No one has had the guts to take legal, moral or financial responsibility for the torture inflicted on these people. In fact, the Canadian government has done everything in its power to cover its ass and sabotage the victims' efforts to get reparations

from the United States government, including withholding information and setting up an investigation that was anything but impartial. (See "The Cooper Report—Another Government Whitewash," Vol. 6 No. 2). Angry Coalition members organized a protest demonstration on Parliament Hill in Ottawa last October 6. Our demands were:

- that the Canadian government release to the victims all the incriminating evidence it has against the CIA;
- that the Canadian and United States governments publicly acknowledge their legal and moral responsibilities to these victims; and

- that the Canadian and United States governments immediately offer these victims reparations for their permanent damage and suffering.

The organizing committee agreed that the focus of the demo would be entirely on the Allan Memorial victims, who had requested that they not be used as a platform for our own antipsychiatry views. This wasn't easy; some people were involved precisely because of personal experiences at the hands of psychiatrists, which led them to identify with the victims. But it was this decision that persuaded NDP MP David Orlikow (whose wife, Velma,

is one of the victims) to acknowledge our letters and join us at the protest. The protest received letters of support from across Canada; statements came from the victims, self-help groups, political action groups, politicians, journalists, the victims' lawyer and concerned citizens.

NDP MP Dan Heap organized a press conference for us in the Parliament Buildings, which, unfortunately, was poorly attended. The demo itself, however, received considerable press coverage, particularly when Don Weitz gave a stirring speech in front of the US Embassy, while the RCMP tried in vain to kick us off the sidewalk. NDP Justice Critic Svend Robinson drew reporters to the action on the Hill. He promised to raise the issue of reparations in the House. It was a good demo: we generated some publicity and support for the victims' demand for justice.

News from the Front

Judi Chamberlin of the Mental Patients' Liberation Front (MPLF) in Massachusetts would like us to tell you about a booklet called *The Psychiatric Patient's Right to Informed Consent—What You Should Know About Psychotropic Drugs*, compiled by the MPLF's Action Committee. The booklet is available free of charge to inmates, and to others for \$1.50 (US). A new edition of *Your Rights as a Mental Patient in Massachusetts* will also be available soon. Chamberlin explains that "both these handbooks are

specifically keyed to conditions in Massachusetts . . . however, people might be interested in them for the factual information, and as models for similar handbooks in other areas." Write to: *Mental Patients' Liberation Front, Box 514, Cambridge, MA 02238.*

Electronic Surveillance

The Toronto branch of the John Howard Society recently proposed the use of electronic leashes to keep track of federal penitentiary parolees who may soon be under its care. As a condition of parole, an inmate would be required to wear a bracelet that would emit an electronic signal. An alarm would sound at a central location if the parolee strayed beyond a designated area.

The use of these Orwellian tracking devices is not limited to prison inmates. In the fall of 1985, St. Thomas Psychiatric Hospital used the leashes in a pilot project to explore electronic surveillance of psychiatric inmates. Marc Industries, a Mississauga, Ontario, company, supplied the equipment for the leashes. While St. Thomas soon decided against their use, Riverdale Chronic Care Hospital was using the bracelets as of November 1985.

The computer age promises to provide the state with the technology for ever-increasing social control.

NEWSFLASHES

Cowichan Valley Psychiatric League's newsletter, out of British Columbia, is available to anyone interested. Just

send one 34-cent stamp (Canadian) per issue to: *UP or DOWN, WE GET AROUND, 5834 Upland Avenue, Duncan, BC V9L 1L8; Attention: Bill Baker, Editor.*

Disabled Persons Working Together is offering three free programs: peer counseling, life skills, and training for interested disabled people who wish to teach life skills courses to others. For more information, or to register, contact Disabled Persons Working Together at 72 *Howard Park Avenue, Toronto, ON M6R 1V6* or call (416) 530-0537 during office hours.

In 1984, the Toronto City Council officially adopted all the major recommendations in a special task-force report on discharged psychiatric patients by psychologist Reva Gerstein. The *Gerstein Report* includes a recommendation to set up a crisis centre in the city. As of late 1986,

there has been *no* action on this recommendation.

"Penetang, by Reason of Insanity" is the title of an upcoming Man Alive program. If interested, tune in to CBC TV at 9:30 p.m. on January 14.

Feminist Paula Caplan is continuing her campaign against the American Psychiatric Association's inclusion of Self-defeating Personality Disorder and Premenstrual Syndrome in the latest revision of the Diagnostic and Statistical Manual (DSM-III-R). The APA now intends to include these new diagnoses in the main text, rather than putting them in the appendix, as originally planned.

Please write to *Phoenix Rising* for further information, or send letters of protest to *Carol Nadelson, M.D., President, American Psychiatric Association, 171 Harrison Avenue, Boston, MA 02111.*

Mental Law in Canada

A new Canadian book, Mental Law in Canada, by lawyers Harvey Savage and Carla McKague, will be published by Butterworth's early next year. The book critically discusses such basic issues as involuntary committal, competence, forced treatment, remedies, and future strategies in light of the Canadian Charter of Rights and Freedoms. Written in plain English, it will interest not only lawyers and law students, but also the psychiatrized and the general public. We will be reviewing Mental Law in Canada in an upcoming issue. Meanwhile we are pleased to publish these excerpts from the "Futures" chapter, with the authors' permission:

One of the most striking developments in North America in the last twenty years has been the emergence of articulate, informed, well-organized and radical groups of people who are, or have been called and treated as "mentally ill" . . . These groups are a strong force for the liberalization of mental health legislation. They are in many cases asking for . . .

the abolition of the psychiatric system. They see civil committal as an abomination . . . and argue that no one should be deprived of liberty unless he or she has committed a criminal offence . . . that the insanity defence should not be permitted by law, and that forcible treatment of anyone, competent or not, is a deprivation of rights.

Mental health legislation in Canada is improperly named. It could be more appropriately called . . . "legislation on the procedure for dealing with persons who are institutionalized" . . . There is another way to conceptualize "mental health" legislation. It could contain clear value statements—for example, that it is better to be out of an institution than in one and that institutionalization is to be resorted to only as a last choice. It could deal with the provision of preventive instead of . . . remedial services . . . independent crisis centres, affordable housing, employment training and counselling, group homes, and other . . . community supports.

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THE BOOKWORM TURNS

IN THE FORESTS OF THE NIGHT

by Stephen Martel

London: George Ronald
1961.

reviewed by Carla McKague

It may seem odd for *Phoenix Rising* to be reviewing a book written 25 years ago, and no longer in print (though available at the Toronto Public Library). We are doing so because the author is a member of ON OUR OWN and, more importantly, because the story is a fascinating one.

Its protagonist, Lieutenant Michael Gill, is a Canadian officer in the Second World War, who is wounded in combat in Italy. At first it appears that his injuries are only physical: a few flesh wounds, an infection and a fractured foot. But the foot does not heal properly and becomes more and more painful, and at the same time his mind seems to speed up and become unbelievably powerful. He feels he has found the answers to most of the world's problems, and demands a chance to pass them on before he dies. He becomes so agitated that he must be sedated, but even then sleeps only fifteen minutes after what a nurse calls "a shot to flatten a horse!"

He writes voluminously, in English and Italian. His psychiatrist

tells him that as a result of an infection in his leg he has "hyperactivity of the brain . . . Your mind is in a flash flood." He writes letters to all the world leaders and insists that they be sent out immediately by diplomatic pouch. One is to Churchill:

At present, I am incarcerated in our military hospital at Caserta, and I am unable to carry out vital plans both for the production of an invulnerable tank, and for the internal overthrow of the enemy in northern Italy. I know that if I could be free to direct these projects the war would end in a very few months, and perhaps a million lives would be saved . . .

Arrangements are made to take him to England by ship. During the voyage, he decides that the military discipline on board the ship is being overdone, and suggests that the other wounded soldiers being transported protest against it. He is moved to the "mental ward"—a cabin with three beds, the other two unoccupied. He raves about doctors, and is unable to remember doing so. He is sporadically angry and violent, and is beaten by orderlies and almost constantly drugged. He imagines he is on an experimental ship, where the patients are undergoing breeding experiments. He fantasizes—or is it fantasy?—being placed in a harness and lowered into the ocean, then hauled aboard to lie on the deck in the sun.

At the Liverpool hospital to which he is transferred, he undergoes insulin coma treatment. He continues to feel excruciating pain in his foot. But in the midst of his suffering, he is still able to make jokes. When the nurse comes to give him his injection of penicillin every three hours, he mutters, "These conscientious injectors!" He introduces himself to a fellow patient

from the Dental Corps with, "I'm in the Mental Corps, myself . . . formerly anti-tank."

When he finally begins to return to normality, he tries to make sense of his experience:

The region, the realm he had been in was acknowledged, unendurable. Only a few lunatics, a few tortured men, a few geniuses had entered there. In the normal world man dilutes reality. By the very weakness of his senses and the very littleness of his soul he shields himself from true reality, from the full potency of beauty and evil . . .

In the Forests of the Night is a moving and sensitive account based on Martel's own experience, and merits being re-issued and widely read.



JUDGE, JURY AND EXECUTIONER

by Huey Freeman

Urbana, IL: Talking
Leaves Publishing Co.
1986

reviewed by Ryan Scott

Judge, Jury and Executioner, a valuable addition to the field of antipsychiatry literature, tries to interweave a political analysis with a personal account of institutional psychiatry. Such an attempt creates a danger that the analysis will become muddled or the story academic and unbelievable. The author largely avoids these pitfalls by placing a well-defined character in a particular historical context.

Huey Freeman's first published novel (based on his own experiences as a psychiatric inmate) is the story of Gene Silver, a university student and anti-war activist who is taken to a psychiatric ward against his will. Set in Nixon's United States at the time of the Viet Nam war, it chronicles Gene's incarceration, first in the psych ward of a general hospital and then in a private institution.

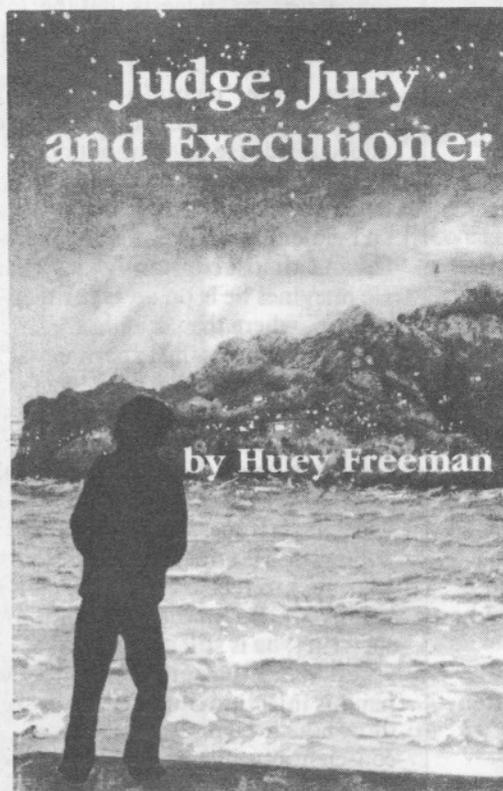
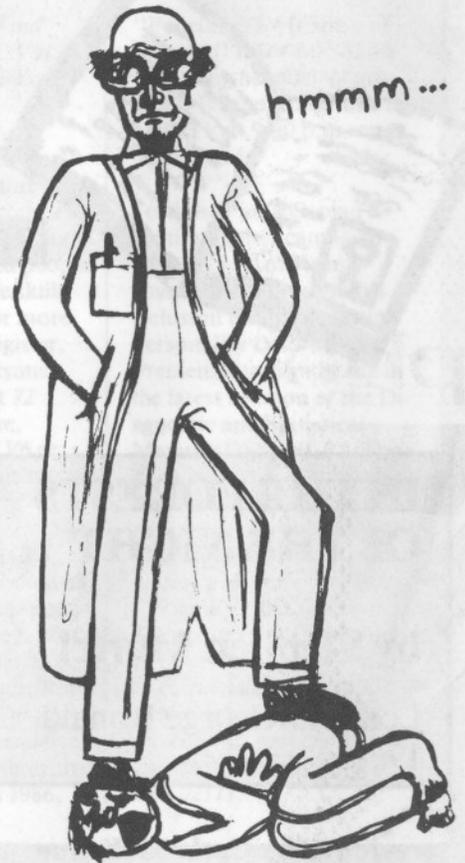
The novel's premise both excuses and explains its extreme self-consciousness. Knowing the context makes it believable that a first-time inmate, eighteen years old, has, from the start of his incarceration, an analysis of the institution of psychiatry as comparable to an oppressive state apparatus. Most of us do not become inmates with this kind of awareness.

However, Gene's political insight is coupled with a profound ignorance of the workings of psychiatry—a dangerous combination. As Gene discovers this strange new world, he attempts to defend himself against it. You find yourself wanting to warn him of the consequences of his self-defence. His rea-

soned and articulate protests are met with further treatment; in efforts to force his compliance, his captors use insulin coma, shock, restraints, isolation and massive doses of dangerous neuroleptic drugs. Gene's anger becomes less articulate but even more passionate.

Judge, Jury and Executioner affords us considerable insight into psychiatry as a form of social control. Its humourous, story-telling style makes the introduction of a political analysis relatively painless. With Gene, we come to understand how the institution creates the "mental patient." Normal human emotions are perceived as symptoms of illness. Protesting treatment/torture is another symptom, requiring further intervention. Human rights become privileges in the strange doublethink of a false generosity. Submission, or the appearance of submission, is the only way out of this upside-down world.

Judge, Jury and Executioner paints a distinct picture of institutional psychiatry, not as a science that is flawed in its application, but as one whose basic premise is invalid.



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My participation in the mental patients' liberation movement began at the 1975 conference in San Francisco. I walked into a room filled with 45 ex-psychiatric inmates. Upstairs in the same building, 200 proponents of radical therapy were discussing how crazy and frightening we were. While they rationalized the use of leather restraints and tried to out-Marxist each other, we huddled together and wept and spoke for hours about our pain and loneliness. My search for a better therapeutic model was over.

—Dianne Jennings Walker
(Vol. 1 No. 2: "Linking
Arms in San Francisco")