



phoenix Rising

THE VOICE OF THE PSYCHIATRIZED

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Fighting for our freedom

- Joyce Brown beats the Big (bad) Apple
- Report on inmates' rights in New Zealand
- Telling the truth – on US national television

Plus • a review of *The Nazi Doctors* • advice on drug withdrawal • lots of news • art by Kristine Starr Erglis • all our regular departments

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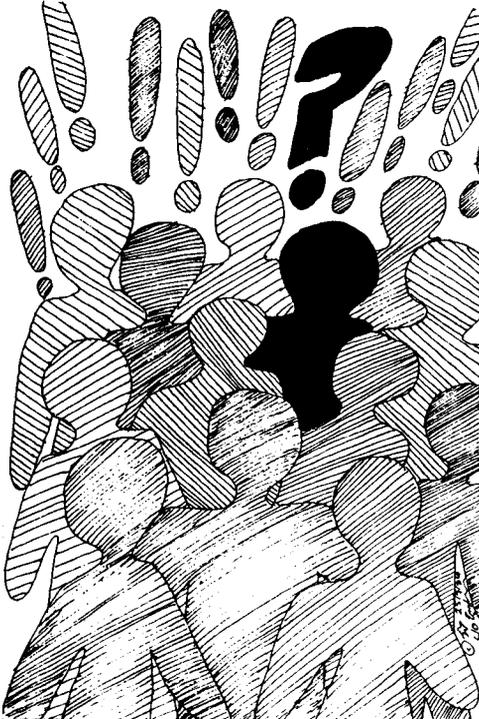
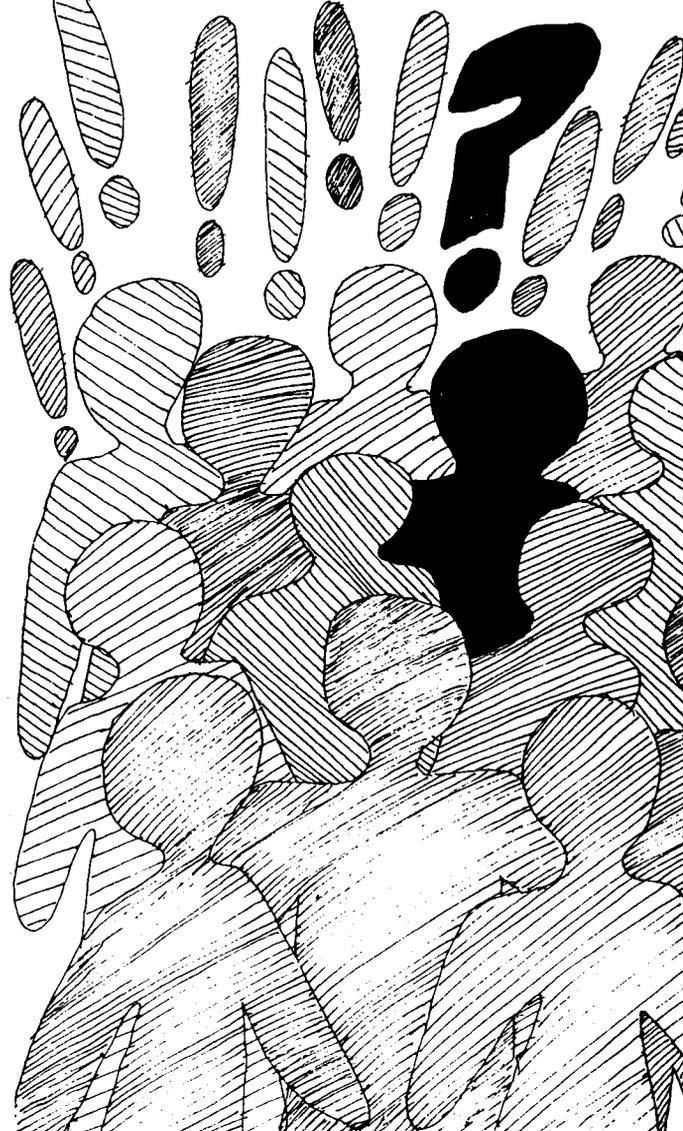
You may have noticed that we are not able to keep to a regular quarterly production schedule, and that the magazine has been thinner lately. This is the result of our extreme difficulty in getting funding on an issue-to-issue basis. It means that we have to put a lot of time and energy into applying for funding and, worse, that we never know until the last minute whether we have money to put out a given issue or not.

We can't go on this way forever. Please, if you (or someone you know) can help us out with a generous donation, send (or have them send) a cheque or money order to *Phoenix Rising*, Box 7251, Station A, Toronto, Ontario, M5W 1X9. Thank you.

Fighting for our freedom

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EDITORIAL

The psychiatric industry has hurt many of us and killed some of us. The industry has many weapons: the poisonous drugs known as "medications," the willful brain damage known as electroshock "therapy," the power to incarcerate people who have been convicted of no crime, the backing of the state (including the police force), misdiagnosis of physical problems, intimidation, humiliation, mystification, the pretence that psychiatry is a science.

Psychiatric inmates and ex-inmates can fight back by letting as many people as possible know what is done to us in psychiatric institutions and on psych wards in general hospitals. We who have survived psychiatry owe it to ourselves and others to join together and pool our strength. We owe it to ourselves and others to realize that the problems that landed us in the bin have nothing to do with the "chemical balance" in our brains – or with disease, or with our being weak or defective – and everything to do with the way our society is organized to keep people in their place.

In this issue of *Phoenix Rising*, Ryan Scott looks at New York City's Project Help – which allows mental health authorities to sweep homeless people off the street and out of sight into psychiatric institutions – and how one courageous woman, Joyce Brown, fought her way out of Bellevue (see story, Page 7). Lawyer John Dawson criticizes New Zealand's mental health legislation, pointing out that the main function of the Mental Health Act is to provide legal authority to detain and treat without consent (see story, Page 13). And Don Weitz tells the tale of how progressive psychiatrist Peter Breggin was threatened with losing his licence for revealing the dangers of psychiatric drugs on US national television (see story, Page 16).

The power of speaking out is not a very strong weapon with which to combat the arsenal psychiatry has at its disposal, but it's the best weapon we have. And if enough people talk about psychiatric abuse, maybe the guys who make the rules will be forced to listen. At worst, we can let other inmates know that there are alternatives to believing they are sick, or at fault for what has happened to them. At best, we can shake the very foundations of psychiatry.

Let's get together and give 'em hell.

We need to hear from you! Please send letters, stories, poems, artwork, reviews, and news articles related to your experience as a psychiatric inmate or ex-inmate to *Phoenix Rising*, Box 7251, Station A, Toronto, Ontario, M5W 1X9. We especially need to know about what's happening in psych wards and institutions, prisons, and "community mental health" organizations outside Toronto and Ontario, in the rest of Canada and in Quebec.



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False council at Oak Ridge

Since Oak Ridge received exposure and criticism of its "trustee" system, where patients are pitted against patients, a new, more secretive and protected "trustee" system has come into existence. In fact, the administration wants to entrench these dynamics by forming a clique of "trustees" who will be masqueraded as a "council" representing patients' concerns.

How are "trustees" used in the interim of ushering in a "council"? Most recently they were used to assist the hospital in whitewashing a complaint being investigated by an outside agency. A couple of patients (who enjoy privileges denied most others) were used to supply information to the investigating officer that

was damaging to the patient's complaint, and was primarily responsible for having the patient placed on the Management Ward.

Several patients who have been here for years have learned what kind of information is being looked for by the hospital once the "word is put out" that a particular patient is a problem. Who gets this treatment? Mostly patients who have raised complaints that are not easily dismissed and for which they are pursuing

redress. Especially where either particular staff members – or the hospital itself – might well be found guilty of the claim(s) brought against them.

A core of sophisticated set-up artists resides on the most privileged ward and has been involved in supplying information that is later used as "evidence" against the patient who has been singled out. And I do not speak of patients who inform on other patients about some truth they have witnessed, but of those who are concocting information which they know the hospital, or certain staff, to be looking for. These patients are known by certain senior management staff, and other staff, to act in collusion for purposes of presenting a "united" version of events.

Any patients who attempt to expose these dynamics are set upon by both the "trustees" and staff. Eventually, trumped-up reports are compiled and used to justify the patient being removed to a ward where he will be under several restrictions and deprivations, all designed to impede or block his efforts at raising legitimate complaints.

These "trustees" are relied upon because they need no prompting or cues to provide such assistance to the hospital.

When a patient who is perceptive enough to see these dynamics at work tries to question staff or doctors (whom he knows are being given false information), he is told the matter cannot be discussed – the staff or doctor says that he must protect the patient's right to confidentiality.

However, the staff does not "protect" this right to confidentiality when discussing information being



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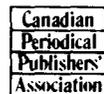
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put forward by patients against another patient.

This creates an ideal situation whereby the hospital can select and use only information that will assist them in supporting any false accusations and justifying the actions they already want to take with a patient. At the same time, the "trustees" are used as buffers to evidence (from the few not afraid to speak up) that an accusation of a patient is false.

Many of these "trustee patients" are willing participants in putting out misleading or false impressions to touring groups and even media. Most recently *Toronto Star* reporter Darcy Henton was here for a few days as a "patient." He was steered around a whole ward which houses many patients who have good grounds for complaint, while he received ample exposure to the "trustees" and the ward that has the most privileges. His "visit" here was known well in advance by the administration and staff, and ample preparations were made to ensure that he would be well "guided" during his days here.

The only complaints "allowed" to be heard – for which a patient won't meet repercussions, and for which he can likely even be favoured – are those that point out the physical defects of the building, or support a call for more staff to be hired.

Since the *Hucker Report* [see *Phoenix Rising*, Vol. 6 No. 2], more staff has been hired; the patient count has been cut down – and yet "short staff" continues to be the frequent justification for lock-ups. Recreational activities (often referred to in this place as "off-ward activities") are frequently cancelled due to "short staff."

The patients continue to be manipulated (some knowingly) to push complaints through the system that the hospital can claim can be resolved by hiring more staff and creating new facilities. It's funny how the hospital keeps needing more "offices." We have already seen the increased number of professional staff being used to build an impenetrable wall, which even the strongest of patients find awesome when trying to voice a concern or make legitimate complaints.

The system here is growing into a bureaucracy that can insulate itself from any complaint.

The patients are being held for ransom to force the government to supply the funds that will ultimately be used to provide the hospital with the means to accommodate itself even further.

There is already talk of locking the front of most wards in the near future "for security reasons." This is being proposed at a time when it has been recognized that the ward space is very confining, and while the same wards have had existing space cut off because offices are being made of certain cells and rooms.

In many ways, this administration is deliberately creating an environment that will become a pressure cooker, which they hope will eventually act as a catalyst for causing incidents and complaints that will then be used to further *their* interests.

Eldon Hardy

Oak Ridge
Penetanguishene, Ontario

Psychiatric insults

How does a psychiatrist judge a person's mental competency? On whether they know what the date is? What day of the week it is? How old they are? When their birthday is? What year they were born? These are some of the questions I've been asked by psychiatrists upon first meeting. It's a real insult.

I know I'm normal, competent, or whatever you want to call it. As a patient in a psychiatric hospital, I've come up against phrases such as, "No one likes to have to take medication, but look at diabetics. They have to take insulin for diabetes. If they don't, they'll die. If you don't get your Piportil needle for schizophrenia, you'll die."

Among the most cutting remarks I've heard from a psychiatrist are: "One of the hardest things for a patient to accept is that they need medication, that they really are mentally ill. You have to realize this about yourself before you can get better"; and "You have to let the medication work for you or it won't." It's such remarks that make me wonder

why I ever went to see a psychiatrist in the first place.

Darrell Surerus
Hamilton, Ontario

The corruptions system

The prison system is an extension of the court system. The court system is adversarial. Being incarcerated in a psychiatric prison is nothing but a punitive psychiatric (drug) treatment situation, the reality of which sees psychiatric nurses and forces working against patients or inmates and their rights. They use the inmates' and the public's belief in rehabilitation as a guarantee to ensure recidivism. The present corrections system is a corruptions system, which produces no rehabilitation.

The layout is one of constant coercion. There is much provocation to anger and aggression, which are then suppressed. Other constants in the repressive, close-quartered environment are discouragement, disturbance, condemnation and dictatorship. There is no encouragement, no comfort, no forgiveness and no compassion.

Stress and tension are always at very high levels in a psychiatric prison. Psychiatrists in prison are no better than Stalinists or fascists.

R.C. Kalichuck

Prairies Regional Psychiatric Prison
Saskatoon, Saskatchewan

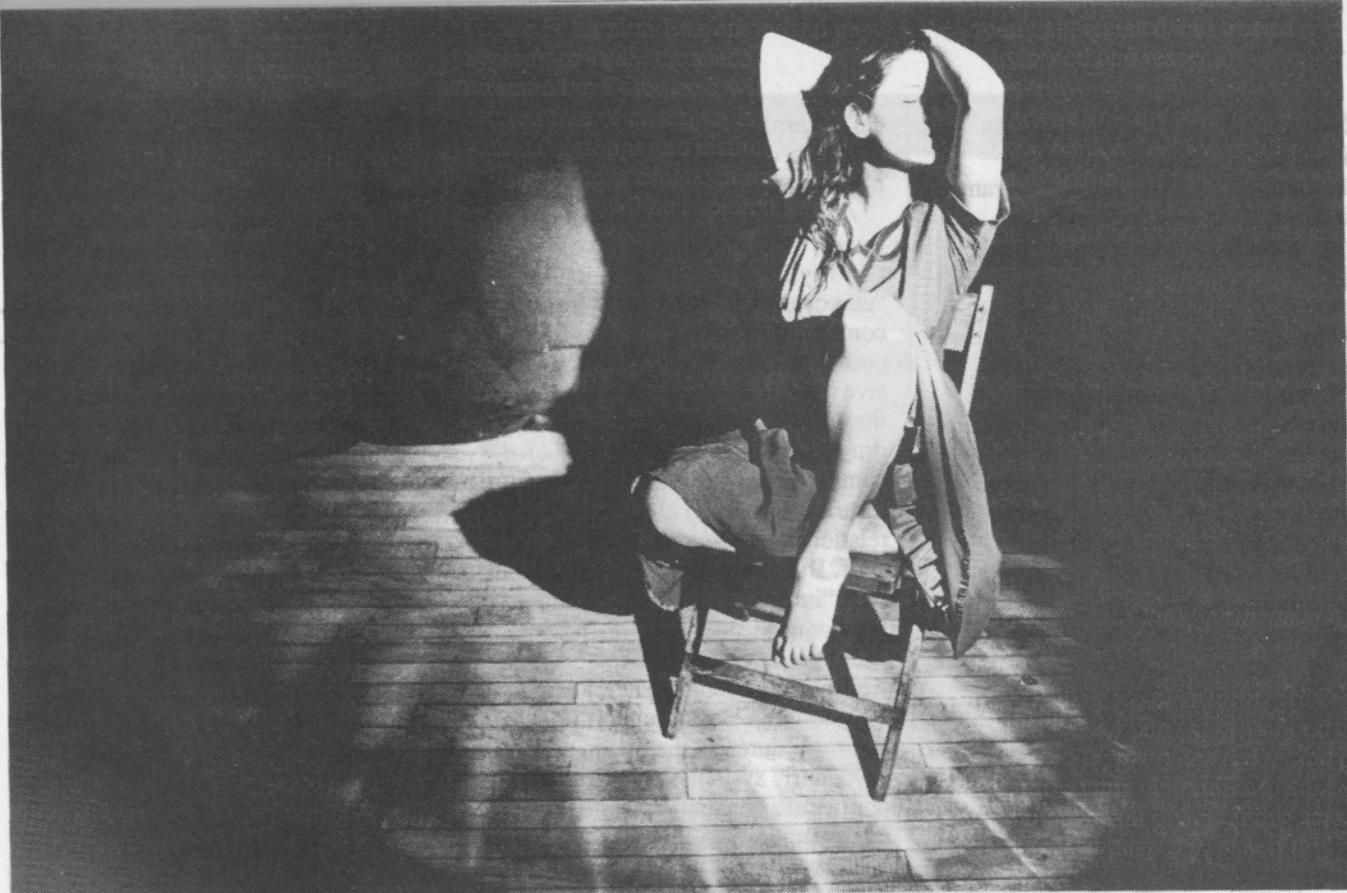
Forced medication in US women's prison

I want you to know that Prudy Correctional Center for Women also uses forced medication. There's one woman from LA who is forced to take Navane, and she is recovering from a stroke. If she doesn't take meds by mouth, she is injected with a double dose. The first three hours she tries to walk off the drug. She's a wonderful person, and a friend. I will worry about her when I parole. I have arranged for the American Civil Liberties Union to come in and check out the medications department here in this prison.

Sincerely,

Gwen Williams

Prudy Correctional Center for Women
Gig Harbor, Wisconsin, USA



"Can you tell me who the prime minister of England is? and of Canada? Do you know why they gave you electroshock therapy? Why don't you like to take your medications? Are we going to have to put you in the hospital? What did you mean when you told your doctor that you often feel far away or not part of the earth? How long

have you heard these voices? How long?"

The above photograph (by Konnie Reich) and accompanying text are from Mia Blackwell's work-in-progress, *Memoirs of Darkness and Light*, which was workshopped at Nightwood Theatre's Siren Soiree in Toronto in March 1988.

Memoirs of Darkness and Light

Like many of you I too have become a survivor; after many years in and out of mental institutions. I endured the usual bout of brain-numbing drugs, shock treatment, abuse, and isolation, because I heard things and saw things they couldn't. They call it schizophrenia; I call it an extra perception.

Ideas for my dancing and performance art used to stem from what I thought, but not really from what I know. I recently realized how incredibly powerful it was to perform what I know: all that I see and feel. This was my initial inspiration for the performance, for which I'm applying for an Explorations grant from the Canada Council, and a multi-disciplinary grant from the Ontario Arts Council.

Entitled *Memoirs of Darkness and Light*, this multi-disciplinary work will portray the experiences of women in institutions. It will explore these experiences and reflect the impressions of women from varying backgrounds and age groups. This very real illustration of the plight of women – the prejudices against the poor, elderly and ethnic – will focus on their isolation, deprivation, and forced treatment, and their abilities to overcome and rise above these predicaments.

The result of this research will be a piece to be presented at the 1988 Fringe Festival in Edmonton, and in September 1988, the piece will be presented in Toronto. It will also be offered free of charge to interested women's groups and institutions.

This piece is unique in that these experiences will be explored so com-

prehensively. It will utilize a multi-media approach and will involve dance, drama, visual arts and writings, as well as a multi-layered sound track including the exploratory work of various musicians.

I am presently doing the research for this performance, and am very interested in meeting and talking to other women who have been institutionalized and who would be willing to share any stories, writings, drawings, or just their experiences while they were in the institutions and now that they are hopefully out and liberated. Any contributions would be greatly appreciated and treated with discretion and respect.

Yours truly,
Mia Blackwell
Box 5153, Station "A"
Toronto, Ontario
M5W 1N5

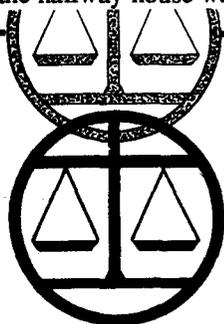
Sweeping us off the streets

I don't know how much you've heard about Mayor Koch's program in New York City, but I thought you'd be interested in a copy of the judge's decision in the Joyce Brown case (see story, Page 7). I don't know what it's like now, but it was so gestapo-like in the beginning of November, when vans with psychiatrists and social workers were cruising the streets with lists of ex-mental patients who, if found homeless on the streets, could be taken to an institution against their will.

In love and struggle,
Elizabeth Stone
Boston, Massachusetts, USA

Are we part of the problem?

This fall I was pleased to become a member of the Board of My Brother's Place. If I take Irit Shimrat's article ("Big Brother's Place?" [*Phoenix Rising*, Vol. 7 No. 1]) to heart, I should reconsider. According to her "Investigation of a mass exodus," the halfway house was a "radi-



Most of us cannot fight back individually against assaults on our basic rights and freedoms. We need organizations to fight for us. That is why concerned Canadians have set up civil liberties and human rights associations across Canada. If you think your rights or liberties have been violated and you need advice and assistance, contact the Canadian Rights and Liberties Federation at 323 Chapel Street, Ottawa, Ontario, K1N 7Z2 or at (613) 235-8978.

cal" alternative, but is well on its way to becoming an Orwellian nightmare.

According to her treatment of the issues, in its first two years of operation My Brother's Place stood for "empowerment." Politically-oriented counselling sessions considered the politics of incarceration, the oppressive aspects of psychiatric labels, and the dangerousness of psychiatric drugs. Gay men were supported for coming out of the closet. Serious efforts were made to create equal relationships between residents and staff. But today, if one goes by Shimrat's "investigation," all that has gone amuck.

Honest attempts at mutual responsibility have become paternalism. The staff and Board support policies and procedures of the prison and psychiatric systems. Their sexual politics are conventional and homophobic. The Board is seen as anti-Semitic and racist toward Natives.

How this transformation came about is not explained. If this is what has actually happened, people interested in the halfway house deserve a carefully considered examination of the problems by a critical outsider, a role *Phoenix Rising* is in an excellent position to fulfill. But instead of insight we get fatuousness. For example, "If you scratch a liberal, you'll find a fascist ..."

It is more than disappointing to see an article coming out in a journal dedicated to the struggle against a system which uses psychiatric labels to oppress people indiscriminately using such loaded terms as fascist and Big Brother. Shimrat has a responsibility to be very clear what exactly she intends to accomplish by including them (even as quotations), why the editor chose to highlight them, and why these terms were needed instead of others.

But the unrestrained use of such labels is not the only problem with this investigation. It is hopelessly naive. Are we to believe that a "radical" halfway house can be funded by the Ontario Minister of Corrections and Correctional Services Canada without serious confrontations? Does it make sense that My Brother's

Place, which is obligated by law to establish a Board and function within the policies of these ministries concerning the operation of halfway houses, is going to espouse radical political action without difficulties? Shouldn't we expect factionalism, disillusionment, and the rise of conservative if not reactionary ideologies among Board members and staff? And are we still so naive as to forget the often conservative (if not outright reactionary) ideologies of the residents?

Anyone who thinks otherwise would benefit from studying the history of radical movements in North America. S/he could begin by looking at how the Mulroney government has co-opted the arguments of the radical feminist position on pornography to justify oppressive censorship legislation.

I suspect, and I can only speculate because the "investigation" does not provide the much needed insights, that My Brother's Place had a Board that was always more or less divided on the specific issues mentioned in the article. Individuals on the Board and persons hired by the director(s), and undoubtedly the directors themselves, had ideas concerning the operation of a "radical" alternative but found it difficult to turn theory into practice. Is that so unusual?

We would benefit more from learning in less passionate terms (but with no less commitment) how these difficulties developed. As a new member of the Board I would welcome some concrete suggestions about how these difficulties can be overcome in the future. This is called *praxis*: ideas and opinions informing every day practice and these experiences serving the crucial role of furthering our efforts to bring about the kind of fundamental social changes that will encourage efforts like My Brother's Place, instead of impeding them at every turn. It is quite unfortunate that the "investigation" published in *Phoenix Rising* missed the opportunity to be part of this *praxis* and instead became part of the problem.

Sincerely,
Howard Davidson
Toronto, Ontario



Ryan Scott looks at how New York authorities define homelessness as a disease, and why they picked on the wrong person when they locked up Joyce Brown

New York mayor Ed Koch has an obsession. It has driven him from his gracious home on Manhattan's Upper East Side out into the streets of New York. It has forced him into the courts, into Bellevue, and finally into the nation's press in an effort to explain himself. What is Mayor Koch's obsession? It isn't fancy cars, loose women or expensive drugs. Koch is obsessed with forcibly hospitalizing and drugging Joyce Brown.

In October 1987, Joyce Brown was also a resident of the exclusive Upper East Side, not a mile from Mayor Koch's dwelling. The 40-year-old former secretary had lived for more than a year on Second Avenue near 65th Street. Her zip code was 10021; she lived in what is said to be

the most affluent postal district in the United States. What was surprising, in this rich white neighbourhood, is that Joyce Brown is Black, and doesn't have a job.

How could an unemployed Black woman take up residence in a neighbourhood where you can spend \$450 a month to have your car parked? Brown lived near a hot air vent in front of Swensen's Restaurant and Ice Cream Parlour, and panhandled money for food. She was one of New York City's estimated 30,000 homeless.

Mayor Koch is the author of Project Help, whose aim is to hospitalize and drug homeless people who are thought to be mentally ill. Under Project Help, little teams of mental health professionals – each composed

of a nurse, a social worker, and a psychiatrist – go out into the streets to ferret out homeless crazies. They go armed with sandwiches and clothing and thick blankets of social work theory. A homeless person who refuses the sandwiches and clothing can be tightly wrapped in the theory and bundled off to the nearest locked ward.

Originally, a person could only be committed under Project Help's guidelines if she or he posed an immediate threat to self or others. This gave the project considerable power, but nothing like the sweeping power it acquired in the fall of 1987, when Koch changed the rules.

After Brown was observed using the sidewalk as a toilet, Koch and his advisors expanded the committal

YOU DON'T HAVE TO BE CRAZY TO WIND UP IN BELLEVUE. PARTICULARLY IF YOU'RE HOMELESS

- 1) You don't have to be crazy to have no place to live in New York City -- especially if you're poor.
- 2) Shelters generally are dangerous and degrading places. You don't have to be crazy to prefer the sidewalks, the subways, or anywhere else you can find.
- 3) You don't have to be crazy to be diagnosed "mentally ill." If you're too angry, upset, unkept, unhappy, unrestrained, different, or--above all--difficult, it's easy to get a psychiatric label. Especially if you're not a middle class adult wage earner, and especially if you're homeless.
- 4) You don't have to be crazy not to want to go to an institution like Bellevue or Creedmoor. Psychiatric wards are rigid, dehumanizing and harmful environments which serve to suppress troubled or troublesome people. They foster dependency, undermine competence, and turn human beings into "the chronic mentally ill." Psychiatric treatment... You don't have to be crazy not to want psychiatric haldol disable and harm body and mind. Effects include shaking, drooling, stupor, muscle spasms, exhaustion, blurred vision, liver damage--and, sometimes, permanent brain damage or sudden death.
- 5) Homelessness is not a state of mind. The current expansion of psychiatrists' power to incarcerate nonviolent evidently competent persons (such as Joyce Brown) is a perversion of justice and a subversion of the bill of rights. Would you trust your liberty to Mayor Koch and the mental health professionals? The roundup of so-called "gravely disabled" homeless people is a cosmetic sideshow which scapegoats victims of destructive housing and welfare policies. It fails to address the unavailability of low income housing and genuine care for people who want it.

If you are or have been homeless, confined in a psychiatric facility, or simply distrust psychiatrists and are concerned about their power, consider joining us in mobilizing against the roundup.

**FOR INFORMATION CALL:
PROJECT RELEASE/ACTIVISTS FOR
ALTERNATIVES at: (212)799-9026**

Project Release/Activists for Alternatives: Box 20651, Columbus Circle, New York, New York, 10023, USA

criteria. Instead of just people who might be considered an immediate threat, they agreed to commit those who the teams decided could be a threat in the "foreseeable future."

Joyce Brown became the first victim of Project Help under its new guidelines. On October 28, 1987, New York City mental health authorities committed her, against her will, to a special psychiatric ward at Bellevue Hospital. She was immediately medicated with Haldol (a neuroleptic, or "anti-psychotic," drug) and Atavin (a "minor tranquilizer").

Even after her abduction and forced drugging, Brown still had it together to call the New York Civil Liberties Union (NYCLU) for legal help. Executive director Norman Siegal and attorney Raul Levy responded. They teamed up with attorney Eric Friedberg to try to win Brown's release. A special courtroom was set up in Bellevue and the case was argued before Judge Robert D. Lippmann of the State Supreme Court (as the trial court is called in New York).

Five city psychiatrists who had examined Brown shortly after her admission to Bellevue stated that she suffered from schizophrenia - paranoid type. They said she was delusional, suicidal, incapable of insight, and incompetent to make decisions. In their judgement, she was incapable of caring for herself and should not be allowed to return to the streets.

The psychiatrists cited as suicidal behaviour Brown's running into traffic and saying that she had a right to do this if she so wished. They decided she was delusional because she tore up or burned paper money offered to her and used the "street names" Billy Boggs and Anne Smith. Part of the basis for the diagnosis of paranoid schizophrenia was Brown's "hostility, aggressiveness and abusive language."

The NYCLU brought in its own psychiatrists, whose diagnosis was completely at odds with that of the city's shrinks. Dr. Robert Gould tes-

tified that Brown was not delusional or psychotic. He found her "warm, coherent, and logical." He found her memory for recent and remote events good, and said she knew right from wrong. He emphasized that she had never been hurt in traffic and so was not suicidal and, in fact, had strong survival instincts. When asked to predict whether Brown was likely to harm herself or others, the NYCLU



Mayor Koch: We're doing exactly what her family would do for her, but in this case her family happens to be the city of New York.

Joyce Brown: It's my choice, my life and my body, and I'll live as I see fit.

psychiatrists said that she wasn't.

As the psychiatrists didn't agree, Judge Lippmann made a very unusual decision. He decided not to listen to them, and instead to listen to Joyce Brown. He placed great weight on her demeanour, behaviour, and tes-

timony.

On the stand, Brown gave her own explanation of the conduct upon which the Bellevue psychiatrists had based their diagnosis. She explained that she used a false name in order to elude her sisters, who were looking for her, and had had her locked up in 1985.

Brown, who panhandled for money for food, had two explanations for destroying money. She only needed seven dollars a day to eat, and never kept more than that because she could be mugged. And if people balled up money and threw it at her, she would destroy it. She pointed out that it was not her job to "make people feel good" by accepting their scornful charity, and said that whether or not she burned the money "depended on the manner in which they gave it to me."

She explained "using the pavement as a toilet," as the result of not having access to a bathroom. Restaurants refused to let her use their bathrooms, even if she offered to buy something.

According to Joyce Brown, if she was crazy, Project Help had driven her crazy. She was taken in handcuffs to Metropolitan Hospital several times. They harassed her for months, keeping her under surveillance and sending people over to talk to her and pretend they wanted to be her friends.

It was only when they refused to leave her alone that Brown resorted to chasing them off and using "obscene" language. One day, she threw the pants they had given her into the street. This is the incident referred to by the hospital psychiatrists when they said she ran into moving traffic.

Lippmann noted that Brown "displayed a sense of humour, pride, a fierce independence of spirit, quick mental reflexes. She has, by her account, developed the needed skills for surviving on the street and it is evident she does not want her condition of homelessness to be treated or viewed as a target for insults, pity or condescension by the

rest of society into whose conventional pattern of living she does not fit."

The trial court accepted the NYCLU's claim that Brown's homelessness was caused by New York's lack of affordable housing, rather than by mental illness. The court also noted that Brown had the ability to provide for herself the necessities of food, clothing, and shelter. Although she was too poor to have good clothes or housing, she entered Bellevue in good physical condition, a fact observed by Lippmann: "Though homeless, she copes, she is fit, she survives."

Brown told Lippmann that she wanted to return to the street, although she would accept a nice apartment in a good neighborhood. Lippmann's decision was that Brown did not have a mental illness likely to result in serious harm to herself or others, and so did not meet the committal requirements under current mental health legislation. He ordered her released from Bellevue on November 12, 1987.

Koch was upset. He did not like the light in which Project Help had been painted. The NYCLU had argued that the project was motivated not, as Koch claimed, by compassion, but by the desire to put the unsightly out of sight.

The City appealed to the Appellate Division of the State Supreme Court, while Brown remained at Bellevue. The appeals court said that Lippmann had put too much weight on Brown's testimony. It rejected his findings of fact in the case, and looked instead at the testimony of psychiatrists and of passersby on the street, who had observed Brown, and whose word was seen to be more credible than her own.

On December 18, 1987, a majority of three found that Brown was indeed mentally ill. The psychiatrists' opinion that Brown could possibly assault someone in the future was deemed reasonable grounds for keeping her locked up. The minority (of two) dissented sharply, noting that New York's laws

for committal require "clear and convincing evidence that there is a real and present threat that that individual poses a substantial risk of harm to herself or others ... a claim that there is the possibility of future assault is too speculative and remote." The minority pointed out that there had been no instance of Brown harming herself or others, and that she had survived on the street for some time.

to court to force her to take Haldol. The February 2, 1988 *Village Voice* reported that "Maevie Mahon, the doctor testifying for the city, insisted with a fixed smile that Brown should be forced to take 10 milligrams of Haldol three times a day. Medication, not psychotherapy, is the treatment of choice, she told the judge, adding that to her knowledge every mental patient at Bellevue is medicated.

Brown's condition could improve with Haldol, Mahon explained, giving her "a new way to see the world."

Robert Gould, however, testified for the NYCLU that this dosage of Haldol would "knock her out pretty strongly."

Again it was Brown's own testimony that impressed the judge: "I am homeless. I am not insane. It's time to cease with this Bellevue psych game and let me get on with my life."

Appellate Judge Irving Kirshenbaum ruled that the city could not medicate Brown against her will. The Bellevue shrinks responded that, if they couldn't drug her, they didn't want to keep her. Brown was released on January 19, 1988. She agreed to live at a hotel for formerly homeless women, located near Times Square.

Since her release from Bellevue, Brown has been the focus of much media attention. On January 24, she appeared on the TV show *60 Minutes* to discuss Project Help with Mayor Koch. Koch still refused to accept the fact that Brown is not insane, and continued to refer to the Project staff as "saints" because they were prepared to go within ten feet of the homeless.

According to the *Voice*, Koch appeared before a Congressional Task Force and attacked advocates for the homeless, claiming that they were attempting to bring down the social service system — conspiring in "a plot" that Koch said he didn't understand. It is becoming painfully obvious who could do with a few dozen milligrams of Haldol.

Mayor Koch: If you mentioned to her, won't you come to a shelter, she would become enraged. And therefore, you must never use that word.

Judge Lippmann: She refuses to be housed in a shelter. That may reveal more about conditions in shelters than about Joyce Brown's mental state. It might, in fact, prove that she's quite sane.

Joyce Brown: More shelters will not do it. We need real housing.

Because the majority did not apply the state's committal standard, the NYCLU appealed the decision to the New York State Court of Appeals — the state's highest court.

Brown remained in Bellevue, but refused all medication. The city went



Channel 5 anchor John Roland berates Joyce Brown. Photograph reproduced from the *Village Voice*

Another person who could use a little something is Channel 5 anchor John Roland. During an interview with Brown, he became incensed when she refused to say that she was crazy. Roland lost it on the air, wagging his finger at Brown and calling her a "disaster." He became even more angry when he couldn't get Brown to admit that she was a better person since her stay at Bellevue. ("I made sense before," Brown told him. "No you didn't, sweetheart," Roland replied.) Roland was temporarily suspended for unprofessional behaviour.

Koch was taken by surprise by Brown's rebelliousness and impudence. Apparently, he can't accept the fact that a poor, homeless Black woman

is asserting her constitutional right to control her own body and life. What particularly upsets him is that she had the gall to refuse his offer of help – a bed in a locked ward and enough drugs to make her forget that the housing crisis is the result of real

Richard Surles, New York State's new mental health commissioner, "proposes to alter mental health care delivery in a bold way that would make it harder for the system to lose the Joyce Browns." According to the January 25, 1988 *New York Times*, Surles would like to create a corp of "case managers" to seek out desperate "patients" wandering the streets, follow them, persuade them to come in for "treatment," and make sure they take medication. Each case manager could draw upon \$4,000 per year per "client" in state funds.

Meanwhile, the NYCLU has its own project to help resist the Project Help teams: lawyers go out among the homeless handing out flyers advising people of their rights.

estate speculation and destructive welfare and housing policies.

We wish Joyce Brown all the best in her new home. We congratulate her on her humour, pride, and spirit. Her story has proven once again that hell hath no fury like a liberal scorned; we hope that she continues to elude the helping professions and the officials who empower them.

If you would like to order a transcript of the 60 Minutes show on which Brown debated Koch, make out cheque or money order for \$3 (US) to 60 Minutes, and send to 60 Minutes Transcripts, Journal Graphics Inc., 267 Broadway, New York, New York, 10007, USA. Specify that you want the transcript of Brown vs

Koch, from the January 24, 1988 program.

psychiatry

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DENDRON

monthly news Issue # 2 February 1988 one dollar

• dissident psychiatrists!
• women: what is your ideal healing place?



The Cape Mountain Zebra is in danger of extinction because of destruction by the white settlers in South Africa. Dendron spotlights another rare species - psychiatry.

exclusive Dendron interview: r.d. laing

"Now suppose I didn't have money for this apartment. Suppose I didn't have friends to help me, I could be on the streets. ANYONE can be."

Dendron editor David Oaks spoke by phone with R.D. Laing on January 25, 1988, during his stay in San Francisco. Dr. Laing was born in Glasgow, Scotland. He graduated in medicine from Glasgow University in 1955, and is the author of more than a dozen books. His most recent: *Widom, Madness & Folly* (McGraw, 1985).

Question: What are your current plans?
R.D. Laing: I'll be back to Scotland at the end of the month. I don't intend to take up any practice - I'll just be reading & writing.
Q: Have you had much contact with ex-psychiatric inmates?
continued on

has the dust really settled in: The Peter Breggin Controver-

is a popular TV program, aired nationally, began was picked up by the influential New York Times. A psychiatric rights activists passionately cheered for who was in the center of the movement of that doctor. That's happen



Another type of forcible injection: airplanes & helicopters sometimes directly spray farm workers with chemicals that can kill or maim.

Psychiatry & Pesticides: Learning from Cesar Chavez and the grape bo-

People concerned alternatives

psychiatry

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monthly news Issue #13 March, 1988 one dollar

• news items from throughout U.S.A.
• readers respond!

Working to prevent brain damage! Psychiatric drugs caused Ira Gruber's permanent movement disorder.

Now he's starting a national association to say "NO" to this massive health cover-up!

In the summer of 1985, Ira Gruber found out why his muscles were twitching uncontrollably. Ira discovered he had " tardive dyskinesia," a movement disorder that was a sign of brain damage. He learned the awful news that the twisting might never go away for the rest of his life. Ira has been traveling around the U.S. trying to ignite a national campaign to prevent others from developing such psychiatric drug-caused disabilities, now an epidemic harming literally hundreds of thousands of Americans. The syndrome's existence is a scientific fact that has been well-known by most psychiatrists for years, but is still hardly known by the general public. When Ira isn't on the road in Seattle, working as the

dust still in The Peter

Last month's vision show psychiatry Alliance tried ur the N edit

psychiatric drug deaths WARNING: back page

organizing movements

The beginning of the black civil rights movement offers vital lessons to activists today. Here are movements from very different points of view

DENDRON

monthly news first issue January 1988 one dollar

SHOCK! Electroshock survivors win important - but partial - victories with the US government

An organization of survivors of electroshock treatment (ECT) has achieved the long-awaited partial victory of securing a permanent ban on the use of electroshock in Washington, DC. This is the first time that the US government has agreed to such a permanent ban on the use of electroshock.

DENDRON

The goal of *Dendron Monthly News* is to provide an independent service to the many individuals and groups concerned about human rights in - and alternatives to - the current psychiatric system.

Dendron includes coverage of US and international human rights campaigns for people with psychiatric labels, the strategies and tactics of organizing for social change, and the exploration and creation of effective, humane alternatives for emotional support.

Dendron is published by the non-profit Clearinghouse on Human Rights and Psychiatry (CHRP). It is edited by David Oaks and made possible by a grant from the Levinson Foundation, with the co-sponsorship of the McKenzie River Gathering.

Subscriptions to *Dendron* are on a sliding scale:

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Challenging New Zealand's Mental Health Act



Lawyer John Dawson discusses the need for improved human rights protection

The following was excerpted from a 1985 address by John Dawson – legal officer of the New Zealand Mental Health Foundation – to the Auckland Branch of the New Zealand Society for Legal Philosophy. The text of Dawson's speech was recently passed on to us by Mary O'Hagan of the New Zealand organization Psychiatric Survivors (see "No Advocacy in New Zealand," Phoenix Rising, Vol. 7 No. 2).

There is a whole *kleensak* of human rights issues to be addressed. But I want to address just one of them, which to me is the heart of the matter: the compulsory treatment of detained patients.

Other issues – such as arrest, committal and discharge, compulsory treatment in the community – all tie in with the core issue: the power of mental health professionals to require some patients to accept treatment without their consent. This, after all, is the main function of the Mental Health Act – to provide legal authority to detain and treat without consent. Without that authority, such treatment is an unlawful assault on the patient who receives it. The law makes this compulsory clinical relationship possible.

The key issue in the review of any mental health act is this: having decided to create this relationship, what role does the law have in regulating it, and in making mental health professionals accountable to the public for the exercise of this formidable power of compulsory treatment?

For the relationship is characterized by an enormous imbalance of power. On one side is the hospital staff, backed by the law, by their training, by their professional associations and trade unions, by the hospital administration, and by the police,

patient – detained, often forcibly medicated, perhaps acutely disturbed, rejected by family, destitute, without access to legal advice, even in solitary confinement – in a position of utter powerlessness.

This powerlessness is actively maintained by the provisions of the present law, which I wish to describe to you, so we know what it is we are trying to reform.

Provisions of the Mental Health Act provide staff with the power to administer whatever treatment they think is necessary. The law does not require that detained patients give consent nor that any specific inquiry be conducted into their competence to give such consent.

Patients have no right of access to their own medical records. They may therefore be unable to find out what treatment they have been given. It has been proposed that the Official Information Act be extended to cover hospital boards, and already there is lobbying for disclosure of all medical records to remain at the sole discretion of staff.

Legal actions for personal injuries caused by psychiatric malpractice are barred by the Accident Compensation Act. Patients may, in theory, claim compensation from the Accident Compen-

This, after all, is the main function of the Mental Health Act – to provide legal authority to detain and treat without consent.

on whom they can call – in fact, by the entire apparatus of the hospital and the state. On the other side is the

sation Corporation, which would refer them to a medical assessor – but there is no remedy in the courts against a negligent doctor personally.

Psychiatric patients have no right to legal information or representation and, in practice, they are not represented, even at committal hearings, where they are formally deprived of basic rights. In the studies I conducted, at 128 hearings fully attended in many different locations, two patients were represented. There are some hospitals at which patients are never represented.

Should a patient somehow attempt to launch before a court an action that is still available, such as an action for false imprisonment or intentional assault, it is unlikely they will ever get a decision on the merits of their case, due to the operation of Section 124 of the Mental Health Act, which says patients must first obtain the permission of the High Court before they can even launch an action against any person who was acting “in pursuance or *intended* pursuance of the Mental Health Act.”

This section, which sets a special six-month limitation period during which leave to proceed may be sought (although the limitation period for other citizens is six years), is currently blocking the only recent patients’ cases I am aware of. In both cases, the judges concede that there was no legal authority for the arrest of these men, which took place in their own homes.

Finally, the medical complaints procedures contained in the Medical Practitioners Act are entirely in-house and confidential. What psychiatric patient would have any confidence in complaining about a grievance to another group of doctors in a closed proceedings?

Together, these features of the law amount in practice to a complete shut-out. There is really no possibility of a lawfully detained patient bringing a successful legal action against a New Zealand mental health professional for abuse of the compulsory therapeutic

relationship. There is no way such a patient can hold hospital staff personally accountable in a neutral, fact-finding forum.

And, indeed, I know of no case in New Zealand’s history in which a patient-initiated legal action has been sustained against a member of a psychiatric hospital’s staff.

So, despite the enormous imbalance of power, psychiatric patients in New Zealand must rely for the protection of their rights entirely upon professional self-regulation. This is ineffective because of the strength of the countervailing notion of clinical autonomy, which means that, even if one’s colleagues’ standards of practice are inadequate, one has a very limited right to intervene. For example, the reluctance of professionals to interfere in the practices of their colleagues who suffer from alcoholism or drug addiction is legendary.

In no other country with similar legal traditions to our own has the law abdicated its protective function so completely, conferring this unique immunity on mental health professionals.

What we have created is an

An inquiry following Watene’s death revealed that he was given ECT over his violent objection, without anesthetic or muscle relaxant, and with no explanation of the procedure.

astonishing breeding ground for the abuse of human rights. And what has occurred?

In 1977, a thirteen-year-old Niue Island boy was given ECT [shock “therapy”] while held in maximum

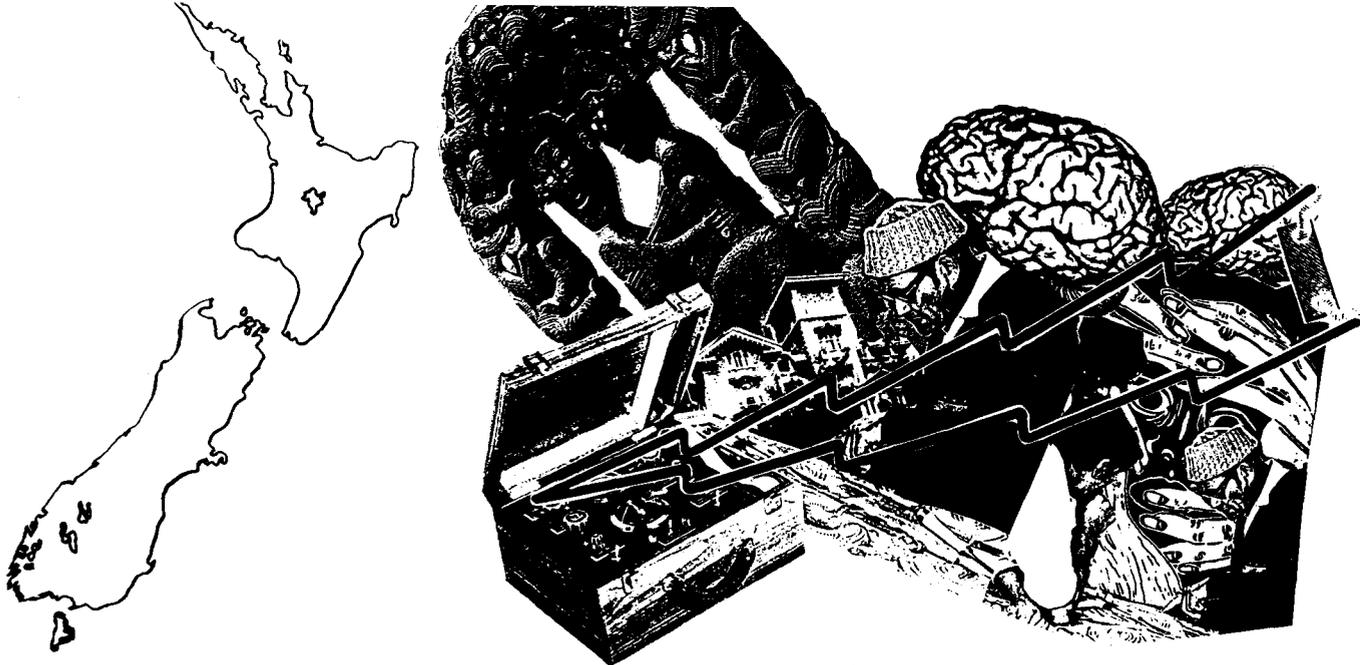
security confinement at Lake Alice Hospital as an *informal* patient, without it even being discussed with his family or the Social Welfare Department, who were responsible for his guardianship. This was not an isolated case.

A Maori man, Mr. Michael Watene, died at Oakley Hospital. An inquiry revealed the “standard practice” of issuing drugs, including Paraldehyde, to be used at the discretion of nursing staff, with no limits set on frequency of use or dosage; the routine placement of newly admitted patients in solitary confinement; admission procedures and examinations that were “cursory and inadequate” and “provided no proper basis for what followed”; the placement of Mr. Watene in solitary confinement for over a week with no explanation to him as to why he was in that position; inquiries made into his history that were “inadequate for the purposes of diagnosis or for treatment”; the administration to Mr. Watene over his violent objection of ECT without anesthetic or muscle relaxant, and without any attempt to explain the procedure to him, when it was questionable whether this mode

of treatment was even indicated by the diagnosis (that of acute paranoid reaction); the extensive use of the drug paraldehyde, which “is no longer commonly accepted as a drug for general use”; the “alarmingly deficient” ECT procedures carried out at Oakley Hospital; the “inefficient and haphazard” internal investigation conducted after Mr. Watene’s death, which resulted in the impossibility of saying “exactly what occurred”; and the lack of an “adequate system of safeguards ... for patients to make complaints of ill-treatment.”

There it is – serious human rights violations in our town. Anyone who can read this and still believe that severe human rights abuses do not occur in our psychiatric hospitals is a fool.

Mental health professionals alone are not responsible for what occurred



at Oakley. We are all responsible, particularly those involved in the criminal justice system. But there is no doubt that the medical profession was in the driving seat at Oakley.

In their submissions on the review of the Mental Health Act, a number of psychiatrists comment that the proposals of the department reflect a basic mistrust of the psychiatric profession. I ask you: who is responsible for the growth of that mistrust?

Is New Zealand law going to provide detained patients with access to legal remedies for violations of basic human rights, or not?

The New Zealand Mental Health Foundation recommends in *Towards Mental Health Law Reform* that patients have the right to legal advice and representation, *in practice*, in all committal and review proceedings. The Foundation also advocates the establishment of a patients' advocacy service; the passage of regulations governing the use of seclusion; the recognition of the right of all competent patients to give consent to treatment; the right of patients found incompetent to a second opinion; the placing of special restrictions on the use of psychosurgery, and hazardous treatments on child patients; an affirm-

ative statement of patient's rights placed within the Mental Health Act; and the establishment of mental health review tribunals that would have jurisdiction over all non-criminal mental health issues, and to which patients could appeal detentions and breaches of rights.

Finally, the Foundation is lobbying for the repeal of Section 124 of the Mental Health Act, which would remove the barrier to patients having

The College of Psychiatrists is actively opposed to the requirement of second opinions for psychotropic drugs. The college claims that a legal requirement of second opinions for psychotropic drugs would be a form of discrimination against psychiatric patients, because drugs with similar side effects are not controlled in other branches of medicine. But this completely misses the point. Certainly hazardous drugs are used else-

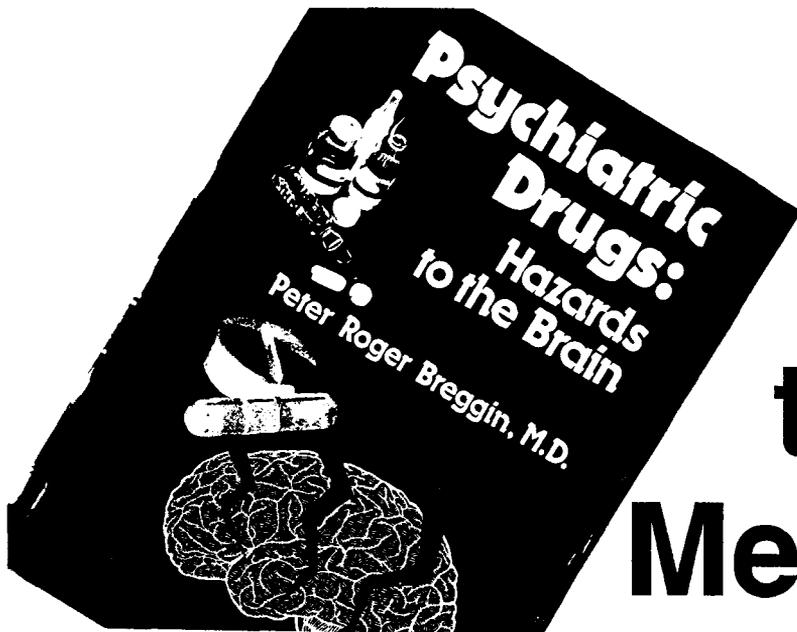
where, but only in psychiatry are they administered compulsorily to detained patients. This is what sets psychiatry apart.

Unless substantial pressure is brought to bear on the health department and on members of parliament, effective legal remedies for human rights violations will not be included in the new Mental Health Act.

At present the sole protection of detained psychiatric patients' human rights is professional self-regulation. This has failed to prevent serious human rights abuses. What we need now are solid legal hooks upon which remedies, and the occasional abuser of human rights, can be hung.

Certainly hazardous drugs are used elsewhere, but only in psychiatry are they administered compulsorily to detained patients. This is what sets psychiatry apart.

a hearing on the merits of legal actions. The Department of Justice supports such a repeal, commenting in its submissions that prison officers have no similar protection and have never felt the need for it.



Exposing the Myth of Mental Illness

Three ex-psychiatric inmate activists – Huey Freeman, Rae Unzicker, and Leonard Roy Frank – appeared as panelists on the *Oprah Winfrey Show* (a US talk show) on April 2, 1987, along with Dennis Clarke of the Citizen’s Commission on Human Rights, and psychiatrist Peter Breggin.

Leonard Roy Frank spoke of electroshock: “The fact that I had two years of my memory wiped out is totally understandable, because memory and brain cells are intimately linked, and when you destroy one you’re bound to destroy the other.”

Rae Unzicker said, “the only way to get out of a mental hospital is to play by their rules, and their rules say you be passive, you be compliant, you be irresponsible, weak, and dependent. All the things that you supposedly went in there to cure are the requirements to get out.”

Huey Freeman pointed out that people do “go crazy and have serious problems. But we need to get away from drug-ging and imprisoning them, and show compassion for them ...”

But it was Maryland psychiatrist Peter Breggin who made the most waves. Breggin, the author of *Electroshock: Its Brain-Disabling Effects* (Springer, 1979) and *Psychiatric Drugs: Hazards to the Brain*

(Springer, 1983), has for 20 years been publicly defending inmates’ right to refuse psychiatric “treatment.”

“When I was a resident in psychiatry,” he said, “I tried not to give shock and they told me I’d be thrown out of the program.... And I didn’t have the courage then not to ... it is really the shame of my life. You can’t become a psychiatrist without passing through that ritual of, in a

brain damage in half or more of the patients given long-term treatment.... I don’t think psychiatry will change from within with crimes like that.”

Breggin also explained that when psychiatrists started getting “more competition from social workers and clinical psychologists and counsellors and other people doing talking ... the question became, how can psychiatrists ... regain their authority and

their status? The decision was the new psychiatry: to emphasize that all these problems are biological. We’ll repeat it in the newspapers; we’ll repeat it in the magazines: depression’s biological, schizophrenia’s biological....

“And it’s all lies. But the lies are repeated again and again to bolster, for economic reasons, the new image that you’ve got to go to a medical doctor for your personal problems.”

Dennis Clarke commented at this point that, in 1986, New York’s Gracie Point Hospital made \$26 million by shocking 4,000 people. Inpatients were charged \$10,000 each, and outpatients \$3,000 each, for a course of twelve shocks.

At the end of the show, when Winfrey asked what to look for in a shrink, Breggin said, “If [the psychiatrist] offers a drug, don’t even say ‘No, thank you.’ You can take the prescription and go. Don’t fight about it. Don’t get in trouble. But go. Don’t take the drugs.”

The major psychiatric drugs, the major tranquilizers – Thorazine, Mellaril – we now know they cause brain damage in half or more of the patients given long-term treatment.

sense, spilling blood....

“It’s actually getting worse ... now, because the profession has a crime that’s even larger than electroshock.... the major psychiatric drugs, the major tranquilizers – Thorazine, Mellaril – we now know they cause

Ex-inmate activists and progressive psychiatrist Peter Breggin tell the truth about electroshock and psychiatric drugs on US national television, unleashing a storm of controversy.

An analysis by Don Weitz



Peter Breggin

After the show was over, Laurie Flynn, executive director of the National Alliance for the Mentally Ill (NAMI), hearing about this last comment of Breggin's, wrote a letter of complaint about Breggin to the Maryland Department of Health and Mental Hygiene, and filed a complaint against him with the Maryland Commission on Medical Discipline, which has the power to revoke a physician's licence.

(Like the right-wing Canadian Friends of Schizophrenics, NAMI is an organization of inmates' relatives who believe in the alleged effectiveness of dangerous psychiatric "treatments." Both organizations function as front groups for psychiatry by spreading the myth of "mental illness" – and both claim to be in favour of "patients' rights.")

While waiting for the commission to hand down its decision, Breggin got a lot of support from ex-psychiatric inmate activists, advocates, the American Civil Liberties Union, several US congressmen, and even such prominent, mainstream psychiatrists as E. Fuller Torrey and Loren Mosher (who defended his right to express his opinion, though they disagreed with his critical views of psychiatric treatment).

He also got onto a second *Oprah Winfrey Show*, broadcast August 17. This time, his panel-mates were ex-

inmate activist Judi Chamberlin of the National Alliance of Mental Patients; Joseph Rogers, president of the National Mental Health Consumers' Association (another group that promotes the idea of "mental illness"); and Dr. Paul Fink, president-elect of the American Psychiatric Association.

Judi Chamberlin said that Thorazine (a "major tranquillizer")

journals ... our scientific meetings ... even the lobbying efforts in Congress.... the Psychiatric Association is not beholden to the patients now, it's beholden to the drug companies." Winfrey asked, "what about chemical imbalances?" And Breggin replied, "It's a myth made up by psychiatry to support the drugs.... There's no evidence."

On October 1, the Maryland Commission on Medical Discipline fully exonerated Breggin, ruling that he had committed "no legal violation or ethical impropriety," and that the matter was "essentially a freedom of speech issue."

Breggin has since stated that "the response to the attack on me has vastly strengthened psychiatric reform throughout the nation. I have received communications from all over America declaring a renewed commitment to fighting the psychiatric abuse of patients, including drugs, electroshock, the medical model, and involuntary treatment."

It is a shame that psychiatrists have so much more credibility than their "patients" do in criticizing the profession.

But at least the US has a handful of courageous, outspoken psychiatrists like Breggin. Too bad Canada has none.

The Psychiatric Association is now beholden not to the patients, but to the drug companies. ... "Chemical imbalance" is a myth made up by psychiatry to support the drugs.

"makes it hard to think ... it's been compared to having concrete poured in your brain." She also spoke of the ways in which psychiatric inmates are treated like criminals.

Breggin said that "drug company money.... supports [psychiatrists']



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You can get a discharge allowance if you qualify for **general welfare** or **family benefits** *and* you have been in an **approved institution**.

Some approved institutions are: psychiatric or chronic care hospitals, jails, halfway houses, nursing homes or homes for the aged, group homes or hostels.

If you have been in another kind of institution, call your worker at welfare or family benefits to see if your institution is approved.

How much money can I get?

If you qualify for general welfare, you can get up to \$450. If you qualify for family benefits, you can get up to \$600.

What if I can't get it?

Find out what the problem is and ask your worker to help you. If you are still having problems call the community legal clinic closest to you for help.

You have the right to know the rules about welfare and family benefits. Ask your community legal clinic for more information, or for help.

(The information in this ad is taken from a pamphlet written and produced by Parkdale Community Legal Services and Community Legal Education Ontario (CLEO), in cooperation with Parkdale Project Read.)



OUT OF THE ASHES

Banging Heads

by Stephanie Stein

Another day in the quiet room. It rains. I enjoy rainy days like this one. They make me feel comfortable with my solitude. I cuddle like a complacent Jewish kitten beneath the two army blankets they give me, and I can move and wiggle my feet to show that I still have energy and spirit. Adam wiggled his feet underneath the blanket he placed on top of us both when we watched *Saturday Night Live* one night. A night I wasn't listening to or laughing at the television program, but laughing at the things he said.

The staff believes they will punish me and thus cause me to suffer so much that eventually I will scream for mercy, like I did silently with Adam as he chased me around and out onto the front step of his half-house with a gun. They will make me scream for mercy as Adam and I did very silently on that rainy evening when he read from Kurt Vonnegut and caressed my nyloned leg.

The thunder had gotten louder and I said to Adam, "Listen to that," like the little girl I was and will probably always be. Adam said "So what," and went back to his reading. Then he put the book away

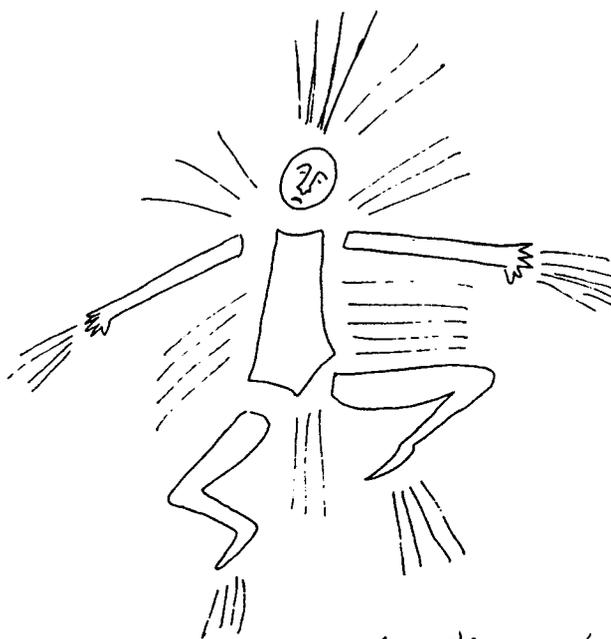
and told me I was not cynical enough for Kurt. He made a sign above my head. I remember asking him what the sign was. He told me it meant

ways begging Adam because I was so charmed by him. I remember one night we were going to plod through the rain to Friendly's and he wanted to bring his "undersea flippers." He often did silly things like this. He liked to throw furniture around in his room when he was mad.

One morning I was having a cup of coffee and an English muffin with butter and grape jelly across from his very distinguished-looking father, who smoked cigarettes, and we both heard strange thumping noises coming from upstairs. Adam's father looked at me and shrugged his shoulders and laughed a little bit like Adam laughed (or Adam laughed a bit like him), and said that Adam liked to bang his head against the wall when he was angry or confused.

He likes to bang his head against the wall, I thought, because he doesn't know what to do with his emotions. Sometimes I would like to bang my head against the yellow walls of this quiet room, but I know I would get tied down or medicated.

Sometimes when the staff comes in to talk to me or give me drugs I play dead like an insect until they



Drawing by Kristine Starr Eglis

that I was too naive for my own welfare.

The staff is waiting for me to beg them for a quick reprieve. I was al-

finally leave the room. One night at dinner with me and his father, Adam fell with a thud to the floor and pretended he was dead. I laughed. His father called him an ass and told him to get up off the floor. His father told me he often did tricks like that.

There is another term for playing dead in a quiet room: Russian Fatalism. And it is not for seeking attention or shocking people. I played dead to keep people from coming in and asking me questions or attacking me with right-wing conversation to get me so mad that I would feel as if I had the urge to kill, but couldn't do it, so the frustration would be even worse than the possible murder itself.

One day I found out that Adam was into playing war games in the woods with his friends, and I thought again about his playing dead. Maybe his ploys were fatalistic and Russian also. Maybe he harboured fears about rooms and locks and barred windows and concentration camps.

They slammed the door on me today and locked it on my scream as they took away my socks and all my blankets and left me primitive with a

green plastic mattress. I had to remain silent and play dead again on the mattress in order for them to "consider" unlocking the door. I wasn't scared of locked doors, be-

feeling his very large, strong hands.

They slammed the door on my face and I didn't even begin to scream. I didn't care any more. They were doing it to me so much that I

was insensitive to their punishments. They slammed the door on my face and thought I would scream and hurt inside, like I did when Adam slammed his door on my face five years ago.

I wanted to do something to shock this time. I took off all my clothes. I thought I would take my clothes off for Adam, but he didn't ask me. And I considered him too special to give myself away to, to hand him my sexuality like a dollar bill. I



no escape

© Englin 7/87

cause I had no problem being alone with myself. But I did want my socks back, because my feet were very cold.

Adam liked to tickle my feet. He was always admiring my small hands. When they tried to restrain me for pummelling a nurse, it took them awhile, because my hands and wrists kept slipping out of the clasps.

Adam had always liked to tickle and touch my hands and measure them against his; and I remember

never gave myself away to the people I think deserve me.

I stripped and watched the men peer through the door. After five minutes I had put my clothes back on, and through the theatrical scene I remembered Adam falling down with an obtrusive thump underneath the dinner table in order to make himself inane and worthless.

Later, in the quiet room, with warm, socked feet and two army blankets, I think Adam is lying next

to me, on another green mattress.

I picture his short brown curls and his witty, almond-shaped, Hebraic eyes. I see myself, with a naive, curious smile, and insecure but pretty hazel eyes. I

see us both lounging casually on the sofa in his living room as we read Edgar Allen Poe to each other, by lamp-light. It is still raining. The rain is a symphony shyly tapping upon the windows. I am reading from one of Poe's elaborate mystery stories. I look up from the book and laugh nervously, because Adam is penetrating me with admiring, inquisitive eyes. I tell him not to look at me. He says "Okay,"

very matter-of-factly, and turns to the window.

I think I am falling in love. I am seventeen and fairly intelligent, barely absorbing a word or idea of Poe, but when I listen to Adam read I am impressed and touched by his intense concentration as well as the eloquent and fast spinning of the tale he conveys in his soft, youthful voice. I think with confirmed satisfaction that he is the young prodigy and genius I can play for keeps, and put in my closet with all the rest of my dolls.

But then one of the reasons I loved Adam was precisely that he was too independent and free a spirit to be my doll. I loved him because he was the better, more masculine side of me.

head against the wall to see if it was still concrete." He spews forth one of those diabolical, raspy laughs of his. "At least my sickness has always been my own and separate from the

neurotic swarms of women like you who come to my house and get me ill."

Adam was being nasty again. I wondered what accounted for the change in feeling and mood.

I played dead. Then I looked around me and saw that Adam and his mattress were gone. They had disappeared, and I was left with a feeling of familiar emptiness and rejection. For five years I love him and then he has to bang his head against the wall. Doesn't his confusion have a mother?

I looked out the window of the quiet room. It was dark. There was a full moon. I could hear myself commenting to

Adam on the full moon. He would say, "So what?" I could hear him in the background saying, "I'll show you sentimentality. Let's play Russian Roulette."

It was time to play dead. A doctor was coming in with the needle.



Drawing by Kristine Starr Erglis

Adam says he would never feed his spirit poison (medication), nor would he feed it bad company.

"So why did you always slam the door in my face?" I ask him.

"You slammed the door on me first. I was only fifteen," Adam replies casually, comfortable on the other plastic green mattress in the quiet room, wiggling his toes and rocking his feet complacently back and forth. "I may have been sick in the past, when I used to bang my

MAD NEWS

Everyone has the right to vote ... well, almost everyone

"Every citizen of Canada has the right to vote in an election of members of the house of commons or of a legislative assembly and to be qualified for membership therein."
— The Canadian Charter of Rights and Freedoms, Section 3

On May 2, 1985, about five months after Ontario amended its election act, inmates of psychiatric institutions were allowed to vote in their first provincial election. In Ontario's ten provincial psychiatric institutions, 2,425 inmates — 56 percent of the population — registered to vote, and almost all voted (see "Gaining the Vote," *Phoenix Rising*, Vol. 5 No. 2/3). The turnout was similar to that of the general population — 61.5 percent.

The numbers of inmates who registered and voted varied remarkably from institution to institution.

- At Penetanguishene's Regional Hospital, only 45 of a population of 193 voted; in the Oak Ridge Division of Penetang, 107 of 158 inmates registered, 72 of whom voted.
- At Lakehead, 74 of 175 registered, but only 30 voted.
- At Kingston, 340 of 426 registered, and 136 voted.
- At Hamilton, only 66 voted, of 286 registered.
- At Toronto, 536 registered, but only 175 voted.
- At London, almost all 376 inmates registered; only 82 voted.

- At Brockville, 140 of 386 registered, and 97 voted.
- At St. Thomas, 122 of 404 registered, and 107 voted.
- At Whitby, 140 of 343 registered, and 97 voted.
- North Bay had the highest registration rate — all 278 inmates, of whom 184 voted.

According to Susan Atkinson, executive assistant of the Psychiatric Patient Advocates' Office, some polling clerks were unable to provide certain information to inmates — especially about how to vote by proxy or how to transfer the voting place from the hospital to the community. Furthermore, although an inmate who is registered to vote is supposed to be able to vouch for a new inmate by attesting to her or his identity, inmates admitted after the enumeration deadline could not be vouched for. (The Patient Advocates' Office is recommending to the government that it abolish the vouching method and replace it with a simple declaration under oath; the oath system is used in city elections.) Finally, no provincial candidates came to the institutions to talk about election issues or to answer questions.

The right to vote is one of the most fundamental rights in a democratic society. The Charter does not disqualify any class or group of citizens from the right to vote or to run in an election. Yet the Canada Election Act and many provincial

election acts deny the right to vote to psychiatric inmates and to prisoners.

Ontario and the Northwest Territories have amended their election acts so that psychiatric inmates have the right to vote. Saskatchewan inmates cannot vote if they are incarcerated under a Lieutenant Governor's Warrant. Newfoundland inmates do not have the right to vote if they are involuntarily committed. And in British Columbia, inmates are not allowed to vote if they are under remand or under a court order.

At present, Quebec is the only province that allows prisoners to vote in provincial elections. In British Columbia, prisoners on probation can vote and can run for election. In Ontario, there may soon be a Charter case, launched by a prisoner, challenging the province's election act. And after two years of government stalling, amendments to the Canada Election Act may be passed in 1988 that would give all psychiatric inmates and people with "mental handicaps" (but not prisoners) the right to vote in federal elections.

It's time that all psychiatric inmates, and all prisoners, be given the right to vote. The fact that people are incarcerated in a psychiatric institution or prison is a poor excuse for denying them this right. We urge our readers in provinces that disqualify psychiatric inmates and or/prisoners from voting to write letters of protest to their MPPs and MPs, and to Justice Minister Ray Hnatyshyn, MP, The House of Commons, Ottawa, Ontario, K1A 0A6.

Don Weitz

Locked up for 58 years for "nervous spells"

In 1929, 24-year-old Blanche Moore was transferred from the State Colony for Epileptics and Feeble-minded in Lynchburg, Virginia (where she had been sent by her family as a teenager) to the Western State Hospital. In her admission interview, she said she'd had "nervous spells" since she was fourteen. Asked to ex-



The theme for this year's International Women's Day celebration in Toronto was Fighting Racism, Sexism, and Economic Inequality. Above, intrepid Phoenix Rising staffers sell back issues, info sheets and buttons at the IWD fair; Psychiatry Psucks buttons sold like hotcakes. Photo by Konnie Reich

plain the difference between a cow and a horse, Moore, who'd grown up on a farm, replied "You milk a cow, and you can't milk a horse," and added, "You are not making as big a fool of me as you think." Though she "generally answered questions reasonably" (according to a November 24, 1987 *Globe and Mail* article), the psychiatrist who interviewed her diagnosed her as suffering from "psychosis, equivalent of epilepsy." Moore spent the next 58 years locked up in the state hospital. Her statement to the *Washington Post* was, "I want to get away from this old place." A state official has admitted that Moore never belonged in an institution, and arrangements have been made to have her transferred to a nursing home.

APA Meeting

The American Psychiatric Association is holding its annual meeting in Montreal, May 7 to 12, 1988. "Patients' Day," scheduled for May 10, will feature three public forums:

Women's Pamphlet Series

The Nellie Langford Rowell Library, a Women's Studies Library located at York University, is proud to announce the beginning of a new pamphlet series. The first three pamphlets are currently available:

Rediscovering History: Bringing a Name to Life. Nellie Langford Rowell 1874-1968 shows how one woman combined a warm and successful family life with work in organizations to better the status of women, illustrating the way women's organizing furthered the social and political development of Canada in the first half of the century.

In *Equality in Sports: Perspectives*, five papers discuss the present legal and practical situation of women in sports, including funding, human rights provisions and the everyday problems facing women who wish to participate in sports and athletics on an equal basis with men.

Pay Equity: Perspectives discusses the philosophical, economic and political sides of pay equity (which is new to Ontario), and its implications for women and for the economy.

The pamphlets cost \$2 each or \$5 for all three, and are available from the Nellie Langford Rowell Library, 202C Founders College, York University, 4700 Keele Street, North York, Ontario, M3J 1P3. Please include an additional \$1 for postage and handling.

"Homelessness and Mental Illness," "Is Patient Advocacy a Conflict of Interest for Psychiatrists?" and "Self-Help Alternatives and Models." Ex-psychiatric inmates from the US will be involved in panel discussions on these topics. The theme of the day will be "Liberation versus Cooperation."

The panels and other events will be held at the Montreal Convention Centre (Palais de Congrès), at the corner of Avenue Viger and Jeanne Mance.

Attend the "Patients' Day" events if you can; let's take advantage of another opportunity to speak out and demonstrate. Hope to see you in Montreal.

CPA Meeting

On Our Own, Toronto's ex-inmates' self-help group (which publishes *Phoenix Rising*), wrote to Dr. Philip Beck, Chair of the Scientific Program of the Canadian Psychiatric Association (CPA), to recommend that the CPA hold panel discussions or public forums dealing with unethical psychiatric practices, and the rights of prisoners and psychiatric inmates, in which ex-inmates would participate.

Beck replied that he regretted "that the current format of our meeting does not include panel discussions or public forums of the type that you suggest. I realise that some associations accept the participation of community groups within the contexts of their scientific meetings, but we have not yet taken this step. Instead, our meeting is limited to the presentation of scientific papers, symposia and the like. Should you have a presentation of this type to submit to the Scientific Programme Committee on the standard abstract form, the committee would be pleased to consider your submission. The abstract forms can be obtained at the head office of the Association at 294 Albert Street, Suite 204, Ottawa, Ontario, K1P 6E6."

We hope there are some anti-psychiatry scientists out there who will take up the challenge and make

a presentation of this type prior to the CPA's 1988 annual meeting, which will take place in Halifax, Nova Scotia, in September.

Announcements

A Place for Women's Art

The work of women artists from across Canada and the United States will appear in *Gallerie*, a new Canadian quarterly. The first issue, which will be available in June 1988, is a book-length publication featuring more than 40 artists, among them Judy Chicago and Sue Coe.

Caffyn Kelley, the founding editor, explains the magazine's rationale: "Many women doing important and valuable work are never going to 'make it' as art-world professionals. Often art is an activity that gets squeezed in between work, kids, and laundry. The meaning and content of art is a conversation with friends over coffee, or notes written in a private journal. *Gallerie* provides an opportunity for these voices to come together and multiply.

Gallerie welcomes submissions from women artists, regardless of medium. For entry guidelines and subscription information, write to Gallerie Publications, 2901 Panorama Drive, North Vancouver, British Columbia, V7G 2A4.

New Voice for Disabled

The Radio Connection, sponsored by the Centre for Independent Living in Toronto, focuses on cross-disability issues. Many programs will feature issues of national importance, and the show will soon be syndicated. For the moment, local listeners can catch *The Radio Connection* on CIUT (89.5 FM) at 6:15 p.m. on Mondays. If you have an issue to air, or a comment on the show, contact John Southern, c/o *The Radio Connection*, 597 Parliament Street, Suite B5, Toronto, Ontario, M4X 1W3, or phone at 1 (416) 963-8073.

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RIGHTS & WRONGS

Victims of Cameron's Brainwashing Experiments Suing CIA

Finally, after almost eight years of CIA delays and stonewalling – and the Canadian government's refusal of help – the eight surviving victims of the late Ewen Cameron's brainwashing experiments, performed at Montreal's Allan Memorial Institute in the 1950s and 1960s, will have their day in court. The eight are suing the CIA for one million dollars each for its funding of Cameron's experiments.

The CIA gave Cameron about \$65,000. But the Health and Welfare department of the Canadian government, which gave him more than \$300,000, is still denying any legal or moral responsibility to his victims.

The "treatments" Cameron inflicted on these people – without their knowledge or consent – included massive electroshock "therapy," which he called "deprogramming"; the administration of LSD, Thorazine and other experimental drugs; "psychic driving," which involved the constant repetition of disturbing taped messages; sensory deprivation; and solitary confinement.

These "patients" of Cameron's suffered brain damage, including permanent memory loss. Thirty years later, they are still unable to work, and disabled in other ways. (See "A Psychiatric Holocaust" and "Canadian Victims Still Seeking Compensation," *Phoenix Rising*, Vol. 6 No. 1.)

On January 19, 1988, in Washington, DC, US District Court Judge John Penn ordered that the

case go to trial June 7. In his decision, Penn rejected the CIA's requests for delays. He stated, "This case clearly has material issues of fact in dispute which must be resolved at trial. The question of whether the CIA should have known that Dr. Cameron's research was clearly beyond the medical standard of care can only be assured once the disputed facts are resolved." Penn also rejected the CIA's arguments that the victims filed their case too late to comply with the "statute of limitation" period.

While the CIA stalls for time, Cameron's victims are getting old. They're in poor health, and some may die before receiving any reparation. (Nine victims were originally named in the case, but one, Florence Langleben, died in January 1986. Her husband will represent her at the trial.) Most of the victims cannot afford to pay the mounting legal costs of seven years of pre-trial litigation. Until February 1988, the Canadian government refused to offer them any support, despite repeated appeals from their lawyers, Joseph Rauh Jr. and James Turner.

MP Svend Robinson, the NDP justice critic, has raised the issue of financial compensation for the victims in the House of Commons both in 1987 and in 1988. Justice Minister Ray Hnatyshyn has stonewalled Robinson's requests.

Hnatyshyn claimed that there was "no legal responsibility on the

government," that the government was "attempting to analyze the situation ... to determine what assistance might be possible," and that the government had been "most helpful" and "shown a sensitivity toward this particular situation." In fact, the Mulroney government has actively obstructed justice in this case.

In November 1987, the Ontario Coalition to Stop Electroshock presented a petition bearing more than 1,500 signatures on behalf of the victims to the government's Standing Committee on Justice and the Solicitor General. The group demanded that the government release to the victims or their lawyers all the evidence it has about the CIA's involvement; and that it publicly acknowledge its legal and moral responsibilities to the victims and offer them immediate reparation.

On February 11, 1988, external affairs minister Joe Clark announced that the Canadian government would pay each of Cameron's victims \$20,000. There was no admission of responsibility on the part of the government, nor was any mention made of reparation or of any further monies to be paid. As far as the government is concerned, this payment is to "assist" with the victims' legal costs.

Cameron's victims and their families were horrified by Clark's announcement. One victim, Velma Orlikow, felt like tearing up the cheque when it arrived. Her husband, David Orlikow, an MP, called the payment "an insult." Harvey Weinstein – the son of another victim, 82-year-old Louis Weinstein – said, "It's telling the Canadian people that my father's life was worth \$20,000. My father has had no life since age 49." Jean-Charles Page complained, "We've been waiting more than seven years for this. It's very disappointing." Rita Zimmerman, 72, said the money was "not enough," and Jeanine Huard called the payment "minimal" and said the government doesn't "want to admit their part in this."

The day Clark's announcement was made, a *Toronto Star* editorial by Don Sellar revealed that George Cooper (the former Tory MP who wrote the 1986 report about

Cameron's experiments for the Justice Department – see "The Cooper Report: Another Government Whitewash," *Phoenix Rising* Vol. 6 No. 2) had recommended an "ex-gratia payment of \$100,000" to each of the victims.

In his recommendation, which was buried in Appendix 53 of the second volume of his report, Cooper explained that \$100,000 would be a "relatively modest" reparation, and claimed that the payment was "not to redress a wrong for which the government should consider itself responsible, but simply ... an expression of the Canadian community's collective sense of accountability for events which took place in good faith but with ill effect."

Cooper thought of the offer as a final, lump-sum payment that would discourage Cameron's other victims from demanding compensation. He was concerned that large settlements might have a "chilling effect" on government funding of future medi-

cal or psychiatric research.

On February 14, three days after Clark's announcement, a *Toronto Star* editorial called the \$20,000 pay-



Ewen Cameron

ment "a stunning insult ... that could further weaken the plaintiffs' chances of winning a decent settlement from the CIA. Coming after so many years and so much pain, the money is just a downpayment on the harm that was

done to vulnerable people, in the name of science."

On February 17, lawyer James Turner was interviewed on Toronto radio station CKFM. Turner called the payment "a dirty tactic" and "a positive detriment to getting some relief for these frail and elderly people." He added that such a payment was "terribly threatening" to the case and that "any meaningful financial assistance ... has got to come pretty damn soon." He speculated that the \$20,000 offered may have been based upon an amount – \$25,000 – that the CIA had once offered the victims as "nuisance payment."

Turner expects to win this case. We want to make sure he does. If you feel, as we do, that each victim should receive at least \$200,000 from the Canadian government, let Brian Mulroney know. Write to: Prime Minister Brian Mulroney, House of Commons, Ottawa, Ontario, K1A 0A6.

Don Weitz

Two More Victims Come Forward

New lawsuits launched by Western Canadian subjects of Cameron's experiments

Linda Macdonald lives in Vancouver. In 1963, Macdonald was a "patient" of Ewen Cameron's at the Allan Memorial Institute. Cameron diagnosed her as a "schizophrenic" and "treated" her for three months.

Macdonald was depressed after delivering four babies in five years. Cameron gave her 109 electroshock "treatments," and kept her in a drug-induced coma (which he called "prolonged sleep") for 86 days. He also subjected her to "psychic driving."

Macdonald has no memory of the first 26 years of her life. In December 1987, she filed a \$200,000 suit against the Canadian government, which, with the CIA, funded

Cameron's activities at the Allan Memorial Institute. She is also suing the Royal Victoria Hospital, where the Institute is located.

"J" – another unsuspecting guinea pig of Cameron's – lives in Edmonton, Alberta. She was eighteen when Cameron "treated" her for more than a year, with massive electroshock and with 40 days of drug-induced "sleep." (During this time, an abortion was performed upon her without her knowledge or consent.) J's memory of her first eighteen years was permanently wiped out.

J, who had planned to become a nurse, cannot work. She is disabled; she can't concentrate and can't

handle stress. In March 1988, J filed suit in Quebec Superior Court. She is suing the Royal Victoria Hospital, the Allan Memorial Institute, and the estate of Ewen Cameron for \$100,000. Her lawyer, Kevin P. Feehan, says J may later sue for a much larger amount.

If you wish to contribute to either or both of the legal action funds that have been set up for these women, please send cheques or money orders. Make them out to:

- "Linda Macdonald Legal Fund" (send to: First United Church, 320 East Hastings Street, Vancouver, British Columbia, V6A 1P4);

- "Don Weitz – In Trust Re J" (send to: Phoenix Rising, Box 7251, Station A, Toronto, Ontario, M5W 1X9).

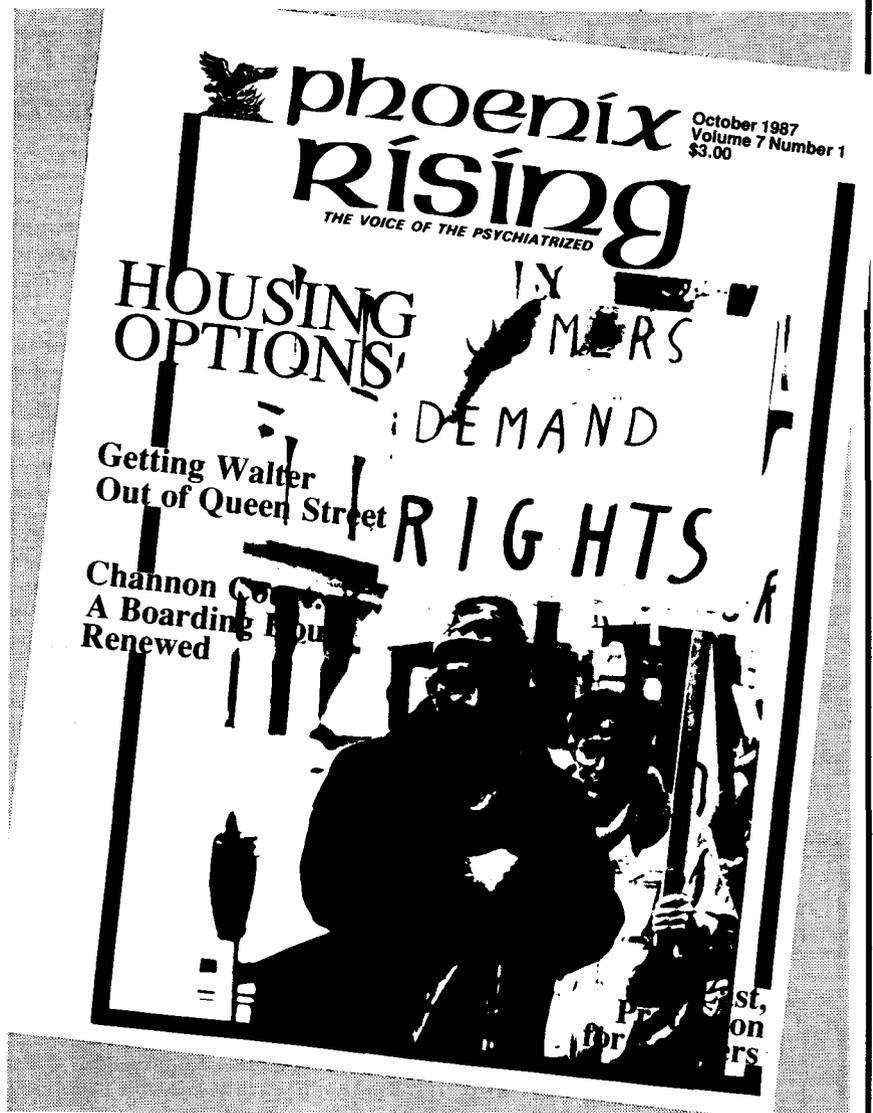
Out-of-Court Settlement

The four children of a Syracuse, New York woman, Avalyne Jackson – who died in Hutchings Psychiatric Centre – reached an out-of-court settlement in a wrongful death suit they filed against the centre and psychiatrist Karl Newton. Jackson died June 6, 1985, at the age of 37, from “undetermined causes,” according to attorneys representing the state. But her children claimed that Hutchings staff members caused Jackson’s death by administering improper doses of Haldol (a neuroleptic or “anti-psychotic” drug), and by improperly monitoring her after giving her the drug. Acting Supreme Court Judge Bernard Reagan approved the settlement, but sealed the documents that detailed its terms. “The state is not admitting any wrongdoing,” said Assistant Attorney General John McComb. He said the state agreed to settle the suit to avoid the expense of going to trial. (Excerpted from *Constructive Action Newsletter*, December 1987)

California ruling on right to refuse

In December 1987, a panel of the State Court of Appeal in California ruled that an inmate who is involuntarily committed to a health facility for short-term crisis care may refuse to take “anti-psychotic” medication. However, the inmate may not refuse if a judge determines that she or he is incapable of making an informed decision about medical care, or that emergency intervention is considered necessary to save the inmate’s life or prevent injury to the inmate or to others. The court said that the forcible administration of powerful mind-altering drugs “involves moral and ethical considerations not solely within the purview of the medical profession.” According to a December 22 *New York Times* article, the ruling is expected to affect the treatment of tens of thousands of patients

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statewide. (We thank activist Judi Chamberlin for this information.)

Woman with TD Awarded \$1.25 Million

Phyllis M. Vincent has been awarded \$1.25 million in medical malpractice damages by a DeKalb County, Georgia Superior Court jury after physician Peter D. Walz put her on the "major tranquillizer" (neuroleptic) Mellaril for seven years, allegedly without monitoring her condition, to treat symptoms of menopause. Vincent, formerly an executive secretary, is now permanently disabled with tardive dyskinesia (see story, Page 34) and, according to lawyer Jim Simmons, will likely need long-term nursing care. (Excerpted from the *Atlanta Journal*, January 16, 1988)

Inmate Wins Freedom

Last November, Helen Dayday, a 73-year-old Toronto woman who had been locked up in the Queen Street Mental Health Centre for six months, was released by District Court Judge Ted Matlow. Matlow ruled that "The Mental Health Act ... does not authorize" the detention of people whose behaviour results in "minor assaults and nuisances to other persons." Dayday had been taken into custody and diagnosed as suffering from "paranoid psychosis" as the result of hearsay evidence from neighbours upset by her annoying behaviour. According to an article in the November 25, 1987 *Toronto Star*, "The judge found that none of the evidence in the case revealed that Dayday 'had ever caused serious bodily harm to anyone.'"

Human Rights Day Events

On December 10, 1987 (the thirtieth anniversary of the signing of the United Nations' Universal Declaration of Human Rights), Ontario citizenship minister Gerry Phillips announced the appointment of lawyer Raj Anand as Ontario's new human rights commissioner. Anand is widely respected, and is committed to equality rights and affirmative action for minorities and disadvantaged groups. He has publicly criticized involuntary committal to psychiatric institutions.

The day of Anand's appointment, the Blind Organization of Ontario with Self-help Tactics (BOOST) and the Ontario Coalition to Stop Electroshock held a press conference at Queen's Park. Richard Santos of BOOST blasted the Ontario government for stalling on passing an amendment to the province's human rights code, which would affect discrimination against people with dis-

abilities in their search for reasonable accommodation — that is, safe, adequate, and affordable housing. BOOST's press release called the amendment "an indispensable component of the struggle" for which people with disabilities have fought long and hard, and announced BOOST's intention "to resist any attempt ... to weaken the relevant sections of the code."

Don Weitz demanded, on behalf of the Ontario Coalition to Stop Electroshock, that mental health professionals and all levels of government respect psychiatric inmates' rights; that forced treatment be outlawed; that all inmates, upon admission, be given copies of legal documents detailing their rights as guaranteed under current mental health legislation and the Charter of Rights and Freedoms, and also be given access to lawyers or advocates; and that a Canadian bill of rights for psychiatric inmates be drafted, enshrined in all mental health legislation, and strictly enforced.

PHOENIX PHARMACY

How to Come Down

Reprinted from *Dr. Caligari's Psychiatric Drugs*

General Information

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

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

Because almost all psychiatric drugs are depressants of the brain and nervous system and act like a brake on body energies, drug stoppage, particularly

when it is sudden, can lead to anxiety, restlessness, insomnia, irritability, gastrointestinal problems, muscular reactions, hallucinations,

experience uncomfortable or distressing withdrawal reactions and might, in fact, merely feel better, more alive, sensitive and energetic, as the drug's depressant effects slowly wear off.

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

fearfulness, and weird behaviour. On the other hand, one might not ex-

being released into the bloodstream. Tests have shown that neuroleptics

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Network Against Psychiatric Assault

[also known as major tranquilizers or anti-psychotics] can be detected in the body and urine for as long as six months after they have been discontinued.

Another factor to be considered is that drug effects are experienced most intensely when drug levels in the blood are either rising or falling; the more rapid these changes, the more intense the effects. Thus, when large and sudden increases in the drug blood levels occur, one is more likely to experience distressing *drug effects*.

Drugs are broken down, inactivated, and eliminated from the body at different rates. This factor, called the drug half-life, is very important. Drugs with short half-lives, which are eliminated quickly, lead to more rapid drops in blood drug levels and more intense withdrawal effects that start and end sooner. Drugs that have longer half-lives are eliminated more

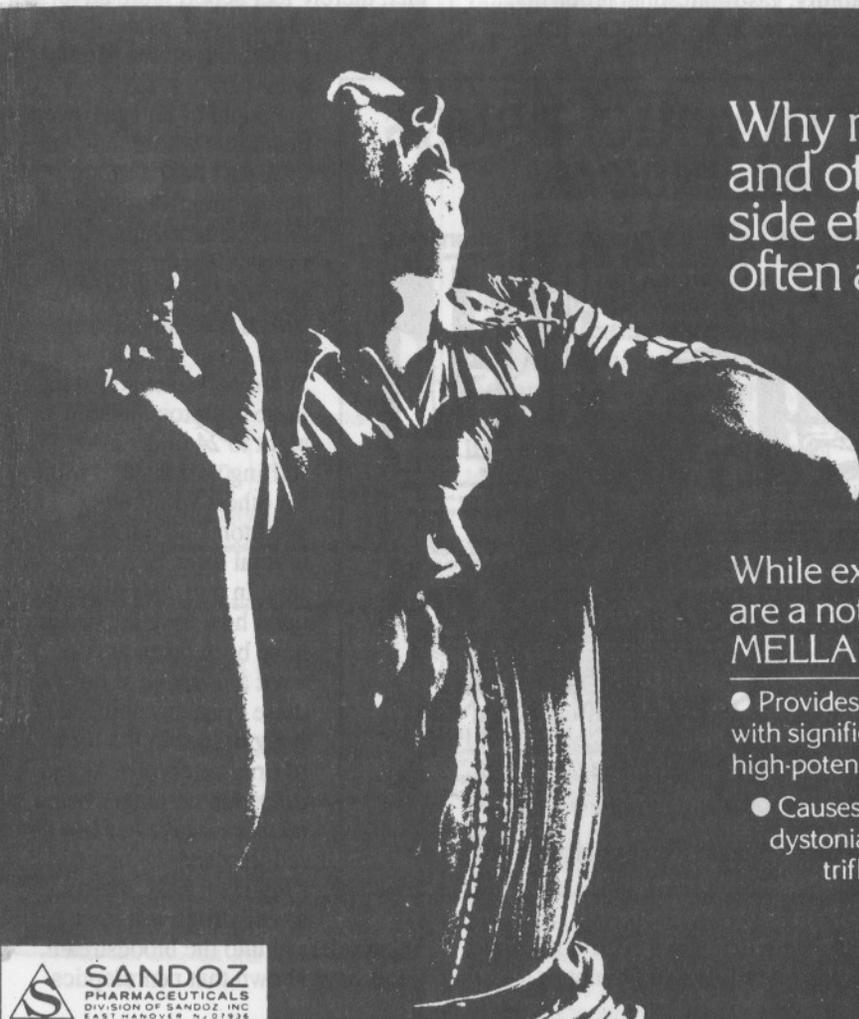
slowly by the body and cause withdrawal reactions that start later, but last longer. Neuroleptics, anti-depressants and other anti-anxiety drugs (like Valium and Librium) have longer half-lives. Lithium and the newer anti-anxiety drugs (like Restoril, Halcion, and Serax) have shorter half-lives.

There are a number of factors that affect the difficulty of drug withdrawal: type of drug taken; dosage level and length of time drug has been taken; the person's general health and attitude about drug withdrawal; the quality of support received during the withdrawal period; and the person's understanding of the withdrawal process, and knowledge of the possible symptoms and problems to be encountered and the concrete measures taken to alleviate such problems.

Scheduling

The best way to minimize drug withdrawal problems is to reduce drug intake gradually. This is especially important if the drug has been taken for more than one or two months. If you have been taking small doses of psychiatric drugs, or have been taking such drugs for a brief time only (i.e., a few days or weeks), then you may wish to try discontinuing "cold turkey," that is, just stop taking the drugs. With neuroleptics, anti-depressants, and lithium, it is possible, although not advisable, to stop all at once regardless of how much or for how long you have been taking the drug. There are no life-threatening consequences to sudden withdrawal from these drugs, but there may be severe discomfort and distress.

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have been taken for long enough periods, there can be life-threatening withdrawal problems. Under such circumstances, we strongly recommend gradual withdrawal.

Gradual, stepped drug withdrawal: the 10% formula

Using this formula, drug withdrawal is accomplished by slowly reducing the drug dose in sequential steps, taking as long as necessary at each step. If you have been taking psychiatric drugs for years, it may take many weeks, or even longer, to withdraw from them completely. Following this plan, the drug dose is lowered by 10% of the current dose in ten successive steps over time.

Here is the way this would work if at the time of starting withdrawal you were taking 500 mg of Thorazine a day: at each step, drug intake would be reduced by 50 mg (10% of 500 mg = 50 mg).

Step 1: Go from 500 mg to 450 mg a day. Wait several days or a week until you are free of distressing drug withdrawal symptoms. Step 2: Then go from 450 mg to 400 mg, again waiting several days or a week until you feel okay. Step 3: Then go from 400 mg to 350 mg, and so on, until you have completely withdrawn from the drug.

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



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plete the drug withdrawal.

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

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

In order to use this step-by-step approach, it may be necessary for you to obtain different pill strengths or to cut tablets or capsules that you have. Pills that have a hard coating are difficult to break evenly. Tablets are usually scored, meaning they have a groove down the middle, which makes it easy for you to break them in half, or ultimately into quarters,

with your fingers. Capsules are harder to cut. If they are cut in half with a knife or razor, the contents spill out, and you must keep the unused half capsule in a container.

Here is an example of a drug withdrawal schedule involving dosage reductions where cutting is necessary. If you are taking 60 mg of Valium a day (six 10-mg tablets) and want to use the 10% formula, reduce the dose in steps of 5 mg, instead of 6 mg (10% of 60 = 6 mg). Thus, at Step 1, take 55 mg (five-and-a-half 10-mg tablets) a day (by breaking one 10-mg tablet in half). Then at Step 2, take 50 mg (five 10-mg tablets) and then 45 mg (four-and-a-half 10-mg tablets) at Step 3, and so on, until you are off the drug entirely. If you ex-

perience some withdrawal symptoms when going from 5 mg (one-half of a 10-mg tablet) to none, try going from 5 mg to 4 mg (two 2-mg tablets), then to 3 mg (one 2-mg tablet and one-half of another 2-mg tablet), and so on. These dosages could be cut even finer; e.g., if you wanted to set the dosage level at 2 1/2 mg of Valium, you could take one 2-mg tablet and with a knife cut another 2-mg tablet in quarters and take one of the quarters (one-quarter of a 2-mg tablet = 1/2 mg).

The 10% formula is not an inflexible system for drug withdrawal. It can and should be adjusted to your individual needs.

Practical Suggestions

Diet

One of the purposes of withdrawing from psychiatric drugs is to cleanse the body; to rid it of accumulated poisons. Nausea, vomiting, and other stomach problems can be anticipated. What you eat during this period will

influence your experience of the withdrawal and its outcome. Therefore, it is important to eat well, regularly, but not to excess. Some people report getting good results by concentrating on grains, beans, fresh vegetables, fresh or dried fruit, and uncooked, unsalted nuts; and avoiding junk food, sugar (candy, cakes, ice cream, and soft drinks), processed foods (canned and frozen), fried foods, animal products (meat and dairy), caffeine (coffee, most commercial teas, and some soft drinks), alcohol, and drugs like marijuana, cocaine, and speed.

Sleep and relaxation

Insomnia (difficulty getting to sleep or staying asleep) is a common with-

drawal problem. Adequate sleep and rest during the withdrawal period is extremely important. If sleep does not come easily, it is better to rest in bed than to pursue some activity. Some people have found it helpful to drink an herbal tea (valerian and camomile are good ones) to relax. Others have benefited from yoga and breathing exercises, warm baths, and massages before sleep.

Physical exercise

In time, as your body becomes free of drugs, you will almost surely have more energy than you had while taking the drugs. This energy can be used to further the withdrawal process if it is channelled into an ex-

ercise program. Some sort of regular activity will assist your body in eliminating the drugs. You might start swimming, walking, dancing, or doing yoga or aerobics. Moderation is a key principle: increase your activities gradually.

Mental exercise

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

The only neuroleptic many psychotic patients may ever need

HALDOL® concentrate (haloperidol) tasteless, odorless and colorless; easily added to food, juices or water for ease of dosage adjustment and better patient acceptability. 2 mg per ml haloperidol (as the lactate).

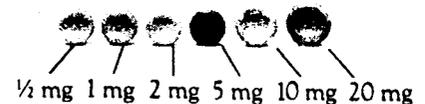
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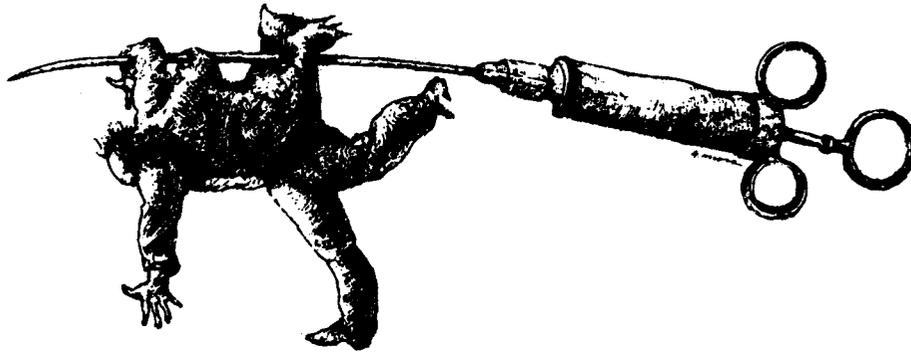
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Mental attitude

Withdrawal from psychiatric drugs can be a very trying experience. You should know that withdrawal can cause moderate to severe discomfort and, at times, outright misery. Being mentally prepared for this decreases the chance that you will become scared or discouraged. Patience and determination are needed.

Environmental factors

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

A note on smoking

It is not wise to stop smoking while you are withdrawing from psychiatric drugs. Each process can lead to an increase in tension. When both are undertaken together, these tensions can be overwhelming. It is far better to get off psychiatric drugs first and then deal with the smoking problem.

Withdrawal Effects by Drug Category

Neuroleptics

Drugs like Thorazine, Stelazine, Haldol, and Prolixin [Modecate] are associated with three basic types of withdrawal reactions, usually starting a few days after the drugs are stopped or reduced, peaking during the first week and generally diminishing by the second or third week.

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

Muscular reactions: neuroleptic-induced parkinsonian symptoms, such as muscular rigidity, tremors, and stiffness, can persist for several months or longer after the drugs are stopped. Other abnormal, uncontrollable, rhythmic movements, particularly around the mouth, can last for many months, or even indefinitely if tardive dyskinesia has developed [see story, Page 34; also see the section on tardive dyskinesia in *Dr. Caligari's Psychiatric Drugs*].

"Withdrawal psychosis": As people withdraw from the neuroleptics, they sometimes feel like they are going crazy. Often this is not recognized for what it is — a condition brought

on by the withdrawal itself. This development can then result in a return to more intensive drugging. A far better course would be to slow down, not reverse, the withdrawal procedure.

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

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

Anti-depressants

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

Lithium

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

Anti-anxiety drugs

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

Withdrawal symptoms can occur immediately or shortly after the drugs are reduced or stopped, and can build in intensity for a week to ten days. It is during this early stage that seizures are most likely to occur. Withdrawal reactions of a milder nature can linger for several weeks or even a month or two after the drugs are stopped. (Particular attention should be paid to withdrawing gradually from Xanax, a Valium-type drug, with which very severe withdrawal reactions can occur.)

Sedative-hypnotics

Sudden withdrawal from barbiturates and pseudo-barbiturates, such as Quaalude, Tuinal, and Placidyl, can be hazardous, with life-threatening seizures a possibility. If you have been taking these drugs continuously for longer than two months, it is

necessary to reduce doses over a period of several weeks. Withdrawal symptoms are similar to those of the anti-anxiety drugs.

Psychostimulants

Amphetamines and quasi-amphetamines like Ritalin are addictive drugs, and withdrawing from them can cause serious problems. Unlike the sedative-hypnotics, there is no danger of life-threatening withdrawal seizures. But suddenly stopping psychostimulants can induce severe despair (at times of suicidal proportions), extreme fear, and "withdrawal psychosis." Therefore, gradual withdrawal is strongly recommended. Other less serious withdrawal reactions include: apathy, fatigue, nervousness, irritability, and gastrointestinal symptoms. There is little documentation concerning psycho-

stimulant withdrawal problems for "hyperactive" children. But there are many published reports of such problems with adults, and it is reasonable to assume that children withdrawing from Ritalin-type drugs sometimes experience difficulties.

Geriatric drugs

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

Dr. Caligari's Psychiatric Drugs

(1984; last updated in 1987) is available for \$6 (or \$4 each for orders of five or more), in US funds, from the Network Against Psychiatric Assault, 2054 University Avenue, Room 405, Berkeley, California, USA, 94704.

Will Wonders Never Cease?

Shrink admits doctors cause tardive dyskinesia

According to the "Science/Medicine" section of the February 6, 1988 *Globe and Mail*, a Toronto psychiatrist has caught on to the fact that shrinks cause tardive dyskinesia (TD).

"TD is the major long-term hazard of neuroleptic treatment" says Ximena Fornazzaria, who has recently set up TD clinics at both the Queen Street Mental Health Centre and Mount Sinai Hospital. "It puts doctors in an awful dilemma because we are the ones that cause it."

"The discovery of neuroleptics 30 years ago," the *Globe* informs us, "was a major breakthrough in suppressing the worst symptoms of psychotic illness." "Psychotics" are people who "break from reality ... their symptoms include delusions, false beliefs and hallucinations."

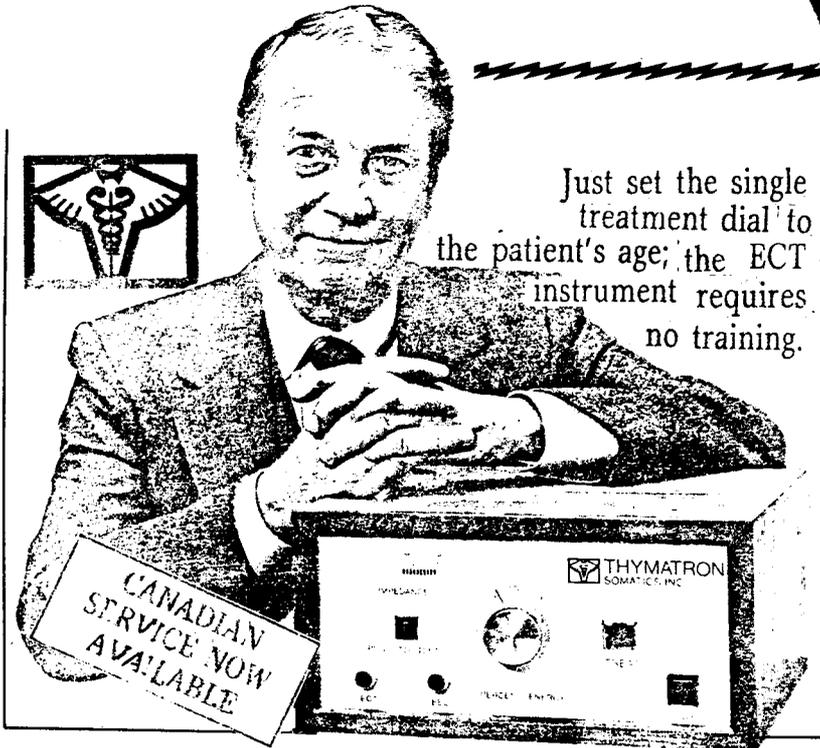
"People with TD have abnormal, involuntary movements of the mouth or face and sometimes, the arms and legs. The tongue may protrude or

flick in and out as though a lizard were catching flies. The lips pucker or smack uncontrollably, while facial contortions can be mistaken for inappropriate smiling or frowning. In short, these disfiguring movements can make people look crazy.

"The spasms are painful and embarrassing. In rare cases ... they can be dangerous, causing irregular breathing or trouble with swallowing."

The article says there is a 40 percent chance that people taking neuroleptics will develop TD, which can show up as early as six months after treatment starts. Several paragraphs later, it states that people who have only been on neuroleptics for three months were diagnosed with TD if "other causes for the abnormal movements were ruled out" and "mild dyskinesia was present in at least two areas of the body."

SHOCK WAVES



There's still time to influence the US debate over the reclassification of ECT (shock) machines

Committee for Truth in Psychiatry update

In 1979, the US Food and Drug Administration (FDA) classified shock machines in the highest risk class of medical devices, Class III, which meant that the machines – and possibly shock “treatment” itself – were earmarked for a safety investigation.

In 1983, under pressure from the American Psychiatric Association, the FDA published a “notice of intent” to reclassify the machines to Class II, which would designate ECT

a “reasonably safe,” or low-risk, treatment, not requiring any investigation.

Since that time, the FDA has only been restrained from taking the next step towards reclassification – the publication of a “proposal to reclassify” – by an unceasing stream of objections from the public. Meanwhile, the petitions of 123 shock survivors organized by Marilyn Rice of the Committee for Truth in Psychiatry (CTIP) to have CAT scans done on their brains, in order to prove the

damage done by ECT, were turned down (see *Phoenix Rising*, Vol. 7 No. 2).

The US House of Representatives is currently debating Bill HR 2595, sponsored by Henry Waxman, Chairman of the Subcommittee on Health and the Environment. In its original form, this bill would have automatically classified all pre-1976 Class III medical devices – including shock machines – as *completely safe* (Class I). Protests have persuaded Waxman to make an exception for the automatic reclassification to Class I in the case of shock machines. But the machines may still be reclassified to Class II (“reasonably safe”), either administratively by the FDA, or legislatively through bill HR 2595.

Thanks to the people mobilized by Marilyn Rice and CTIP, the FDA’s files are now bulging with reports of injury, including brain damage, related to shock machines, and the FDA has so far made no further moves. It is now important to persuade Waxman that shock machines should not be reclassified. Says Rice, “Just a simple ‘Please pass legislation to keep the ECT device in Class III’ will suffice.”

Write to: The Honourable Henry A. Waxman, Chairman, Subcommittee on Health and the Environment, US House of Representatives, House Annex No. 1 (Room 512), Washington, DC, 20515, USA.

ECT a "Preferred Treatment," says NYT Magazine

A November 22, 1987 *New York Times Magazine* article ("Shock Therapy's Return to Respectability," by journalist Susan Squire) claims that a person who is "overwhelmed by feelings of hopelessness and worthlessness" and "broods about death" has an "illness" with "about a 15 percent mortality rate from suicide." The sufferer is a "prime candidate for ECT, the most powerful anti-depressant available." And shock treatment is "now accepted by growing numbers of psychiatrists as the preferred treatment for major depression and mania for patients who cannot take or do not respond to medicine."

Squire admits that former "patients" say shock causes irreversible brain damage and long-term memory loss, but gives more weight to "the procedure's proponents — whose ranks include organized psychiatry and the scientists involved in memory research ... who vigorously contest these points."

The article laments that "Like the current controversy over the forced hospitalization of mentally ill homeless people in New York City [see story, Page 7], the ECT dilemma underscores the sometimes-irresolvable clash between civil rights and medical need."

The invention of ECT, we are told, was based on the observation that epileptics rarely seemed to suffer from schizophrenia ("a severe illness characterized by delusions and hallucinations"), which led doctors to figure that brain seizures were "anti-psychotic."

Although shock was overused in the old days, people get fewer shocks now, and are "put to sleep" with anesthetics. Furthermore, "temporary paralyzing agents" are now used to "prevent bone fractures from violent muscle contractions during the seizures."

"One patient," Squire reports, "may require ten times the amount of

current as another before a seizure occurs. Experimental medication to block seizure-induced amnesia is now undergoing trials in hospitals in New York City and Philadelphia."

While she mentions the fact that Marilyn Rice of the Committee for Truth in Psychiatry "says that she lost 'decades of knowledge' ... including her entire professional memory" after eight shock treatments, Squire also asserts that "It is at present impossible to prove or to refute categorically the charge that electroconvulsive therapy causes brain damage."

She further points out that people who receive ECT stay in hospital for an average of thirteen fewer days than those on medication — a saving of about \$6,400 per "patient": "If you're a responsible administrator, you don't want a patient to wind up in a state hospital because he had only 60 days' [medical insurance] coverage ... your job is to get him stabilized."

Squire's article essentially rehearses the concern expressed by psychiatrists that people who want and need ECT may be denied it because of the actions of "misinformed" lawyers.

The December 20 issue of the magazine ran three letters in response to the article: one from a pro-shock MD, one from a social worker who wants to "see research focus on the long-term, emotional impact of ECT," and one from Linda André, who is suing the New York Hospital, her doctors there, and three shock machine manufacturers for a million dollars (see *Phoenix Rising*, Vol. 7 No. 1).

"I had a course of ECT at a prestigious New York hospital in 1984," wrote André. "Today, I struggle with a permanent loss of normal function. I don't need to wonder whether ECT causes brain damage; I have the result of my own brain scan to prove that it does.... One hundred twenty-three former patients have volunteered for a study of the effects of ECT. However, the Food and Drug Administration, which is responsible for the regulation of ECT machines, has so far denied our petitions."

How to produce normality with electricity

"Classic" methods of treatment aim to change the organism in order to produce a change of mood. This applies to electroshock. Hanfried Helmchen, leader of the university "clinic" in West Berlin, said in 1982 that "The electrical stimulation produces the highest possible activity of all parts of the brain at the same time...."

The control of motion is regulated by the nerve cords from and to the brain; therefore a current passed through the brain becomes noticeable all over the body; this causes the so-called jumping-jack motion.

Psychiatrists have known for a long time that "patients" don't receive electroshock with enthusiasm. In a 1961 article called "A study about the permanent treatment — the point of view of the patients and staff," published in Volume 5 of the journal *Medicina Experimentalis*, three French psychiatrists explained:

"ECT in many cases led to the apprehended persistent disturbance of memory, or to confusions, which were even harder to interpret.

('You've weakened my heart' ... etc.) One of the patients experienced the electroshock treatments, which occurred at regular intervals, as regularly repeated torture. Even when the general condition had sufficiently improved ... the electroshock treatment showed a ... destructive result."

But it is not only the emotional and intellectual damage it does that makes electroshock a "classic" treatment. During autopsies performed in the 1950s, individual case-examinations were done on the brains of "schizophrenics" who had undergone electroshock, and psychiatrists and neurologists often found many different kinds of brain deformation, including softening of whole parts of the brain, destruction of the hippocampus, bleeding and thrombosis at brain vessels, and change of nerve cells at the thalamus, the hippocampus, and the neocortex.

The number of patients who showed hypersensitivity to this kind of treatment (with or without curare), and therefore didn't survive, cannot be counted. The Zurich neurosurgeon Hartwig Heyck, after examining the brain of a "schizophrenic" whose heart couldn't endure a 355th electroshock, came to the conclusion in 1955 that "The result doesn't permit one to presume that electroshock treatment is harmless."

We owe knowledge of how electroshock affects cats to a 1971 study by East German neurologist Helma Sommer: from the third electroshock on she observed in her "patients" an essential change of mind, a shaken sense of direction, which became obvious when the animals quickly fled into the protecting darkness. In addition, she observed a decline of sexual instincts and of appetite. With a growing number of electroshocks, these effects increased, and some months later they apparently caused permanent damage.

In the course of examining the advancing destruction of brain cells after an increasing number of electroshocks, Sommer thought about the exact origin of the brain damage: "It is possible that the repeated effect of the current used causes a gradual blocking of the metabolism between brain cells, by which means the metabolism of the cells is slowed down temporarily. Eventually the irreversible malfunction is inevitable."

Sommer calls this an acute cell disease: "As we can see from our tissue preparations, the destruction of the nerve cell starts with the disintegration or atomization of the Nissl-substance [accumulation of nucleic acid, which, as the fundamental substance of the cells, receives all information about the construction and function of the body organs]. Also, the cell

membrane dissolves. The disintegration finally spreads to the cell's nucleus, and the end of the progressive development is that the cell dies."

Former acting sublieutenant Erwin Pape, who underwent this treatment more than 100 times in the 1950s, described in 1972 how the procedure strikes the person concerned:

"Dragged to a rubber mattress, the rubber gag between his teeth; both electrodes, which end with a common wire in an electric box, are attached to his temple by the doctor. Sometimes with a long cry, always accompanied by a heavy gasp, begin

of electroshock has hurt a psychiatrist.) In 1982, Hanfried Helmchen, in whose "hospital" the electroshock room was insulated against noise, called electroshock treatment "particularly humane."

According to Erwin Pape, it was the second world war, a year after Ugo Cerletti's pioneer work, that brought the triumphant march of electroshock. Pape wrote in 1981: "Raging patients, strong as an ox, who previously had beaten up several nurses and had torn thick leather belts, would suddenly become sleeping 'apostles of peace' [conscientious objectors] ... [and] were all at once cured. And malingersers, who before had remained in the station in spite of large doses of castor oil, quickly learned that it was more agreeable to fight against hostile gunfire than to suffer from electroshock."

According to psychiatrist Ditlef Ploog from the Max Planck Institute in Munich, electroshock treatment is often "the only remaining method to normalize the state of mind." Other psychiatrists report the safety and success of the treatment with stubborn soldiers on a warship, where electroshock "therapy" had "turned raging patients into quiet, obedient individuals, who were willing to cooperate. The port authorities ... were astonished to receive a shipload of obedient and controllable patients...."



From *The History of Electroshock*, edited by Leonard Roy Frank

the cramps – so violent that they sometimes cause fractures of the jaws, vertebra, thighs or arms. Soon half a dozen unconscious patients lie in their beds, and the others – with horror in their limbs – are glad that it wasn't their turn."

California psychiatrist Leon Epstein was quoted in a 1977 issue of *Psychology Today* as saying that electroshock was "safer than Aspirin." (Indeed, no known incident

Excerpted from Die Chemische Knebel (The Chemical Gag), by Peter Lehmann. Translated by Ulrike Stamp, Berlin. To order a copy of Die Chemische Knebel, write to Peter Lehmann c/o Irren-offensive, Pallasstrasse 12, 1000 Berlin 30, West Germany.

REVIEWS

Nazi Doctors: Medical Killing and the Psychology of Genocide

**Robert Jay Lifton,
Basic Books, 561
pages, \$19.95 (US)**

**Review by Lenny
Lapon and John Judge**

There is a joke about a long line of people waiting for judgement at the gate to heaven when a man with a beard, a pipe, and a tweed coat runs to the front and pushes his way in. "Who on earth was that?" asks the woman at the head of the line. "Oh, him," says St. Peter, "that's God. He thinks he's a psychiatrist."

Historically, there were lines of people waiting at the ramp to Auschwitz, on their way to hell. Often a eugenicist doctor in an SS uniform would run to the front of the line and begin selecting the workers from those about to die in the gas chambers. Inmates there recall that he acted like God. His name was Josef Mengele.

Drawing on numerous sources and direct interviews, psychiatrist Robert Jay Lifton presents a detailed study of the role of doctors in the Nazi holocaust. By

hiding the fact that these doctors were primarily psychiatrists, Lifton obscures the real reasons for the killings, which are rooted in the long and sordid history of psychiatry and eugenics.

Always at the cutting edge of social control, psychiatry was instrumental in the Nazi holocaust. For two full years before the development of Auschwitz and the other death camps, psychiatrists invented deadly gas chambers and sent 300,000 psychiatric inmates to "killing centres." This program was misnamed "euthanasia," or mercy killing. These technicians of death became the "experts" when Hitler set up the concentration camps.

Lifton's book goes into detail

concepts as the "Nazi biomedical vision," and "the socialization of Nazi doctors to the killing project," which supposedly led otherwise ethical doctors into demonic acts of mass murder. In his introduction, Lifton defines his study:

"At its heart is the transformation of the physician – of the medical enterprise itself – from healer to killer. That transformation requires us to examine the interaction of Nazi political ideology and biomedical ideology in their effects on individual and collective behavior."

Where does Lifton believe such "biomedical ideology" originated? In claiming it came from the writings of Hitler and the political leaders, he becomes an apologist for the psychiatric system.

The basic concepts of eugenics – genetic origins of "mental illness"; "selective breeding" for certain values; "negative selection" (including sterilization of those "unfit to reproduce"); racial and ethnic differences in intelligence and behaviour; and "surplus population" – go back to the writings of Malthus, Darwin, and Galton. Psychiatry and eugenics were the symbiotic pseudo-sciences developed in the nineteenth century, rooted in the racism and emerging fascism of that era.

No one has looked so long and so hard for something good to say about the Nazis as has Lifton. In the place of political analysis we find such psychological nonsense as Lifton's claim that his "goal in this study is to



Robert Jay Lifton

about how the "euthanasia" program was carried out, but his analysis places the blame on such abstract

uncover psychological conditions conducive to evil.”

Lifton’s explanation of how he was able to contact and interview the Nazi psychiatrists may be a key to the whole book:

“I could best approach them through introductions of Germans of some standing in their society who were sympathetic to my research. The process was enhanced by a formal appointment I was given as a fellow at the Max Planck Institute for Research in Psychopathology and Psychotherapy, directed by Dr. Paul Matussek.... Professor Matussek would send a form letter [that] described me as a prominent American psychiatric researcher who was conducting a study of ‘stresses and conflicts’ of German physicians under National Socialism.... [The letter] emphasized my commitment to confidentiality; and urged the person in question to cooperate fully with me.... The recipients of those letters undoubtedly understood that ‘stresses and conflicts’ were euphemisms for more sinister matters.” (It deserves mention that the Max Planck Institute was the scene of Nazi experimentation during the war.)

Also revealing is Lifton’s description of his interviewing methods:

“An ironic element in the approach was the requirement (made by the Yale University Committee on Research with Human Subjects, and generally followed in American research) that I obtain ‘informed consent’ from the Nazi doctors. The requirement itself stemmed from the Nuremberg Medical Trial, and was therefore a consequence of the misbehaviour of the very doctors I was interviewing, or their associates. That touch of humanity seemed exactly right. Therefore, in correspondence with these doctors before our meeting, I reaffirmed the principles of confidentiality.... These principles were stated in written forms I asked each doctor to sign, sometimes at the beginning or the end of the first interview and at other times during the second meeting ... (depending on my estimate of whether introducing the

form at a particular time would intensify an already stressful situation and thereby interfere with the work).”

Lifton thus refuses to name these doctors, some of whom reveal to him unindicted criminal acts. His admitted misuse of the “consent forms” is common among psychiatric researchers, who often begin the drugging or surgical procedures *before* they ask for the signed consent.

Lifton also admits that the use of “pseudonyms” for “interviewees” extends to “a few others.” This not only protects the identities of Nazi criminals, but also frustrates further study, exonerates war crimes, prevents future trials, and obfuscates these people’s present work and positions. This, for Lifton, is “a touch of humanity.”

Funded by unnamed “foundations,” Lifton travelled extensively in Europe to interview and research Nazis. He seems to ignore the fact that the United States has also been a breeding ground and immigration point for fascist psychiatry since the second world war.

Lifton decided not to “mention [his] Jewishness,” lest the Nazis “refuse to see [him].” He opted for “psychological probing rather than confrontation.” He claims that his “professional identity” made him feel “an obligation to be fair to these former Nazi doctors.”

Thus, Lifton replaces political clarity with psychological confusion, and condemnation with counselling. He used a similar approach with veterans returning from Viet Nam (who were often forced to take part

served to mask the real nature of war.

It is instructive to look at Lifton’s past activities. During the Korean war, for example, Lifton and Dr. Louis Jocelyn (“Jolly”) West participated in studies on the “brainwashing” techniques that had supposedly led US Air Force pilots to confess to the use of germ warfare in China. These studies were used to justify the joint CIA/Department of Defence mind-control programs known as MK ULTRA.

Lifton states that the first extermination camp, Chelmno/Kulmhof, used “the T4 [psychiatric killing centres] procedure,” administered by “SS officers [who] wore white coats and carried stethoscopes.” He ignores the probability that these SS men were themselves psychiatrists. Many of the psychiatrists involved in planning and executing the “euthanasia” programs were high-ranking members of the SS. For example, Max de Crinis, Chairman of the Department of Psychiatry at the University of Berlin, was an officer in the SS who was active in psychiatric killings.

In addition to camouflaging their identities and their profession, Lifton builds a defence for these people’s behaviour, using the common psychiatric trick of calling lying “denial,” and deceitfulness “confusion.” He falsely exonerates psychiatrists by claiming that they did not comprehend the purpose of the questionnaires that led to transfer to the killing centres. “Dr. Günther E.” Lifton says, “told us how confused he and his colleagues were as patients ‘were taken from us ... I don’t know where to.’”

Lifton talks about “the extent to which psychiatrists could continue to disbelieve what was happening – especially when they did not *want* to believe it ...” (emphasis ours). Psychiatrists continue to the present day to refuse to take responsibility for their “patients,” or to “understand” why some of them die.

Lifton admits that “If ... susceptible to the idea that mental patients ... lack ordinary human qualities ... and hence to the idea of eliminating that group ... one might also be more amenable

“ . . . many psychiatrists could harmonize with . . . the larger Nazi vision of curing by killing.”

in that genocidal war) by inventing a psychiatric diagnosis – Post Traumatic Stress Disorder – that

to embracing a new 'therapy' ... in accordance with ... one's organic-genetic principles. In that way ... many psychiatrists could harmonize with, even epitomize, the larger Nazi vision of curing by killing."

He claims that something he calls "the doctrine of absence of empathy ... led to the development of violent somatic procedures (whatever their efficacy) such as insulin and metrazol shock therapy, electroshock therapy and lobotomy. Under duress, those who held to the doctrine of absence of empathy might have been more ready than otherwise to collaborate in killing their own patients."

Lifton seems to be much more concerned with the "duress" of the executioners than that of the victims. "German cultural stress on authority and obedience," he claims, made it "difficult for ... psychiatrists to consider ... defying the state when summoned to participate in virtually any kind of project." This argument, taken up by nearly every Nazi apologist, was effectively discounted by Stanley Millgram, author of *Obedience to Authority*, who started out to prove the "Germans are different" thesis, but discovered just as much obedience to authority in the US.

Lifton's final explanation is his most insidious. Crucial to his work is the idea that the Nazi killer-psychiatrists were able to carry out mass murders only with the help of a "psychological double," whose existence is brought about by stress and "numbing."

If anyone has done any "doubling," it is Lifton himself. For each historical instance of abuse, experimentation, or genocidal attack carried out by the Nazi psychiatrists, Lifton has created a "good doctor" who has stooped to these crimes only because of being blinded by the "Nazi biomedical vision," or "brutalized" by the killing programs.

Dr. Hermann Pfannmüller was infamous during the war for starving children to death at the killing centres. One student remembers him

grinning and holding aloft a dying, skeleton-like child, discussing the technical aspects of starvation as a method of murder. Lifton claims Pfannmüller was both "a simple man [who] ordinarily could not hurt a fly," and one who had a "deep commitment to the ideology of 'life unworthy of life' ... a depressed person who overcomes his own anxiety ... by harming others," with "a strong brew of sadism and omnipotence." Still, Lifton claims, "he could have continued to see himself as for the most part idealistic and even decent ... Pfannmüller remains the epitome of the brutalized physician turned killer."

One has to ask, since Lifton won't, who was brutalizing whom?

Tens of thousands of psychiatric inmates met their deaths at the hands of Dr. Carl Schneider, one of the top three directors of the "euthanasia" programs, who functioned as an "expert consultant" in signing the forms that ordered transfers to the killing centres. Lifton claims that Schneider "exemplifies the moral descent of a distinguished academic psychiatrist into the Nazi worldview.... A pre-

ecutioner."

And of Dr. Karl Brandt, another major figure in the mass murders, Lifton claims that he "is more than any other doctor, the prototype of what I shall call the 'decent Nazi' ... [his] ethical concerns seemed strikingly at odds with the depth of his Nazi commitment ... [his] religious-romantic involvement contributed to his extensive numbing toward mass killing."

Any objective study of psychiatric practice in the twentieth century, both before and since the Nazi years, reveals its dehumanizing character, its eugenic and biological misconceptions and prejudices, and its propensity first to sterilization and then to murder, either by intent or by neglect. Today, more people survive (with permanent brain damage) the same procedures that killed so many in the experimental stage of their use. Does anyone believe that modern psychiatrists must go through some sort of ideological transformation, moral dissolution, or "numbing" and then "doubling," to let their patients die or risk death from these procedures?

Lifton's *Nazi Doctors* could serve as a handbook on stress and conflict management for those who want to renew the slaughter.

We suggest that you read Lenny Lapon's *Mass Murderers in White Coats: Psychiatric Genocide in Nazi Germany and the United States*. Lapon names names, draws historical and political connections, and makes the links between eugenics, psychiatric killing and other psychiatric practices, and fascism.

To order *Mass Murderers in White Coats*, write to Lenny Lapon, *Psychiatric Genocide Research Institute*, Box 80071, Springfield, Massachusetts, 01138-0071, USA.

Does anyone believe that modern psychiatrists must go through some sort of ideological transformation, moral dissolution, or "numbing" to subject their patients to brain-damaging procedures?

viously sensitive man's deep immersion in Nazi ideology in general enabled him to function as both empathetic psychiatrist and medical ex-

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“Today, psychologists have a favourite word, and that word is maladjusted. I tell you today that there are some things in our social system to which I am proud to be maladjusted. I shall never be adjusted to lynch mobs, segregation, economic inequalities, ‘the madness of militarism,’ and self-defeating physical violence. The salvation of the world lies in the maladjusted. By resisting nonviolently, with love and unrelenting courage, we Negroes can speed up the coming of a new world . . . in which all . . . will respect the dignity and worth of all human personality.”

– Martin Luther King

From a speech paraphrased in the biography **Let the Trumpet Sound, The Life of Martin Luther King, Jr.**, by Stephen B. Oates (NY: Harper & Row, 1982)