

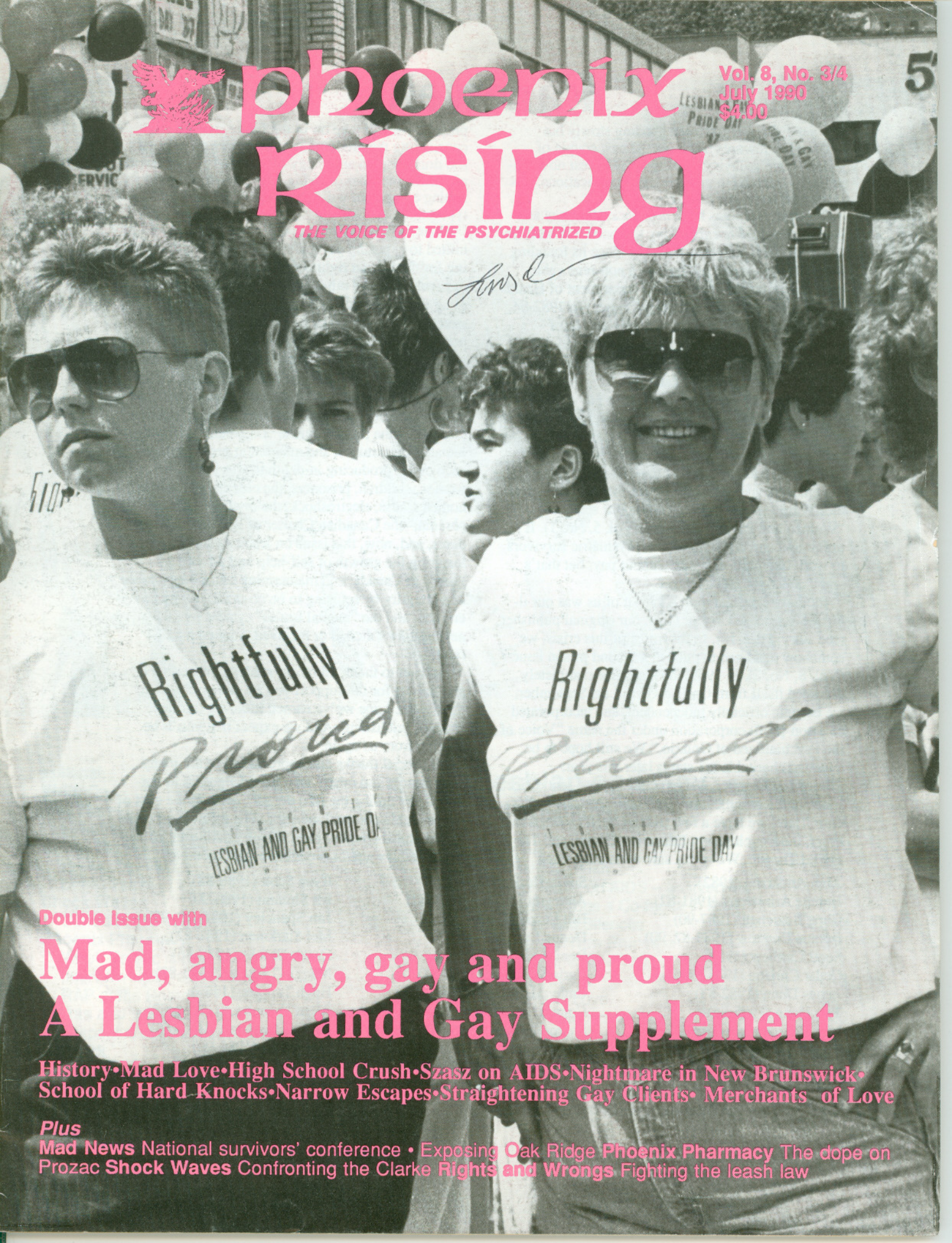


phoenix Rising

THE VOICE OF THE PSYCHIATRIZED

Vol. 8, No. 3/4
July 1990
\$4.00

Shirley



Double Issue with

Mad, angry, gay and proud A Lesbian and Gay Supplement

History•Mad Love•High School Crush•Szasz on AIDS•Nightmare in New Brunswick•
School of Hard Knocks•Narrow Escapes•Straightening Gay Clients• Merchants of Love

Plus

Mad News National survivors' conference • Exposing Oak Ridge Phoenix Pharmacy The dope on
Prozac Shock Waves Confronting the Clarke Rights and Wrongs Fighting the leash law

Farewell

Phoenix Rising has been heading slowly but steadily towards death for the past couple of years, so we're laying the magazine to rest now. Although we intend to produce other publications, this is our last issue of *Phoenix*.

The basic problems have been lack of money and lack of people. *Phoenix Rising* has been in a state of financial crisis almost continually since its founding in 1980. The one exception was a non-renewable, two-year grant from the federal department of Health and Welfare (Health Promotion Branch) in 1982-84. Before and since that time, virtually all our of government grants have been short-term and tied to specific theme issues. Foundations have routinely rejected our funding applications.

Obviously, we haven't been able to pay salaries, and have therefore lost some very creative and dedicated people, such as former business/circulation manager Maggie Tallman and editor Irit Shimrat (who came back to edit this final issue). They can't be replaced, and neither can Nira Fleischmann, who died before she'd finished editing our second "Women and Psychiatry" issue (Vol. 5, No. 1). It's unfair and unrealistic to expect psychiatric survivors to work hundreds of hours without pay, but that's what we have depended on.

Another event that took a lot out of us was our illegal eviction by On Our Own, our original publisher (see story, Page 12). In the midst of this crisis, we somehow managed to publish a second prison issue (Vol. 8, No. 2). In 1989, the magazine completely divorced itself from On Our Own. Last September, we became officially independent, and incorporated as a non-profit corporation under the name "Voice of the Psychiatrized of Ontario." We still hope to be awarded charitable tax status later this year.

Since last October, we've occupied low-rent office space in the basement of 394 Euclid Avenue in Toronto. Here, we have a few friends, such as Blackbird Press, the Development Education Centre, and The Euclid Theatre. We're not sure what publishing

projects we will take on in the future, but we are considering the production of a booklet on psychiatric drugs and an anthology of some of the best work published in *Phoenix Rising*. Our new desktop publishing equipment will enable us to do our own typesetting.

Whatever we end up doing, we remain firmly committed to exposing psychiatric oppression and fighting for the human rights of all inmates incarcerated in psychiatric and other prisons, and all people struggling to survive in boarding homes and on the streets. We are proud of our many achievements: exposing Ewen Cameron's brainwashing experiments, which took place in Montreal during the 1950s and 1960s, and supporting some of his surviving victims; helping psychiatric inmates and ex-inmates become more aware of their legal and constitutional rights (especially the right to refuse "treatment"); helping inmates, ex-inmates, and movement groups contact each other; producing in-depth theme issues on women, children, prisoners, the elderly, advocacy, homelessness, electroshock, the myth of "schizophrenia," the Canadian Charter of Rights and Freedoms, and, now, this issue on lesbians and gay men; inspiring the growth of self-help and advocacy groups in Canada; and maintaining our independence and integrity by refusing to be co-opted by the government and the "mental health" system (we have never either solicited or received "mental health" funding).

We want to thank all of our readers, subscribers, and donors for the support you've shown *Phoenix Rising*. We hope we've earned it during our ten years of publishing. And we expect that you'll be hearing from us again.

Our special thanks and appreciation to the many contributors and others who have helped us at various times during the past decade, often at the cost of considerable personal sacrifice. The following people (listed alphabetically) have served as editorial collective members and/or production staff members:

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Bonnie Armstrong (1981-82)
Chris Bearchell (1987-90)
Bonnie Burstow (1983-87, 90)
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James Dunn (1982-83)
Tim Dunn (1985-86)
Nira Fleischmann (1984)
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Carla McKague (1980-81)
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Connie Neil (1981-83)
Sharon Nelson (1986-87)
Bud Osborn (1983)
Carmen Palumbo (1986-87)
Douglas Robinson (1988-90)

Ryan Scott (1986-88)
Irit Shimrat (1986-90)
Jim Spencley (1986, 88, 90)
Mel Starkman (1981-82)
Carole Stubbs (1985-86)
Maggie Tallman (1985-89)
Hugh Tapping (1985)
Allan Tenenbaum (1981-82)
Patricia Urquhart (1983-85)
Don Weitz (1980-90)
Jo-Anne Yale (1980-81)
Mike Yale (1980-81)



Photo by Konnie Reich

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EDITORIAL

I ran away from my last mental hospital in 1980, when I was 22 years old. I stopped seeking professional help in 1984. That was the year I came out as a lesbian. I was extremely lucky to fall in with a weird and wonderful crowd of sex-positive, left-wing gay liberation activists of various genders.

Very quickly, the bad ideas the shrinks had given me (that I was crazy, sick, schizophrenic, clinically depressed, mentally ill, and so on) melted away. What happened was, I started having a lot of fun. My sex life and social life started to resemble what I had always needed. And I realized that I was okay. The despair and rage that had been stewing inside me since doing time in the loony bin and being on tranquillizers turned into something I could let out – and use – in fighting the oppression of gay people and, later, of people who have been psychiatrized.

Not surprisingly, lots of lesbians and gay men get psychiatrized. To me, psychiatry said: conform, control yourself, be compliant, shave your armpits, wear a bra, take your pills, believe what you're told. But gay liberation says: fight back, respect yourself, love your body, celebrate difference and diversity. Psychiatry was terrible for my mental health. Gay liberation has been great for it.

Conformity is a valuable commodity. People living in unconventional ways (sex workers, street people, runaways, mad

people, gay people) are regularly persecuted by the police and the thought police – the psychiatrists.

Psychiatrists, therapists, and counsellors (including many who are gay) have been especially quick to get into the AIDS pork barrel. As this magazine goes to press, studies are being commissioned on the mental health needs of people with AIDS or HIV. These studies will no doubt show that people who have AIDS, people who are depressed about AIDS, and people who are worried about AIDS all need psychiatric medication or expensive professional help in order to be mentally healthy.

But I believe that what people with AIDS or HIV need is the same as what lesbians and gay men, psychiatrized people, and everybody else needs: good food, a decent place to live, good friends, interesting things to do, lots of love, political activity, and respect for their particular reality.

People need freedom of movement, of thought, and of choice. And no one's freedom and abilities should be reduced by psychiatric incarceration, "medications," electroshock, or any other kind of forced psychiatric treatment.

Non-conformists of all stripes, and especially sexual "deviants," need to get together and oppose the agents of social control, and particularly institutional psychiatrists, who wield such powerful weapons against difference.

Irit Shimrat

Phoenix Rising



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The opinions of the editorial collective are expressed in the editorial and in unsigned articles. Otherwise, articles, stories and letters reflect the views of the writer.

Phoenix Rising is published by Voice of the Psychiatrized of Ontario, Inc. and may be contacted at 394 Euclid Avenue, Toronto, ON M6G 2S9 or by telephone at (416) 929-2079. July issue. ISSN 0710-1457
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Phoenix Rising is listed in the Alternative Press Index and is a member of the Canadian Periodical Publishers Association.

WRITE ON

Behaviour med-ification

The worst thing about being a psychiatric patient, even more than the stigma, is the medication, or, more specifically, the side effects of the medication. For whatever reason, I found myself being very seriously overmedicated the first and second time I stayed in a psychiatric hospital. The worst part was the tremors in my arms and legs. It felt like I had been doing chin-ups for two months straight, or running a marathon. This was unbelievably, totally exhausting, and the only respite was sleep. The tremors look like the mild shaking of someone getting into a car on a very cold winter day. But they feel like every muscle in your body is fighting, full strength, against every other muscle in your body. And the more you move, the more resistance the opposing muscles inflict. The only difference between this and running a marathon is that you can't decide to quit this race. I started to call the treatment "torture therapy," "behaviour med-ification," "a chemical straitjacket," or just plain "pure, chemical hell." I still can't understand why it wasn't reduced, despite my insistent pleas. Maybe because it was so debilitating that I couldn't always express my objections effectively. At one point I was unable to compose a single, simple sentence to express my dismay at being sent to Brockville.

Another almost unbearable aspect of the medication was the restlessness and agitation. To say that every position

you can possibly imagine assuming – standing, sitting, or lying down – is extremely uncomfortable, is putting it mildly. To say that it feels like a caustic chemical like Ajax or Drano is flowing through your body, causing a severe sunburn on the inside of every vein, comes closer to describing it. Saying that it is like standing in a lineup for something for five hours, on one leg, with an abyss on either side of you into which you would fall should you lose strength, gets closer. But still, you'd have to consider that it's a hundred times worse than a disinterested observer could possibly imagine. Even now, thankfully, I can't entirely recall the sensation completely. But at the time, you don't know how much longer you will have to tolerate this indignity. Probably just as long as it takes for your doctor to start to think that he might be beginning to talk some sense into you.

Anonymous

Complaint ruled frivolous

(The following letter was a response to the radio series "Analyzing Psychiatry," broadcast on the CBC Ideas program in April 1990 [see Page S40]. The writer asked that the letter be forwarded to Phoenix Rising.)

Thanks for "Analyzing Psychiatry." I've just heard the first program in the series, and I plan to recommend it to an opposition member of the Yukon legislature.

The territorial government has introduced a proposed new Mental Health Act, Bill 20, which supposedly protects the rights of patients, but which seems to me to be a lot of legal doubletalk. They'll probably debate it soon after Easter.

On or about April 7, 1972, I was wrongfully arrested by the Metropolitan Toronto Police. I was not charged with anything but I was held without legal aid and without a court appearance for three months. I'm just lucky I wasn't kept longer!

I had been visiting my friend Laurene at her apartment in East York. We were listening to records, talking, and drinking coffee when the phone rang. It was my father and he was upset because I hadn't come home the night before. He told me the police were looking for me, and that I ought to "go quietly." I became upset, so Laurene took the phone and suggested that my parents come to Toronto and join us for dinner. They declined the offer. When the police arrived I was eating some salad. They told me to come and "see what the man says downtown." It would only take a "half an hour."

They took me to the Queen Street Mental Health Centre, where I was persuaded to sign in as an "informal" patient. They promised I would be allowed to leave in the morning. It was a "half truth," because in the morning I was drugged and put in an Ontario government car and taken to the Hamilton Psychiatric Hospital, where I was detained as an "involuntary patient." The reason? Because my doctor (Dr.

German Alvarez of St. Catharines) had committed me. I was drugged, and for the first week or so, I wasn't even allowed off the ward, with or without supervision.

But after I'd been held for about two weeks, I simply didn't bother going back to the ward after being sent for a lithium-level check. I walked downtown and took Go-Transit back to Toronto. That evening I went back to Laurene's place and rang the buzzer. I wasn't in her apartment for very long before a knock was heard at the door. It was the police. Laurene gave me some more salad and told me to sit down. The police were not amused and told me I'd get something to eat downtown.

When they got me back to the Queen Street Mental Health Centre, I was once again promised that if I'd sign in as an "informal patient" I'd be allowed to leave in the morning. I explained that I'd been through the same routine two weeks earlier and was not about to be fooled twice. I turned to walk out past the police. They just stood and watched as a goof in a white lab coat pulled my jacket up over my head and turned me around. I told them that if it would make them feel better I'd sign the stupid form.

In the morning I was again drugged and put in a car and taken to the HPH. This time they took my clothes and put me in pyjamas and paper slippers. They changed my prescription and took away my "privileges."

After I'd been there about a month, Dr. Terry Heins renewed my commitment for another 60 days. The reason? "Some of your behaviour is a bit odd." I protested to a "review board." They met with the doctor and *then* met with me *afterwards*. I've no idea what he told them, so how could I refute or rebut? It was up to me to prove I should be released. They refused.

At one point, Dr. Heins said he'd let me out if I got a job. He actually had me sending out letters while keeping me zonked on drugs. The only work I got was in an industrial sweatshop on

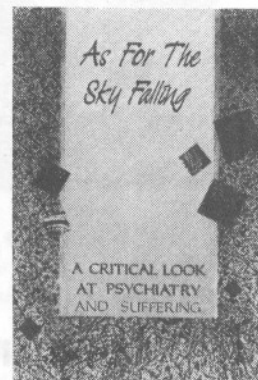
hospital grounds. I packed candy cigarettes for the Allan Candy Company and filed burrs off little metal things for the Chrysler Corporation for ten cents an hour. That's right, ten cents! The medications made me feel terrible and it was hard to do any work under the circumstances. But maybe it was better than staying on the ward with a woman who shit on the floor and a man who stole other patients' clothes and pissed on them.

When I was eventually released, I was too chicken to go see Dr. Alvarez. But after about a year I went and asked him why he had me committed. *He denied it.* He asked, "How could I commit you when you were in Toronto?"

For years I could find no way to prove anything. But I eventually found out, through the Ontario Ombudsman's Office, that Alvarez had signed a "Form One" saying I had a "history of self-destructive drives." Further, the letter confirmed that Dr. Heins had renewed my commitment on the grounds that I'd "threatened a woman in Toronto." Now that is a lie. Heins's whereabouts are unknown to me. But I phoned Alvarez in St. Catharines. He still made no sense: "I did not deny it! How could I deny it when my name is on the form?"

I complained to the College of Physicians and Surgeons, who rejected my case and gave me 20 days to appeal to the Health Disciplines Board. They held a hearing in 1984 at Queen's Park. Alvarez said a lot of things that were untrue. He said I had "threatened to jump off a bridge." He said I had "exposed myself" to a woman in Toronto. He said my father had told him these things. I couldn't disprove anything on the spot, because I'd never heard these particular lies before, and anyway, I wasn't allowed to bring a witness, nor a tape recorder. But I finally got a sworn statement from my father, setting the facts out clearly on these and other points of contention. The Board didn't care. They ruled that my complaint was "frivolous,"

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"vexatious," and a "misuse of the system."

I tried to get help from Premier Peterson but the best I could get from his government was that health minister Elinor Caplan sent me a copy of the Mental Health Act and another form to fill out. I told her to "sit on it." And it seems that's all she's doing.

Yours truly,

Stewart Jamieson

Whitehorse, Yukon

Files will never show truth

I have suffered emotional and mental abuse which left no marks because it was done to the mind. I do not like being told that I must be subjected to this kind of rape if the psychiatrist wishes and leave with the quality of my life destroyed instead of improved as a result of my visit to his office. I signed no paper; I never said I was his. I found myself followed from psychiatrist to psychiatrist with words I only uttered once, without even knowing it, so quiet they were within my soul. I wish to keep private this indefinable personal thing within me. As I was trying to walk out of his office, he raped me with manipulative double-talk which even if I wanted to I could not explain. For I am not corrupt. I have to live out my life as an emotional and mental cripple, as well as physical damage to my heart as a result of the attack, given up by doctors and lawyers who allow, and protect him for, his actions. I'm sure my files will show how he believed it happened, but they will never show the truth.

Sincerely,

Ms Howard

Barrie, Ontario

Rekindled enthusiasm

At the age of sixteen, I spent more than six months in a mental "hospital" to "treat" a severe "psychosis." I under-

went a full course of ECT (twelve shocks) and was heavily drugged. In spite of such "treatments," I made a miraculous recovery. The principle aftermath, apart from perpetual dependence on certain noxious substances, was severe memory loss and greatly reduced ability to form new memories – despite assurances from my psychiatrist (who, of course, has never prescribed ECT for himself) that such things do not happen.

Unfortunately, the same thing (but worse) happened in 1985 when I was 23. Admittedly, my relapse may have been precipitated in part by my refusal (much against "medical" advice) to continue with my Dipixol injections. But, whatever "blame" is attributed or attributable to me in no way lessens my resentment at being forced to endure a second course of ECT together with so high a dose of neurotoxins that it was almost impossible for me to form one single coherent thought!

I have since been put under the wing of a different psychiatrist. Perhaps surprisingly, I consider both men to be truly caring and compassionate individuals, conscientiously doing the best that psychiatry's myopia will permit them. I like them quite a lot, despite what the first one sanctioned and despite the present one's reluctance to stop chemotherapy and his refusal to provide an assurance that I will not be "given" (i.e., forced to have) ECT under any circumstances in the future. It is only the sincerity of their good intentions that lets them off the hook. Nonetheless, evil is being perpetrated, however subtly.

It was not until recently that I began to appreciate the enormity of this evil in the larger context. Ironically, it was my current psychiatrist who unwittingly set me on the path to an appreciation of this heretical truth. Observing that I was starved of a sufficiently high calibre of social intercourse, he put me in contact with an amicable and gregarious social worker, Miriam, who kindly introduced me to some of her very entertaining and supportive

friends. Miriam brought me to a greater awareness of the nature and effects of psychiatry (which would probably upset my psychiatrist if he knew). Her motive was to give me something constructive to do by involving me in patient advocacy and the like.

Having read much of the voluminous material Miriam has given or loaned to me (including the excellent magazine *Asylum*, which is where I found out about *Phoenix Rising*), I am very interested in the topic. My enthusiasm has been rekindled and I am keen to take action. Although there are advocacy groups in Nottingham, there are none in Mansfield, despite the presence here of a large psychiatric clinic called Millbrook. I hope to participate in the formation of a group to act as a "voice for patients/users/victims/survivors" in Mansfield.

John McCarthy

Mansfield, Notts.

England

Drugs down the toilet

In October 1987 I went into Sunnybrook Hospital's psychiatric wing as a mentally disturbed patient and was put into the hands of Dr. Ivan Silver, whose partner in crime was Dr. Kenneth Shulman.

In December I was given eleven shocks, which I believe were illegal. I am checking this out now. In July 1988 I was discharged from Sunnybrook on drugs. A year later I threw the drugs down the toilet. I have never gone back. I feel great now and would like these doctors' names published in your magazine.

Yours very truly,

ex-shrink patient

William Heffernan

(age 64)

Toronto, Ontario

PROTECT YOURSELF FROM PSYCHIATRY

If you live in Ontario, are over sixteen, and are deemed "mentally competent" by a doctor, you can appoint a personal representative who can refuse psychiatric "treatment" on your behalf (or permit disclosure of your clinical record) in the event that you are subsequently found "incompetent." The document below can be used as a sample appointment form. You, your representative and your lawyer should each keep a copy of the form). It is also a good idea to obtain a letter from a doctor (if at all

possible, a sympathetic psychiatrist), stating that you are mentally competent (as in the sample letter below). If you are in an Ontario psychiatric facility, pre-printed forms (Form 44 under the *Mental Health Act*) are available. A lawyer or patient advocate can help you fill out the form. Your own form and letter must of course use details from your own background, and your own wishes concerning "treatment" – the following are just examples.

SAMPLE FORM FOR APPOINTMENT OF A REPRESENTATIVE

To whom it may concern:

I, _____ (your name) _____, of _____ (address) _____, _____ (city) _____, _____ (province) _____, appoint my friend, _____ (representative's name) _____, who lives at _____ (address) _____, to be my personal representative under Subsection 1b(1) of the *Mental Health Act*. _____ (representative's name) _____ is willing to act on my behalf should I be found incompetent to provide a consent(s), as may be required under the *Mental Health Act*, to treatment, or to the disclosure/examination of my clinical record.

I am over sixteen years of age and believe that I am competent to appoint a representative and make decisions on my own behalf, particularly with respect to psychiatric treatment.

My wishes with respect to treatment, and I so instruct my personal representative (or other person who may be called upon to make treatment decisions on my behalf), are as follows:

- a) It is my firm wish that under no circumstances is ECT to be authorized for me.
- b) It is my firm wish that under no circumstances is any neuroleptic treatment is to be authorized for me.

In the past, such treatments have not proved to be beneficial for me.

Dated this _____ day of _____ (month) _____, 19__.

(witness signs here)

(you sign here)

SAMPLE LETTER FROM DOCTOR

(date)

To whom it may concern:

On _____ (date) _____, I examined _____ (name) _____ and found her to be mentally competent. In particular, it is my opinion that she is mentally competent to appoint a representative and to make decisions regarding medical treatment of herself and that her expressed wish that _____

_____ has been arrived at rationally, and on the basis of considerable information concerning these modes of treatment.

(doctor's signature)

(doctor's name)

MAD NEWS

Montreal hosts national gathering of survivors "Our Turn" at last!

Canada's first national conference for survivors of psychiatric "services" took place in Montreal, November 23 to 26, 1989. The conference, whose English name was "Our Turn," was sponsored by the Ministry of Health and Social Services of Quebec and by the Secretary of State of Canada, and was hosted by Le regroupement des ressources alternatives en santé mentale du Québec, a network of alternatives to psychiatry.

"Our Turn" was exhausting and thrilling. About two hundred psychiatric survivors showed up, and a wonderful time was had by nearly everyone.

There were workshops on such issues as housing, self-help, survivor separatism, the alternatives movement in Québec, and psychiatric "medications." (Irit Shimrat argued against psychiatric drugs at the "medications" workshop —

see box, below, for excerpts from her presentation.)

One of the highlights of "Our Turn" was a superb performance by Toronto's ex-psychiatric inmate theatre company, The Puzzle Factory. "Brain Forest, or, How *do* you slam a revolving door?" was directed by Ellen Litvak. The show was strongly antipsychiatry, and had nothing good to say about "medications." (A new version of the show was performed, under the direction of Linda Carter, in Toronto some months later.)

Another highlight of the conference was an international plenary session that featured Toronto mental health lawyer Carla McKague, Ontario New Democratic Party Member of Provincial Parliament David Reville, Louise Pembroke of the British organization Survivors Speak Out, inmates' rights activist Hans Wiegant of the Netherlands, and Judi Chamberlin of the National Association of Psychiatric Survivors of the United States.

For an excerpt from what Louise Pembroke had to say, see next page.

The following is excerpted from Irit Shimrat's presentation on psychiatric drugs at the "Our Turn" conference (see above).

If a doctor chooses a drug for you and decides how much you will take, when you will take it and in what form, that's called medication, and you can sometimes be forced to take it. If you choose to buy a drug from a friend, and make your own decisions about using it, that's called drug abuse, and you can be punished for it. It makes no difference if the drug you choose makes you feel better and the

drug your doctor chooses doesn't. I don't think that's right.

When a psychiatrist decides that there's something wrong with your brain and gives you drugs to make you stop acting strange, that takes attention

you're overwhelmed by real problems that you can't solve — like poverty, homelessness, or prejudice. Or maybe other people expect you to act a certain way because you're a woman, or because you're a man, or because they

assume you're heterosexual. If you act differently, they may give you such a hard time that you go crazy. You might go crazy because sexual, family, or other relationships are making you so miserable you can't stand it anymore. But if everyone believes that the problem is a chemical

imbalance in your brain, then no one has to worry about anything else:



Photo by Brian McKinnon

away from whatever is upsetting you. You might be acting strange because

"One day in the bin, when I had two nurses holding me down to force a needle into my backside, I thought, I'm going to get out of here one day and I'm going to tell people what's going on.

"Self-help is becoming increasingly important as we discover the power and safety of turning to each other, to people who have the experience. There is definitely a cohesive cry for non-medical, user-led crisis houses, where people would be allowed to go mad, with adequate rage facilities [where people can hit and destroy things without hurting themselves or anyone else] instead of being instantly medicalized and categorized.

"At three o'clock in the morning, when I'm experiencing what I term perceptual differences – say, some kind of creature, like a snake, trying to burrow itself under my skin – if I call a professional, I'm spot on for my diagnosis of schizophrenia and I'm going to be jabbed and all the rest of it. Whereas a fellow survivor who knows me and whom I trust is much more likely to be able to pull the snake out for me."



Photo by Brian McKinnon

Here is an excerpt from Judi Chamberlin's speech:

"When I was a patient, I was diagnosed as a chronic schizophrenic. I was told that I would spend the rest of my life going in and out of hospitals, that I had a lifetime need for neuroleptic drugs, that I had a chemical imbalance, that I should think of myself as a diabetic who had to take insulin. I was told I was someone who had to

take Thorazine to correct my disordered brain chemistry, that I would always be dependent on the mental health system, and that I wouldn't function as a normal person, although I might have periods where I could function relatively normally. That was 23 years ago. I've stayed out of the mental health system. I take no neuroleptic drugs. I sometimes get depressed, but I choose not to define that as a psychiatric or medical problem and I

you take your medications, and that's all there is to it.

Psychiatry deals with madness by using restraint. In the old days, crazy people, many of whom happened to have nowhere to live, were restrained by crowding them into a big building and locking the door. Then came the ideas of mental illness and treatment, with crazy people being restrained in straitjackets, or cold wet sheets wrapped tightly around their bodies, to calm them down. Then came the idea of restraining your brain instead of your body, with lobotomy, insulin shock, electroshock, and drugs. By restraining your brain, the hospital could have total control over you, and it didn't look as bad as tying you up. Finally, there was deinstitutionalization: letting you

**At first
psychiatrists just
restrained
people's bodies.
Then came
the idea of
restraining your
brain.**

out of the hospital and keeping you on the drugs. This way, psychiatrists can still get paid for treating you but don't have to bother with managing, housing, or feeding you. Drugs take care of the management. As for food and shelter,

you're on your own. With no money and no job, you might end up in a boarding house that is just like the hospital, only smaller and maybe dirtier.

I've talked with many people who have been in mental hospitals. What we all had in common was that bad things had happened to us and we felt helpless to do anything about it. The problem is, you're not likely to get together with other people to fight things that make you sad or angry if you get shots or take pills to make you *stop* feeling sad or angry.

The symptoms of mental illness are conveniently vague. According to the pamphlet "Understanding Schizophrenia," published by the Ontario Ministry of Health, the symptoms of schizophrenia are hallucinations, delusions,



Photo by Brian McKinnon

don't look for psychiatric interventions to help me with it. I've found alternatives.

"What saved me, and what has saved many people, is the ex-patients' self-help movement, and more important than that, the ex-patients' liberation movement. On the one hand, there are those who call themselves mental health consumers, who tend to accept

the medical model, who tend to want to work with others in the mental health system to make a better mental health system. For myself, I reject that approach and I reject that label. I emphatically believe that I am not a consumer of mental health services. I think the system tried to consume me.

"Our national organization is called the National Association of Psychiatric

Survivors. We like the word 'survivor' because it's positive and it denotes strength. Someone who has survived something is seen as strong. The key issues for our organization are to oppose all forms of forced or coerced psychiatric treatment, whether in institutions or in the community, and to work for the development of a wide range of user-controlled alternative services.

"The thing most lacking in mental hospitals is human contact. People should have other people to talk to when they're feeling bad, to sit with them, to hold them, whatever they need, and they must be the ones to direct what they need, and there must be enough people there to respond."

The most important result of "Our Turn" was the beginning of a national network of psychiatric survivors, independent of the Canadian Mental Health Association or any other body that is part of the mental health system.

If you are interested in being part of such a network, contact Irit Shimrat at Ontario Psychiatric Survivors' Alliance, 3107 Bloor St. W., Ste 201,

disordered thinking, disturbances of feeling and preoccupations. So if, for example, you are upset about being hospitalized and medicated, your psychiatrist might call that a disturbance of feeling, or a preoccupation, caused by your illness, and respond by increasing the dose. Also, if one drug causes bad effects, psychiatrists add other drugs to counteract the effect of the first one, which can make you very sick. You can read about the effects of psychiatric drugs in the *Compendium of Pharmaceuticals and Specialties (CPS)*, or the *Physician's Desk Reference (PDR)*. You can also find them in advertisements for the drugs in medical journals, listed in very small print on the second page of the ad.

Psychiatrists and hospital staff are not a reliable source of information. They are likely to tell you only that the medi-

Psychiatric drugs cause confusion, mania, anxiety, hallucinations, delusions, agitation, and nightmares.

cations are good for you, because keeping you medicated makes their jobs a lot easier, and also because they have no idea what else to do for you.

According to an ad in the *Canadian Journal of Diagnosis*, Ludiomil, a popular antidepressant, can cause confusion, hallucinations, disorientation, delu-

sions, anxiety, restlessness, nervousness, agitation, nightmares, mania, exacerbation of psychosis, decrease in memory, and feelings of unreality. And those are just the mental effects. Among the physical effects are dry mouth, blurred vision, constipation, headache, numbness, tingling, tremors, seizures, urinary retention, perspiration, hypotension, hypertension, palpitations, heart block, stroke, bone marrow depression, nausea, vomiting, diarrhea, cramps, black tongue, impotence, skin rash, itching, nasal congestion, and obstructive jaundice. Just what you need when you're depressed.

This is not an unusual list of effects. If you look at drug ads or books that describe prescription medications, you will see that this is pretty typical, not only for antidepressants, but for

Etobicoke, ON M8X 1E3 for more information.

Media-watching

On October 3, 1989, I took the *Toronto Star* to the Ontario Press Council, an agency that deals with complaints against Ontario newspapers.

The *Toronto Star* has been biased in its reporting of issues concerning psychiatric survivors. Between October 1988 and August 1989, the *Star* printed several articles precipitated by calls from *parents* of so-called schizophrenics. When the *Star* asked for comments on legislation and social issues concerning survivors, the Ontario Friends of Schizophrenics (a group of family members of people labeled "schizophrenic") and some government officials were consulted – but rarely were the opinions of survivors sought. The Press Council dismissed the complaint, but the hearing itself was a vehicle for bringing the media's pro-psychiatry bias into the open. We need an organized media-watch committee to monitor the *Star* and other print and broadcast media reporting on our issues.

Angela Browne

Newsletters

For information about what's happening with the anti-psychiatry movement in the United States, you can subscribe to the following excellent newsletters:

Peer Advocate, Box 60845,
Longmeadow, MA, 01116-0845, USA,
Attn: Alice M. Earl, editor.
Dendron Monthly News, Box 11284,
Eugene, OR, 97440, USA, Attn: David
Oaks, editor.

Exposing Oak Ridge

Chanting "Brick by brick – demolish it" 50 picketers converged on Ontario's only maximum-security institution for men deemed "criminally insane," on January 6, 1990.

One of the two divisions of Penetanguishene Mental Health Centre, Oak Ridge houses 140 inmates, many of them held on Warrants of the Lieutenant Governor; in "corrections" parlance these men are referred to as WLGs. Critics of Oak Ridge have called it the most archaic prison in Canada and say it should be shut down.

Opened in 1933 as the maximum-security division of a penitentiary, Oak Ridge has since been transformed into a "mental health centre." Oak Ridge has been the subject of many reviews

and inquiries. The latest was commissioned by the Ministry of Health in 1984 and conducted by psychiatrist Stephen Hucker of the Clarke Institute of Psychiatry (see *Phoenix Rising*, Vol. 6, No. 2).

A few of Hucker's 89 recommendations dealt with such issues as lack of fresh air, concrete slab beds, dinginess, lack of medical and dental care, lack of recreation for inmates, and the use of open toilets as the only source of running water in most cells. He outlined four possible options for the future of Oak Ridge; all of them involved tearing it down.

The Ministry of Health's current plan is to tear Oak Ridge down, but replace it with a more modern facility in the same location. But this could fail to

psychiatric drugs of all kinds.

In the long term, neuroleptics are likely to cause movement disorders – diseases like tardive dyskinesia. "Tardive" means late in appearing; the disease often doesn't appear until after the medication is stopped. Tardive dyskinesia causes involuntary movements of your face, tongue, and lips, and sometimes other parts of your body. Antidepressants and lithium are more likely to cause organic brain syndrome, a form of brain damage in which your intelligence, judgement, and memory are impaired. In severe cases of organic brain syndrome, you can become excited, restless, and euphoric. Both tardive dyskinesia and organic brain syndrome make you *look* crazy.

What is craziness, anyway?

How are "hearing voices" and "seeing things" – the most common symptoms of schizophrenia – different from talking to god or having religious visions, which people have been doing for centuries without requiring psychiatric intervention? Some cultures have so much respect for difference that they see people we would call crazy as having magical knowledge and powers, and treat them with reverence, rather than with medications. What if hallucinations really *are* visions? What if what we experience when we're crazy actually means something?

Even if going crazy has been useless and horrible for you, drugs don't have to be the only way out. Last year when I was in Banff, Alberta, at a conference called "Women and Mental Health," I

lost my mind. I was under a lot of pressure. I hadn't slept for several days, and I was surrounded by mental health professionals, which is always stressful for me. About four o'clock in the morning on the last day of the conference, I started hallucinating strange faces on the wall and thinking that everyone was out to get me. I was crying and moaning that I wanted to kill myself. Fortunately, I was there with a good friend, who listened to me, talked to me, held me, and tried to help me sleep. After a few hours, my hallucinations and terror went away and I just felt very tired. If my friend hadn't been there, I'd probably be locked up somewhere out west right now, and I'd probably still be crazy.



Demonstrators at Oak Ridge. Photo by Konnie Reich

solve a lot of problems that have nothing to do with the institution's physical structure. For example, Dan Parle, the public information officer at Oak Ridge, admits that the institution's administration has a history of poor labour relations with the attendant staff. He confirms critics' claims that inmates are caught up in those problems when attendants use two- and three-day illegal lock-ups of inmates to bring attention to their grievances.

Hucker recommended that some of the old-guard staff at Oak Ridge be replaced. Parle says the staff has been retained; Ministry

of Health media officer Terry Moran explains that, rather than dismiss attendants, the institution trained its nurses in psychiatric work.

Randy Pritchard is an WLG who has been held at Oak Ridge. Although he is not currently in custody, under the terms of his warrant Pritchard could be returned to a locked ward at any time, on the say-so of a psychiatrist. He and

other former and current inmates of Oak Ridge and WLGs in other institutions in Ontario have formed the Ontario Coalition for Humane Treatment of Psychiatric Offenders (OCHTPO). They say that Oak Ridge's inmates should be transferred to medium-security facilities in their own communities where they

can have access to their families and to other resources.

According to Pritchard, "People come to Oak Ridge to be treated, made well, and sent back to the community. What happens here, because it's so de-

humanizing, only fosters what is called illness. Oak Ridge doesn't deal with the genuine problems that bring people here – in fact, it may even aggravate them. If we're concerned about protecting the public, what takes place here could put the public at greater risk."

Hucker surmised that certain conditions and practices at Oak Ridge violated the Canadian Charter of Rights and

Freedoms. He questioned the constitutionality of the WLG system's power to place people in custody indefinitely and to retain control over them when they are no longer in custody. The WLG system relies on predictions of dangerousness to effect release. According to Hucker, "there is no evidence that mental health professionals can accurately predict dangerousness" and, furthermore "re-

search carried out at Oak Ridge amply confirms this position."

OCHTPO and its supporters – human rights advocates, prison reformers, and former inmates of psychiatric institutions – are determined to carry on their campaign to implement Hucker's ultimate recommendation. Pritchard hopes he won't have to bring the demonstrators back to Oak Ridge until they can have a picnic on the front lawn to celebrate – the day after the place is torn down, never to be replaced.

Chris Bearchell

Reprinted from NOW magazine.

The latest events at Oak Ridge

In May 1990, two lawsuits were launched on behalf of Oak Ridge inmates.

It appears that the Ontario Public Service Employees' Union (OPSEU) will finally be held accountable for staff using "patients" as pawns in labour disputes with management. Every time OPSEU didn't get its way, inmates were immediately locked in their cells until management caved in to demands. These actions were clearly illegal but, until now, that seems not to

What happens here is so dehumanizing that it only fosters what is called illness.

have mattered. Suit has been filed on behalf of a number of inmates to the tune of more than \$300,000 in damages, and this may make OPSEU members think twice the next time.

The second suit involves the right to treatment. Since Oak Ridge staff members are no longer allowed to physically torture inmates as a result of the Hucker Report, they have given up any pretence of being able to "treat" people. Since they are obligated to pro-

vide "treatment" to WLGs and never have, they are going to have to publicly admit this very simple truth.

To the heroes incarcerated at Oak Ridge, I'd like to say that there is *finally* a light at the end of the tunnel. The lies and manipulations used to punish you are beginning to be exposed. OPSEU will shortly be on the run – it's already started. Oak Ridge *will* close.

Randy Pritchard

Phoenix Rising evicted by its own publisher

Late in the summer of 1988, On Our Own – *Phoenix Rising's* publisher since our inception in 1980 – dissipated itself from *Phoenix* and expelled the magazine from our jointly occupied offices.

After ridding itself of *Phoenix*, the Toronto-based self-help group (legally known as the Ontario Patients' Self-Help Association) shut down its drop-in, closed The Mad Market – its used goods store (a primary source of funds) – and discontinued its role as an outlet for the Daily Bread Food Bank. The board of On Our Own has since ceased to exist, and the organization's status and future are uncertain.

Since this is the final issue of *Phoenix Rising*, it is time for the disturbing story of our eviction to be told.

On August 22, 1988, we were informed that an "emergency board meeting" involving *Phoenix Rising* was scheduled for the next evening. The following afternoon, collective member Jim Spencey called to tell me that a "no admittance" sign had been posted on the outside of the *Phoenix Rising* office door. He took the sign down and entered our office at the risk of being charged with trespassing.

On Our Own president Peggy Rush both chaired and dominated that eve-

ning's stormy two-hour meeting. She accused *Phoenix* of "lack of support" for members, saying that the magazine did not represent what she called "our people." Then she criticized the magazine for its non-payment of rent, which she said threatened and undermined On Our Own.

I pointed out that *Phoenix* had frequently paid rent, and that there were cancelled rent cheques to prove it. As I

Our opposition to psychiatric drugs and forced drugging was not shared by many members of On Our Own.

told Rush, we had paid rent whenever we had a grant, as specified in an unwritten agreement between *Phoenix* and On Our Own some years earlier when the group agreed to waive the magazine's rent whenever we had no grant or other outside funding. Apparently, Rush and all the other board members didn't know about – or chose to ignore – this fact.

Rush said that she did not believe that *Phoenix* had paid a lot of rent over the years, and insisted she could find no receipts proving that rent had been paid. She admitted that she'd consulted Ken Sylvan, then On Our Own's Ministry of Health Project Officer, about this without telling *Phoenix*. A letter from Sylvan, dated August 16, 1988 and addressed to Rush, contained the statement that, "as discussed during our meeting, Ministry of Health funds are not to be used to support the activities of *Phoenix Rising*."

When I later interviewed Sylvan I asked him why he wrote what he did to Rush in light of the fact that the Adult Community Mental Health Program of the Ministry of Health (under which On Our Own was funded) had never funded, or been asked to fund, *Phoenix Rising*. He replied, "When I met with the executive [of On Our Own], it was indicated to me that members of On Our Own felt the office space occupied by *Phoenix Rising* was preventing members from occupy-

ing that space. Seeing that *Phoenix Rising* was not paying rent, I felt an obligation to meet members' needs first. . . . The board members were saying, 'We need the space' . . . [I said], 'What can I do to help you? If you need a letter, I'll be very happy to do so.' It was unfortunate. . . ." Apparently Rush and the rest of the executive accepted Sylvan's offer of a letter in order to use it as ammunition for evicting us from

our own office.

In the end Rush announced that *Phoenix* had to move immediately, adding that the decision to evict the magazine had been made at the last general meeting of On Our Own, held July 31. The motion to kick the magazine out was made by Ron Marion and seconded by Linda Miller. As recorded in the minutes, the motion read: "That

from this day forward, *Phoenix Rising* be taken from On Our Own completely and become a self-contained group under *Phoenix Rising*. Also, that from now on On Our Own's drop-in not be up-dated with notices of rallies and such. This means that Jim Gorrie our Treasurer no longer sign *Phoenix Rising* cheques. Carried."

I asked lawyer Carla McKague what she thought about On Our Own's actions, and she replied, "It is my opinion that the motion passed by the [On Our Own] membership on July 31, the actions of the president in denying *Phoenix Rising* members access to their office . . . and the decision of the board . . . were all in contravention of the by-laws of On Our Own."

We believe that the board deliberately lied about the group's need for more space – the space formerly occupied by the magazine ended up being used for storage. The real reason for our eviction was our radical political stand against psychiatry. We know that our opposition to psychiatric drugs in general and to forced drugging in particular was not shared by many members of On Our Own. Board members had complained about our criticisms of psychiatric "medication" to Phyllis Moss, then On Our Own coordinator, and to Ken Sylvan.

We ended up having to move by September 9. Fortunately, David White of the Supportive Housing Coalition came to our rescue. The Coalition agreed to give *Phoenix* rent-free space for one year. This gave us some breathing space until we moved to our current office in October of 1989.

In light of all that has happened, the following members of *Phoenix Rising* have resigned from On Our Own: Don Weitz, Bonnie Burstow, Irit Shimrat, Jim Spencley, and Harvey ("Alf") Jackson.

Don Weitz

Shrinkwatch

by Don Weitz



Aloneness no symptom

Some psychiatrists have finally discovered that just being by yourself or enjoying solitude is not a symptom of anything! All loners can stop worrying – for now.

In a January 1, 1989 *Toronto Star* article entitled "Solitude is no sin, psychiatrist says," British shrink Anthony Storr informs us that voluntary isolation is "not pathological," and Harvard University psychiatrist Arnold Modell states that "People need to maintain an area of themselves that does not communicate with other people."

If shrinks really believe it's okay to be alone, they should start pressuring their colleagues to remove "withdrawal" from the *DSM-III-R* (the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, or psychiatric bible), where it is listed as a symptom of "schizophrenia."

Shrink accused of sexual abuse

A 42-year-old businesswoman and two other women in San Diego, California, have accused psychiatrist Gary Carl Aden of physically and sexually abusing them and drugging them in private psychotherapy sessions between 1973 and 1980.

According to an article in the January 1, 1989 *San Diego Union*, the three

women reported Aden, a prominent 53-year-old psychiatrist, to the San Diego Society of Psychiatric Physicians in 1988. If a state board's investigation upholds some or all of these allegations, Aden could lose his medical licence.

Other allegations, dating from 1982, from another woman patient assert that Aden "hypnotized her, beat her, brought other men to her house to engage in sexual intercourse with her, and asked her to die for him," court records state. This lawsuit was dropped in 1988 when the woman accepted a "substantial settlement."

Aden's lawyer, David J. Danielson, denies all the allegations of sexual abuse as "sensational nonsense" and "ludicrous."

Nundy cheats "patients"

Jyotirmoyee Nundy, once a staff psychiatrist at Toronto's notorious Queen Street Mental Health Centre, was found guilty of defrauding inmates and staff in the amount of \$109,401.95 over a three-year period.

According to the December 1989 Report of Proceedings of the College of Physicians and Surgeons of Ontario, Nundy had been receiving a salary of "77,000 a year under a contract which required her to work for six hours daily." Apparently not satisfied with this amount, she soon started overbilling people at Queen Street for psychotherapy sessions and charging them for non-existent services. In her billings to the Ontario Health Insurance Plan, she listed group sessions "for which she was entitled to charge \$6.00 or \$7.90 per hour, whereas she billed for individual psychotherapy at hourly rates in excess of \$30 per hour. The total amount under this heading was approxi-

mately \$56,000." She also billed staff members for "services which were not rendered and this amounted to approximately \$17,000." She billed "private patients excessive amounts for services not rendered. This constituted approximately \$32,000." Finally "she treated outpatients and ex-patients of the centre in amounts of approximately \$4,000."

The sentence imposed on Nundy for this massive fraud was light: "20 days' imprisonment to be served intermittently, probation for a period of three years, and . . . 300 hours of community service."

The College's Discipline Committee was content to suspend her medical licence for three months, in part because she admitted the fraud in court, said she was sorry, and served her sentence.

Frightening intolerance

In a letter dated April 10, 1989, addressed to Lewis Judd, director of the U.S. National Institute of Mental Health (NIMH), biological psychiatrist E. Fuller Torrey alleges that the NIMH has funded "anti-psychiatry" groups and conferences such as the October 1988 annual conference of the National Association for Rights Protection and Advocacy, held in Portland, Oregon. He's wrong — the vast majority of the funding came from private sources.

Torrey is mad because such critics as psychiatric survivor, activist, and author Judi Chamberlin, as well as dissident psychiatrists Peter Breggin and Thomas Szasz, and former psychiatrist Jeffrey Masson, have openly challenged psychiatry for some of its well-known abuses and injustices.

In a May 30, 1989 letter to Torrey, Chamberlin denounced his intolerance, stating, "I can only conclude from

your letter to Dr. Judd that you respect neither the opinions of those who disagree with you, nor their right to make those opinions known, and this I find truly frightening."

"Reverse racism," eh?

The following is excerpted from E. Fuller Torrey's *Schizophrenia and Civilization* (New York: Jason Aronson, 1980):

"It has generally been accepted in the United States that schizophrenia is more prevalent in the lower socioecon-

omic classes. . . . Since the lower socioeconomic class is composed of large numbers of minority-group individuals in most parts of the United States, the question of prevalence of schizophrenia amongst these groups is closely related. Blacks are the largest minority group. . . . To say that blacks experience a higher rate of schizophrenia, however, is considered very *gauche* in the current psychiatric milieu, even if it is true. Psychiatrists as a group pride themselves on their liberalness (at least compared with the rest of American medicine) and tolerant racial attitudes; most would be loath to say publicly that blacks have more schizophrenia even if they believed it to be true. If schizophrenia is a heterogenous group of biological brain diseases, however, as this book assumes it to be, ignoring racial differences slows progress on understanding the disease . . . if schizophrenia does turn out to be truly more prevalent among blacks, the current polite ignoring of possible racial differences by psychiatrists could be construed in the future as a form of reverse racism."

Shock lies

Shock doctor James H. Ewing believes that electroshock is "not used as a . . . punishment like in *One Flew Over the Cuckoo's Nest*," but "can take somebody from the depths of despair and produce a really fine exhilaration and optimism."

Ewing, currently chairman of psychiatry at Crozer-Chester Medical Center in Delaware, also believes that electroshock is "useful for some patients suffering severe thought disorders such as schizoaffective, catatonic and suicidal impulses . . . [and can] help relieve depression in patients

with Alzheimer's Disease and pseudo-Alzheimer's." He claims that shock is particularly helpful for pregnant women, people with cardiovascular disorders, and elderly people who cannot withstand the physical side effects of antidepressant drugs. Ewing calls shock "a safe procedure that has become safer and a reasonably specific procedure that has become more specific." (See "Shock Waves," Page 17.)



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Canadian shrink discovers new "disease"

David Bakish, a psychiatrist at the Royal Ottawa Hospital, says there is a new "mood disorder" called "dysthymia," which he claims is a mini-depression.

Bakish claims the basic cause is — you guessed it — a "chemical imbalance" in the brain. Paraphrasing Bakish, a March 8, 1990 *Toronto Star* article states that "dysthymia responds to antidepressant medications" and that a new drug called Ritanserin "has fewer side effects than some antidepressants." Bakish figured this out after he "tested 31 people with dysthymia . . . about 70% reported feeling happier if they received drugs."

More psychiatric fraud

Psychiatrist Frank McCrystal was recently convicted of defrauding Ontario's provincial health plan of at least \$100,000, sentenced to jail, and fined and ordered to repay \$75,000.

According to an article in the March 22, 1989 *Toronto Star*, during his March 1989 trial in Kitchener, Ontario, a jury heard evidence from 53 former and current psychiatric "patients" who testified that McCrystal had overbilled or exploited them. During the trial McCrystal tried to discredit the inmates' testimony by "going over details from patients' personal files . . . in an attempt to cast doubt on their evidence."

Chouinard gets award for drug "discovery"

Montreal psychiatrist Guy Chouinard, a researcher at Louis-Hippolyte Lafontaine Hospital and the Allan Memorial Institute, was given a major international award at the World Congress of

Psychiatry in Athens, Greece, in the fall of 1989.

Chouinard was cited for discovering compound magnesium-aspartate as a safer "treatment" than lithium for "severe manic depressives." According to a December 5, 1989 *Toronto Star* article, Chouinard "remains a strong backer of lithium used with L-tryptophan, a drug that has been blamed in the United States for causing a rare blood disease."

Drugs can damage elderly

U.S. psychiatrist Peter Rabins, head of the psychogeriatric unit at Johns Hopkins School of Medicine in Baltimore, Maryland, admits that psychiatric drugs can have damaging effects on older people. According to the September 19, 1989 *Globe and Mail*, Rabins claims that "almost every drug can cause mental impairment."

Wonder if he still prescribes antidepressants or neuroleptics for some of his elderly patients?

Laing dies

Scottish-born psychiatrist R.D. Laing, was 61 when he died on August 24, 1989.

One of the original "anti-psychiatrists," Laing was the author of such dissident books as *The Divided Self* and *The Politics of Experience*, which reinterpreted "schizophrenia" and "mental illness" as existential crises.

In 1964, he founded the Philadelphia Association, a British network of community houses for those labeled schizophrenic. Laing "refused to treat patients with drugs or electric shocks unless they asked for them," and was a bitter and formidable enemy of biological psychiatry.

Nevertheless, he believed that involuntary commitment was necessary for some people. (Partly based on obituaries in the *Toronto Star* and *The Globe and Mail* of August 25, 1989.)

With the Power of Each Breath: A Disabled Women's Anthology

This important book is back in print after being unavailable for nearly a year.

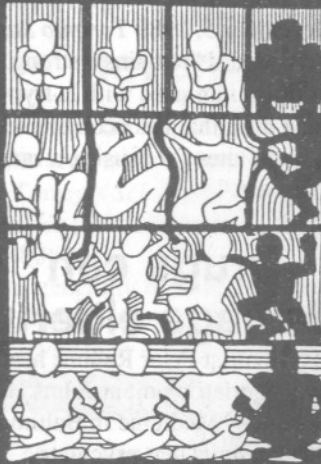
This feminist anthology, first published in 1985 by Cleis Press, documents the experiences of more than fifty-five disabled women. Since its publication, this book has had a tremendous impact on the lives of disabled women, making visible this "shut in, shut out, shut up" segment of society.

Editors Susan Browne, Debra Connors and Nanci Stern have received several awards for *With the Power of Each Breath*, including the President's Committee on Employment of the Handicapped 1986 Book Award. The book has been widely reviewed, and used as a text by teachers of women's studies, sociology, psychology and health. It is available on tape: write to Womyn's Braille Press, Box 8475, Minneapolis MN, 55408, USA.

If you cannot find this book in bookstores, contact Felice Newman, Cleis Press, Box 8933, Pittsburgh, PA 15221, USA or phone (412) 731-3863.

SHRINK RESISTANT

the struggle against
psychiatry in Canada



Bonnie Burstow & Don Weitz, editors

SHRINK RESISTANT

Edited by Bonnie Burstow and Don Weitz

"**Shrink Resistant** is both powerful and disturbing and should be read by anyone with an interest not only in mental health, but in the relationship between power and powerlessness, and in social change." – Judi Chamberlin

"It is disturbing reading but it is essential to hear these voices. No society can afford to submit so many to folly and error." – June Callwood

"An important piece of work that will stand as a lasting contribution in the struggle against psychiatric tyranny and violence." – Thomas Szasz

"Poignant personal accounts, dramatic graphics and useful information make this book more worthwhile than all 11 volumes of the *America Handbook of Psychiatry*. That's because it's written by those who have endured institutional psychiatry – including drugs and shock – rather than by those who perpetrated it." – Peter Breggin

***Shrink Resistant* – \$11.95 (soft cover)**

Published by:
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Vancouver, BC V6K 1E3

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Mad, gay, proud & angry!

**Lesbian & Gay Supplement to *Phoenix Rising*
Vol 8, No. 3/4, July 1990**



Mad Love

by James V. Sciana

I love to see him smile. I love to hear him laugh. The stream-of-consciousness tapestry of inspired humour that flows between us is richly threaded with impromptu characters, "right angle thinking," personal, inside-joke references and a healthy dose of nonsense and nonsequiturs; not to mention joy and laughter.

To an outsider, specifically the doctors who "treat" him for his "illness," we seem to be quite mad. They can't understand what we're talking about or laughing at. We seem to be using a language known only to the two of us. They look at us with eyes narrowed in suspicion and brows knit with professional concern, and write furiously in their secret black spiral notebooks (they have written many volumes about each of us).

We can't help it – we stand out in stark contrast to the others, visitors who sit in quiet desperation with their brothers, sisters, sons, daughters, husbands. The inmates go through the motions of their own "Stelazine shuffles" and irrational rhapsodies, and their visitors nod sagely, at regular intervals, in mock understanding and token support. They all wear the same vacant expression on their faces, like people on stage before a dark, faceless, silent audience. And they have no idea what their lines are or what their role is. You want to scream at them, "Once more, with feeling!"

And yet, he and I don't worry about playing roles, though we play many. Mainly, like kids, we just play.

When we hold hands, or pinch each other's noses, caress each other's forearms – when I have my arm casually around his shoulders – some of them look on with expressions of alarm and suspicion. They talk amongst themselves as they look at us.

He looks down meekly, embarrassed, but I return their intruding gaze, head level, face proud and defiant, challenging them with a glance to do or say something. Sometimes they do. But for now, something in my steady stare causes them to flinch and look the other way.

And yet, they continue to check on us every five minutes as we sit talking behind a bush or corner or some other temporarily private place away from the powers that be. When we both have to use the bathroom at the same time, two or three of them come in to "straighten up" and "check on things."

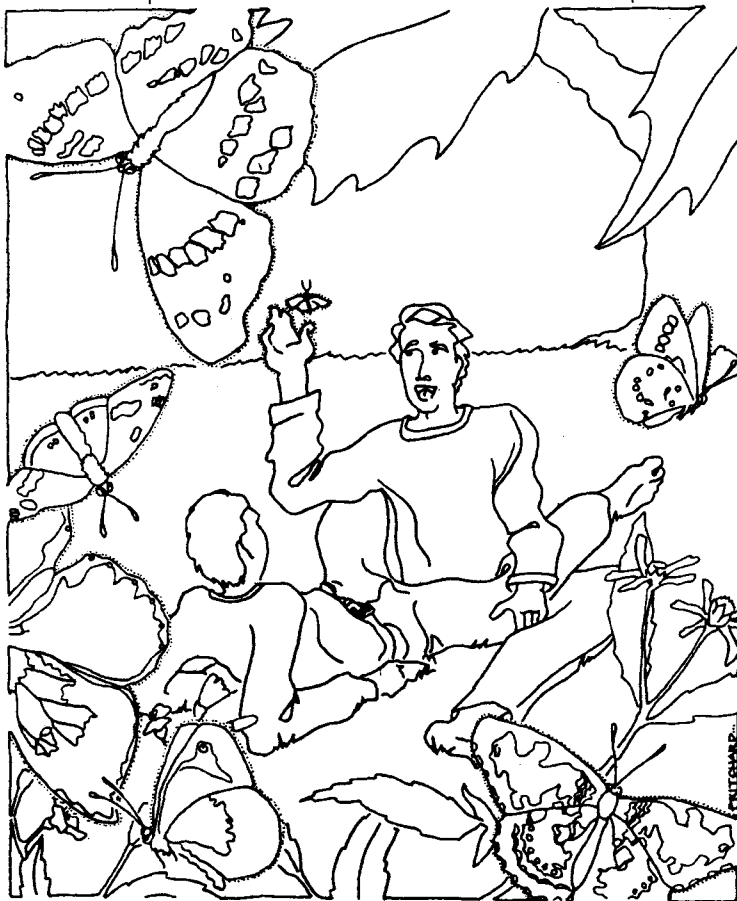
Such behaviour, if observed in those they take care of, would be labeled "paranoia." But in their case it is referred to as "professionalism." There is another word that seems, in my mind, to apply: homophobia.

And yet, we manage to wring some laughter, understanding, tenderness, joy, and even (gasp!) physical contact out of the few visiting hours we spend together in this oppressive, adverse atmosphere. Except, at the end, I always leave and he always stays.

In the beginning, when we met, we were both in a place like this, for our "psychotic acting-out episodes." We were both labeled "schizophrenic." But eventually, I followed the "psycho"-path of least resistance out of the system, and he continues to stay. It has

been this way for a long time. It's been a long, often painful road but, just for today, we are happy. Maybe not as happy as we could be in better circumstances, but happy all the same.

His name is also James. He was born in Canada and "lives" in San Jose, California. Acting as his conservators, his



father (a prominent professor at San Jose State University) and mother (a practising psychiatrist), hold the reins of his legal rights and his life. He is 26 years old. He has been locked away in mental hospitals and facilities for almost all of his adult life. He is my lover.

As I understand it, at a time not too long before our own, it was decided (by whoever it is who decides such things) with the stroke of a pen that homosexuality need no longer be a "mental illness" . . . as long as the subject is comfortable with his or her own homosexual identity. Any "illness" re-

sulting from this "condition" lies only in the subject's conflict in accepting his or her sexuality. Now, I'm paraphrasing, but that's the gist of the decision. I also understand that this new view on the matter (which seems to me like a natural, common-sense view) was extremely controversial at the time and met with great opposition from psychiatrists. It seemed that an entire population of potential patients (read: potential income) had been declared "well" overnight. Why?

My initial reaction upon hearing this piece of psychiatric history (a thought that I'm sure occurred to, and scared the hell out of, many psychiatrists in the opposition camp) was, why stop there? Why not make the same decision in the case of "paranoids" and "schizophrenics," "manics" and

"depressives"? Physically impaired individuals, whether they be blind, deaf, amputees, or people who suffer from diabetes or muscular dystrophy, have been able to learn to accept and compensate for their physical limitations. Society has, on the whole, gone to great lengths to accommodate and assimilate them into itself. Why, then, are

the *mentally* "less than normal" packed away in mental warehouses and snake-pits for the sake of "treatment"? Why are they sequestered from a society that doesn't want either to deal with them or to modify its own attitudes so that they can be part of it?

The fact is, people would rather tolerate the current state of affairs (as long as it doesn't happen to them) than assimilate people who do not behave "normally" (read: like carbon copies of everybody else).

The controversy surrounding the change in the diagnosis "homosexual" opens up a whole can of worms that undermines the very need for a "mental health system." It shouldn't be surprising, therefore, that this change has been effectively ignored by most of the psychiatric community.

When I met James, I was having a lot of problems accepting my gayness. I had tried to kill myself because of the pain these problems were causing me. On reflection, this seems to have been a turning point in my life. Over the next seven years, I was to learn the mental health system's real stance on homosexuality.

I have been in therapeutic situations almost constantly from the time I was nine years old (I'm twenty-five now). And I have not met one psychiatrist, therapist, or psychoanalyst who was really interested in helping me accept myself for who I am: a homosexual.

Even as I type that word in reference to myself, it is uncomfortable for me.

I've actually had a psychiatrist to whom I had described my feelings tell me that I "should go out, find a hooker, and get fucked." He was dead serious. Not too long after, I gave him basically the same advice.

My current psychiatrist maintains that my "sexual problems" stem from being

who would tell me that – I've just never run across any of them. Neither, apparently, has James.

Yesterday, James was moved once again, back to his "home base" – a long-term facility called East Valley Pavilion, where he has spent the past few years.

The people there have effectively

banned me from visiting him on orders from his parents/conservators because, as his mother, the therapist, told me, she doesn't "approve of the nature of James's and your relationship." I've checked this out through legal channels and they have no right to do this, and are in fact violating James's inherent right to have any visitors he chooses. It is the second time they have done this. The legal powers that be refuse to act on this matter this time, unless James initiates the investigation himself. But James is intimidated by his parents and his captors, and seriously doubts his own ability to change his current lot – an attitude that is in his captors' interests to foster.

They insist that he has the initiative and competence to take care of such affairs, yet have kept him effectively locked away for the past seven years because of his *lack* of such initiative and competence. He's trapped. Nobody does anything about it, and we both keep on getting older. His "problems" continue unabated as his parents hustle him from one institution to another.

Life, if you can call it that, goes on.



"molested" as a child, even though I had fully consented to the event in question and had enjoyed it. I feel that her insistence on this point is her attempt to create a "problem" to be solved; a puzzle to which only she has the answer.

In all my years in the system, I have *never* been given any sort of real encouragement that my feelings are okay. I'm sure there are lots of people

High School Crush

by Kim Mistysyn

Pale white walls with thought-provoking paintings hung here and there.

The room is small with a fake coziness about it. She sits opposite me in her swivel chair, at her desk, staring at me intently to the point where I want to yell at her, but that would give her the satisfaction of my making "the first move to communicate." I don't want to be here.

In this room I wasted a good hour – three times a week, every week, for two long years.

She is a social worker, under the direction of a male psychiatrist. I've been sent here by both my school and my parents, but they tell me it's "my choice." Sure.

I had a crush on a female teacher. I was depressed because I didn't know why, and it wasn't the first crush I'd had on a female teacher. I was in grade ten, when boys should have interested me, but didn't. I did a horrible thing. I told her I loved her.

She wanted to be the one to cure my depression, and told me she loved me too, in her own way. I took that the wrong way. Anyway, she decided to meet with me once a week to talk and lavish some of her attention on me. Then she found this to be too stressful for her schedule and felt there was something not quite right about this whole relationship, so she sent me to the school counsellor.

I was angry, confused, and very hurt. The school didn't understand why I was attracted to this teacher and why I couldn't let go of the feelings, so they shipped me to a counselling institute for a family evaluation.

After observing our family dynamics, the institute pronounced sentence – I should come in for counselling on a regular basis – but left the final decision up to me. My parents said if I didn't go then I'd have to deal with

worker then had a meeting with my parents to confirm that I was *not* gay, but seemed to need more of a mother figure – or that perhaps something traumatic in my past was making me act this way.

Yeah, right.

I knew I was denying I was gay, but that was because I had had no reassurance that being gay was okay. But these "professionals" didn't seem to be right about anything, and I was angry

about having to be dissected by these people anyway. So I didn't talk. I sat in my sessions saying nothing. "She" sat there waiting for me to talk. So we sat in silence together.

After two years of playing these anger games with her, I said, "I'm not coming back," and I left. I felt relieved and glad that I'd gotten up the courage to do this, finally. That night I received a phone call from her at my home. Basically she told me that if I never went back, all my future relationships would be a mess and that no one would ever want me. She said I *had* to return and that if I didn't, she would never be there for me again.

To an adult woman who was sure of herself,

this would seem a very unprofessional phone call – perhaps even bordering on a threat – but to me, a young, confused teenager . . . it took a lot of strength to say to her that I would prove her wrong and that she had no right to be saying this to me. Even after standing



them instead – not very appealing to any teenager – and my school was insistent that I go. Therefore I "chose" to go.

For the first few sessions I talked – I've always been fairly cooperative with people in general. My social

my ground, I spent weeks wondering if she just might be right!

I think she was shocked that I stuck to my word and never went back. Last year I came out openly as a lesbian and I'm now in a relationship with another woman, which is going very well. My only regret is that I wasted two years of my life feeling horrible because they had decided I was not gay and would not really discuss it with me. What I needed was to deal with feelings of shame, not to be treated for some traumatic event that never

happened. And I like my mother just fine, thank you. The mental health profession has never understood homosexuality; maybe we'd be better off if they stopped trying. I hate to think of all those lesbians who have gone through considerably worse than I – through mental institutions and the whole bit. The only good thing I can say about that period of my life is that it strengthened me – but not everyone would have been strengthened by such treatment, and that indicates a problem in the system.

Interview with a dissident American psychiatrist Szasz on AIDS and Psychiatry

The following is adapted from an interview with dissident psychiatrist Thomas Szasz, conducted in Toronto on December 12, 1989, on the FM radio station CKLN. Szasz had just written a response to an article called "ECT for Major Depression for Four Patients Infected with Human Immunodeficiency Syndrome," published in the June 1989 issue of the American Journal of Psychiatry by people at Johns Hopkins University Medical School in Baltimore, Maryland. "ECT" stands for "electroconvulsive therapy," also known as shock "treatment." Szasz's response, entitled "Psychiatry in the Age of AIDS" and subtitled "The doctors see a new chance to be jailers," was published in the December 1989 issue of Reason.

I have devoted the better part of the last 40 years to criticizing some aspects of psychiatry. Psychiatrists have a tendency to define life events, which are part of the normal course of events, as mental diseases. They do this in order to have a turf on which

they can operate and where they can make money and gather prestige. Being depressed – not only for a person with AIDS, but in many circumstances that befall people – I consider to be a reaction to life events, not a dis-

**It is
significant
that the
article does
not mention
whether the
patients are
voluntary.**

ease. People get depressed because they get divorced or because they are unhappily married, or because they

don't have enough money, or god knows what.

The practice of psychiatry rests on the psychiatrist's ability to coerce the patient. This, I think, is the most objectionable thing about psychiatry. I think there can be no decent psychiatry until this is abolished. And this is not about to be abolished. Psychiatrists love this.

Psychiatry rests on force, just as Communism rests on force. We will see what happens when the Russians gradually give up force. If psychiatrists would give up all coercion – if they would start practising like eye doctors or gynecologists – I think psychiatry would simply disappear.

Life is very complicated, and it so happens that a lot of people like to repress the unhappiness in their lives. From a political point of view, my primary emphasis here is on individual liberty and responsibility. If somebody wants to deal with his or her problem by repressing it, that should be the person's right. I personally think it's rather unfortunate, but they should have a right to do that. And if they want to enlist psychiatrists to repress them with electric shock, they should have a right to do that too.

That's why it's extremely significant that a scientific article like the one we are talking about does not mention whether the patients are voluntary or involuntary. Psychiatrists don't consider that important. Because they consider that patients are patients, regardless of whether they want to be patients. So all of psychiatry, in this way, is based on a deception.

Coercion is legitimated by the fact that the patient is treated like a child. After all, there are only two situations in a

modern, free society in which the state can coerce you.

One is that you can be coerced if you are a convicted criminal. The other is if you are declared to be "psychotic" or "crazy," in which case you can be coerced because you are now like a child, and the state, via the psychiatrists, takes the position that the professional is acting as though he or she were your parent.

Psychiatrists, for the better part of the last hundred years, have waged a war on homosexuality. Homosexuality was one of the favourite mental diseases of psychiatry from Freud's day up until a few years ago. It was only in 1973 that the American Psychiatric Association, under political pressure from the homosexual lobby, voted that homosexuality was no longer a mental disease. So the politicization of homosexuality as a mental disease or not a mental disease is very deeply ingrained in psychiatry. Psychiatrists' position on this whole thing is tainted from the bottom up.

These days, psychiatrists generally posture as if they considered homosexuality an acceptable lifestyle. But if you scratch the surface, you find the hostility to it and the desire to repress it. And this, I think, resonates in society, so people would be very happy if homosexuals with AIDS were locked up.

I don't think depression is a technical or medical problem in any way. First of all, I don't think it's any of society's business. It is the business of the person depressed, and those close to him. Secondly, I would not make any distinction between a person who is depressed because he has AIDS or

because he has cancer of the prostate, or because his wife died.

But we are touching on complicated issues – in particular an issue that Western society is very confused, in my opinion, and very skittish about: suicide. Now, I think suicide is a perfectly reasonable option in many life situations.* But this is not the accepted view. The article from Johns Hopkins in a way reflects this. I think it mentions one of the patients who was treated with electric shock and who

died – they don't say of what – three or four months later. Now, why this is better than if the person had committed suicide is not entirely clear to me. Why is this preferable, to be electroshocked if you are depressed from AIDS, and then live another three months?

** Editor's note: It is important to realize that a positive HIV test, or even a diagnosis of AIDS, is not a death sentence. See the story below.*

Psychiatric Drugs A Co-Factor in AIDS? by Colman Jones

The Human Immunodeficiency Virus (HIV) is thought to play a role (as yet unproven) in the development of Acquired Immune Deficiency Syndrome (AIDS). But there is still healthy speculation about what co-factors, or additional factors, may contribute to the progression of the diseases that make up the syndrome. Some of the things that people think may be co-factors are syphilis, African Swine Fever Virus, Epstein-Barr Virus, and cytomegalovirus. However, a recent article in a psychiatric journal potentially suggests another,

more insidious co-factor in hastening the onset of AIDS: psychiatric drugs.

The December 1989 issue of the *Canadian Journal of Psychiatry* featured a chilling article detailing the treatment of a person with AIDS by psychiatric staff at Mount Sinai Hospital in early 1988. "AIDS: Clinical and

Ethical Issues on a Psychiatric Unit" was written by psychiatrist Brian Hoffman and colleagues. Hoffman is an associate professor at the University of Toronto's faculty of medicine and head of the Division of Inpatient Psychiatry at Mount Sinai.

Hoffman paints a pretty clear picture of the attitudes and

procedures in this busy downtown unit. His article provides a fascinating and terrifying glimpse into how the psychia-

**Only 1% of
a group of
HIV-positive
people
developed
AIDS over 10
years.**

tric profession views AIDS and the people who are living with the syndrome.

He begins by reciting the generally accepted information about AIDS – “facts” that guide the course of the treatment and set the tone for what is to follow. He informs us that “the world is being confronted with a deadly infectious virus [HIV]” and then declares that HIV infection “progresses in a high percentage of cases to ARC (AIDS-Related Complex), AIDS, and death.”

This assertion comes from widely publicized but highly speculative studies of disease progression in small groups of people. These studies have been contested by many people as having little predictive value. Even one of the authors (Kung-Jong Lui, a mathematician who works for the Centers for Disease Control in the United States) admits that “existing data were not adequate to estimate with any reasonable degree of accuracy the proportion of people with HIV antibodies who would eventually develop AIDS.” And a study at the New York Blood Center determined that only 1 percent of a group of HIV-positive people developed AIDS over ten years. Most notably, the co-discoverers of HIV, Luc Montagnier and Robert Gallo, have repeatedly stated that HIV infection does not inevitably lead to AIDS if the immune system is supported and co-factors are alleviated.

Still, the scenario of certain death fits in well with Hoffman’s agenda. So we are spared these niggling details, and

are led to believe that HIV equals AIDS equals death. Hoffman matter-of-factly asserts that the average time of survival after an AIDS diagnosis is ten to fourteen months.

This last “fact” is critical to the way people living with AIDS (PLWAs) are seen and treated. Removing any hope of recovery or survival right at the outset ensures that a “patient” will only

15 percent of PLWAs (not those who are merely HIV-positive, but those who are diagnosed with full-blown AIDS) are still very much alive five years after diagnosis.

But in the realm of psychiatry, the idea that AIDS is always fatal has even graver consequences. Family, friends, the media, and medical doctors can influence the decisions and at-

titudes of someone living with AIDS. But psychiatrists, with the help of the police, have the power to lock up PLWAs in institutions. Psychiatrists can and do deprive PLWAs of their freedom and at the same time deprive them of access to potentially life-saving treatments and information. (Most such information originates from gay community treatment information networks, such as AIDS Action Now! in Toronto and Project Inform in San Francisco.) On a psychiatric ward, PLWAs’ control over their own health is given up to doctors who assume that these “patients” are going to

die soon anyway.

Such issues do not interest Hoffman. The focus of his article is about how these “AIDS carriers” will affect psychiatric staff and practice, rather than how psychiatric staff and practice will affect people living with AIDS. Hoffman’s preoccupation with the fear and frustration of staff and the effect of PLWAs on the “ward milieu” speaks volumes about the attitudes and priorities of this psychiatric unit. The article discusses clinical issues (that is, issues of diagnosis and management), effects on day-to-day practice on the ward,

Hoffman’s article is about how these “AIDS carriers” will affect staff.

get palliative care. In other words, since it is assumed that the person is going to die soon anyway, staff can ignore the need to help PLWAs in any way, and can focus instead on “patient management” and behaviour control.

Dismissing the hope of survival of PLWAs through the use of statistics has been well documented (see “The Epidemiology of Fear,” *New York Native*, No. 276, August 1, 1988). It allows the interests of legal, medical, and journalistic institutions to override those of people who are actually living with AIDS. It also ignores the fact that

staff issues, family counselling, discharge planning and, of course, the all-important "administrative issues."

Nowhere is there any mention of support or counselling for PLWAs, or any acknowledgement of their diverse medical, spiritual, emotional, and sexual (that's right, sexual) needs. Nor is there any discussion of the rights of PLWAs who are admitted involuntarily, or prevention or treatment for the conditions from which PLWAs suffer – not even so-called HIV dementia.

The real agenda here is all too clear, and is brought into sharp focus by the distressing case history of "Mr. A," admitted to Mount Sinai in January 1988. ("A" must stand for "AIDS," since it is not his real last initial.)

As if they are somehow related to AIDS issues on a psychiatric unit, we are provided with juicy details of Mr. A's personal life prior to admission. We are told he was "bisexual," lived in an apartment with a "male friend," and had had between 100 and 200 lovers in his life, one-third of them women. Presumably these details are supplied in a not-so-subtle attempt to illustrate and reinforce the connection between homosexuality, "promiscuity," and AIDS, with "bisexuality" thrown in for good measure (or perhaps shock value). The author's own moral framework becomes clear at this point.

The case history describes the "symptoms" that led to Mr. A's admission: he was "over-talkative, exuberant, argumentative, violent and neglected his hygiene." Apparently, one night Mr. A went running through the hallways of his apartment, screaming that he had been raped. The police came and took him to the hospital. Tests, including brain scans, were performed. Aside from the HIV antibody test, all the tests were negative. Nothing was ob-



AIDS Action Now! outside the Westbury Hotel, where the Ontario AIDS Advisory Committee was meeting April 25, 1990. The demonstration focused on Richard Schabas, the Chief Medical Officer of Health for the Province of Ontario, who was recommending to the Committee that the status of AIDS, under the province's public health laws, be changed from that of a "communicable" disease to that of a "virulent" one.

Such a change would give public health officials greater power to lock up people who they believe are putting other people at risk for the disease. According to an interview Schabas gave the *Toronto Star*, this includes people who know they are infected with HIV, the virus associated with AIDS, who have any kind of intercourse – *even if they're using a condom*.

This proposal undermines the work being done by AIDS educators and is dangerous for people living with AIDS (PLWAs). It would leave them open to incredible abuse of power as well as unfounded fear and hostility from others. PLWAs do not have a "virulent" disease the way people with tuberculosis do, and no one is in danger from casual contact with them. Schabas's scheme is dangerous to the rest of the population because it suggests that condoms don't really work (so why bother with them?) and that, since the government is quarantining those who are possibly infectious, people don't have to take responsibility for protecting themselves from AIDS and other sexually transmitted diseases.

As it is, Schabas and his public health authorities already have the power to declare PLWAs – or anyone else – "incompetent" and have them locked up under the Mental Health Act. Photo by Konnie Reich

viously wrong with him. He was then put on the psychiatric ward and put on a neuroleptic drug – Haldol, 20 mg per day.

According to the *Compendium of Pharmaceuticals and Specialties* (CPS), Haldol (the brand name for haloperidol) is an antipsychotic and anti-emetic drug used to manage hyperactivity, agitation, “schizophrenia,” “psychosis,” and “mania.” The CPS admits that “the mechanism of action has not been entirely elucidated” – meaning they don’t even know how the stuff is supposed to work. (This sounds a lot like HIV in relation to AIDS.) There are several warnings listed – notably the long-term development of tardive dyskinesia, although this was clearly not a concern to Hoffman, since he felt sure this “patient” would not survive long enough for long-term effects to be an issue.

Haldol’s other known adverse effects include brain seizures, neuromuscular problems, and various gastrointestinal effects, including diarrhea, weight loss, nausea, and vomiting. The latter are problems commonly experienced by people with AIDS even without the benefit of psychiatric “treatment,” and pose a terrible risk to someone whose immune system is already compromised. The CPS warns that “severe reactions, necessitating discontinuation of the drug, may occur at relatively low doses.”

“Lower doses” of Haldol are recommended for people who are debilitated, which you’d think would apply to

PLWAs. What is a lower dose? Well, the regular dose listed is 1 to 2 mg, two or three times daily, and the CPS claims that “it is seldom necessary to employ doses greater than 4-6 mg, 3 times daily” – which comes to 18 mg a day at the high end.

The initial dose for Mr. A was 20 mg per day, even though Hoffman admits later in the article that Mr. A could be very sensitive to toxicity from psycho-

returned. He is described at that point as having been “unco-operative, disorganized, paranoid” and as having “threatened staff with sharps [meaning sharp objects, such as scissors or needles].” This is hardly surprising for someone being drugged and held against his will. (Strangely, two paragraphs later, he is referred to as a “voluntary patient.”) Other words used to describe Mr. A’s behaviour are

“grandiose,” “euphoric,” “sexually exhibitionistic,” “agitation,” “elevated mood,” “tangential thinking,” and “paranoid ideation.” It is interesting to note that the CPS lists among Haldol’s adverse effects behavioural effects, including “toxic confusional states,” “restlessness,” “agitation,” “anxiety,” “euphoria,” and “exacerbation of psychotic symptoms.”

How did Hoffman respond to Mr. A’s difficulty? By increasing the dose to 40 mg per day. Threats to staff understandably continued, and Mr. A finally attempted to leave the ward again, striking out at staff and even biting another “patient” who

tried to stop him. Staff responded by giving him forcible intramuscular injections of 60 mg of Haldol per day, along with physical restraints that were “used intermittently but liberally to prevent harm to the patient and others.”

This produced “considerable improvement,” which is to say that he fluctuated between being confused and behaving in a way described by Hoffman as “pleasant.” After three weeks he was “stabilized” to the point where the dos-

Haldol poses a terrible risk to someone who is immune-compromised.

tropic medications. Furthermore, Hoffman seems to have been unconcerned about the fact that Haldol can impair lung function, leading to such complications as terminal bronchopneumonia. This in spite of the fact that Mr. A had recently been treated for two episodes of pneumocystis carinii pneumonia, or PCP – one of the most common diseases in PLWAs.

Mr. A responded to his “treatment” by leaving the hospital, but his freedom was short-lived – he was forcibly

age was reduced to a mere 35 mg a day.

A variety of medical problems then developed, and Mr. A was given AZT and an anti-fungal agent. (AZT is a highly toxic chemical that is supposedly useful in controlling HIV but has not been proven to alleviate the symptoms of diseases associated with AIDS.) This treatment is mentioned in passing and doesn't come up again.

Also, it is noted that one of the problems that developed in Mr. A (who, you will remember, had nothing medically wrong with him when he came in, aside from his HIV-positive status) was "ulcerative oesophagitis" – a gastrointestinal abnormality. (As mentioned earlier, Haldol is known to cause a variety of gastrointestinal problems.)

Clearly, in this setting, the first priority was the chemical and physical control of Mr. A's actions and behaviour. The only discussion with the "patient" mentioned at this point concerned what resuscitation efforts he wanted used to keep him alive if he were to fall into a "vegetative state," so that "appropriate guidelines" could be developed "to meet this eventuality." (Hoffman is concerned about the consternation that this discussion caused among staff.)

This blind acceptance of AIDS as a death sentence denies to people living with AIDS, in the words of PLWA Michael Callen, "the reality of – but perhaps more important – the *possibili-*

ty of survival." It is the most important, though by no means the only, vicious distortion in the complex mythology surrounding AIDS. This mythology is based on contempt, hatred, and hysteria that originate, in part, from the psychiatric profession – which not so long ago labeled homosexuality itself a disease.

The rest of Hoffman's article deals with various clinical issues, such as jus-

The first priority was chemical and physical control of Mr. A.

tifying the admission of PLWAs and dealing with the fear and anger of staff (but not, it seems, of "patients"). At one point, Hoffman writes that "individual staff members may have the right to refuse to attend AIDS patients" – but not, he cautions, "solely because [the patient] is infectious." However, Hoffman fails to specify other, allowable reasons. There is much talk of HIV testing, physical and chemical restraints, blood precautions, masks, gowns, and gloves. Yet Hoffman says

that "it was important not to lose seeing the patient as a person"!

In fact, the article contains a number of comforting liberal platitudes and generalizations about confidentiality, staff burn-out, education, and support for working through staff feelings of "hostility, loathing and terror" (how encouraging for prospective patients!), as well as issues of quality of life, dignity, and so forth.

But none of these polite sentiments should excuse the fact that a person living with AIDS was forced into a system that was convinced he was soon going to die. Nor should one ignore the fact that his "caregivers" – acting with good intentions but blind to the social, physical, and emotional consequences of AIDS – attempted to control his subsequent violent reactions with physical restraints and excessively high doses of a drug known to cause severe reactions at "relatively low doses." The case history ends with Mr. A. being transferred to Casey House, an AIDS hospice, where he died three weeks later. No cause of death is given.

The CPS warns that "cases of sudden and unexpected death have been reported in association with the administration of haloperidol." It goes on to state that "the nature of the evidence makes it impossible to determine definitively what role, if any, haloperidol played in the outcome of the reported cases [of sudden and unexpected death]. The possibility that haloperidol caused death cannot, of course, be excluded."

Can it be that psychiatric drugs were a co-factor in this AIDS case?

Pressures and Silences

by R.D.

It started when I combined drugs. And I beat up my lover's car.

It was an accumulation of pressures and silences. I just wouldn't talk to her. She hit me prior to that and I didn't strike back. But then I beat up her car. She was in the car at the time. I was aware that I was losing control; not blanking out but – out of control.

She managed to call the ambulance, and she took me to the general hospital in Sault Sainte Marie. I guess I was hitting everything by then. I was hitting myself, mostly. They were going to give me drugs but one of the doctors said no, because I had a lot of drugs in me. So they restrained me; they tied me to a stretcher and threatened to lock me up if I didn't calm down. By then I had let everything that I had blocked away come back.

Well, they let me go. They restrained me until they felt that I was safe. When I was calm, I convinced them that I was okay. I went home. But my hands and arms were all bruised, both from the restraints and from hitting the car. I couldn't "transfer" – get from the chair to somewhere else – since I rely on my arms for doing that.

I went back to the apartment with my lover, and spent a few days in bed. She



Photo by Konnie Reich

was my caregiver. But we didn't talk about it.

I had been taking Librium. See, I can't handle drugs very well, but that was prescribed for me. I was also going through a depression. I knew there was something bothering me, something I couldn't talk about. My lover would take care of me, and give me the drugs, the Librium. I went by what the doctor had prescribed; four times a day, or when needed.

But I felt bad on it. I went down to the hospital one night because I was hallucinating and feeling really strange.

So they gave me Valium instead. It calmed me down and made me really numb. But later I stopped taking that, and was on my own. I was really quiet after that.

The drugs just compounded what I was feeling; a lot of stress and depression.

That's one of the reasons why she hit me. Because of my silence; she couldn't understand my moods. It was like she had to damage me to make me speak.

A few months later I started to hear things. I heard voices; not voices of people I knew; other voices. What they were saying made sense; it connected, but . . . I think it was just me saying this stuff, but it sounded different. It was loud and clear in my head. It seemed like another person.

I tried to seek help, but they just brushed it off. I didn't have any real friends at that time. I went down to the hospital and talked to one of the nur-

ses. She said "You're okay." Then I left.

One night, a couple of months later, I was drinking to excess; I was drinking doubles. I came back to the apartment. I lost my jacket on the way back. I started to get really violent – not towards my lover but towards the cupboards. I started striking them. I started breaking dishes. I fell out of my chair onto the floor and I started striking the floor. And we were in an apartment on the fourth floor. The floor was concrete underneath the carpeting.

She couldn't handle me so she called some friends over. I started hitting them when they tried to restrain me by holding me.

They had to take turns because I was too strong.

One of them stayed with me till I calmed down. Then she put me to bed.

I was really quiet the next day. These other two friends came over and one suggested that I see a shrink. I said no. I didn't want to get caught up in that. I was aware of the mind-fuck games and tactics they put you through by having the power to manipulate you and to do whatever they want to you. I'd known a couple

of people who'd been psychiatrized and institutionalized, and it bothered me when I visited them in the wards they were put in. What bothered me

once you get written down – once you go see a psychiatrist – you're labeled. It follows you around. I knew about that, and there's no way I wanted to

go. They limit you. And they can lock you up.

I didn't want to be locked up. I knew that if I got locked up I would die. I would have killed myself. I would have slashed my wrists. I knew hospital personnel who used to work in emergency. They used to see a lot of wrist-slashers come in, who would die right on the table. I know they take sharp things away from you when you're locked up. But if you want to find a way badly enough, you'll do it.

Anyway, I said no. So then she said, how about a psychologist? I said, I don't know. She said she knew one who was pretty good.

I was pretty desperate, so I did eventually go to see the psychologist. She appeared to be warm and concerned. I was very cautious with her at first. But she helped me, anyway.

For a while I went once a week; then once every two weeks. She operated out of her home. She charged 30 bucks an hour. I couldn't afford it, but my lover, a friend and

an institution – the church! – paid for me.



Photo by Konnie Reich

the most was the various medications they were on, which completely altered and controlled their behaviour. And

Then I was okay; at least, it appeared that I was okay. So I only saw her once a month, for another year. And I went to school; I went to university through Vocational Rehabilitation. I was taking an Honours B.A. in visual arts. But I was going through a rough time. Voc Rehab was paying my tuition and medical expenses.

By Thanksgiving I felt suicidal again; I really needed to see her. They paid for that visit. By Christmastime my marks had gone down. My Voc Rehab counselor, whom I had to see at that time, started to tell me that I had to be really careful, because my "mental illness" was starting to come to the fore. He said that there was nothing to be alarmed about. "You can admit that you're sick – it's okay to be mentally ill. We understand." He was blaming my poor marks on mental illness.

I was still seeing my therapist, and he wanted to know what was going on with her. My therapist wouldn't give out the information he tried to get from her. So Voc Rehab wanted me to see their clinical psychologist, rather than my therapist, because she wouldn't give their counsellor my records.

This guy was a doctor. I had only seen him once, when they did the evaluation. It's one of the prerequisites of Voc Rehab. If you're going to university they give you an aptitude test, and you have to see their psychologist. I somehow had an idea about the "test" and his observation of me. So I played

the game – the game I had learned earlier in my life, when I first saw a psychiatrist at a Rehab for children who were "crippled." I somehow knew the results of such tests, so I went "their" way instead of telling them what I really felt and visualized. I did the same with Voc Rehab's clinical psychologist; again I played the game, and won.

But by Christmastime the psycholo-

ness, because that idea was disturbing me.

Finally I quit school so that I could get away from him and avoid getting locked up. I lived in silence, and eventually came into my own resolve. After a few months I could *name* the *name* that had silenced me all those years. I called my therapist and named it: lesbianism. I am a lesbian! Fuck, I felt

good!

I saw her three more times after that – the last time was in January 1987. I was feeling really bad from the side effects of an antidepressant prescribed by my physician, compounded by taking prescribed narcotics for headaches.

After that I no longer wanted to see my therapist. I felt I could no longer trust her, especially after she indicated that I'd probably have to see therapists on a long-term basis for my "personal safety." She wanted me to conform to her standards.

I asked if she could write me a letter of support, indicating her faith in me to succeed (conform) in the "real"

world, which she did. But she felt obliged to inform me that her name was going on this letter and that I'd better "do right."

Since then I have sought support from trusted friends, and have unravelled the lies of conditions dictated by the corporate system to protect the privilege of patriarchal hierarchy and dictate how we should live.

**I called my
therapist and
named it:
lesbianism.
I'm a lesbian!
Fuck, I felt
good!**

gist was saying that he wanted to see me. He started threatening me that they were going to cut my tuition. In the end, I said okay. I gave my therapist permission to give out information, but only information she thought he should know. I don't know what she did. She didn't tell me what was going on. But she didn't reveal everything we had talked about. She wanted to clarify what he meant about my mental ill-

Nightmare in New Brunswick

by Ray Glendenning

Bathurst, New Brunswick, was no place for a gay fourteen-year-old to confront psychiatry. I was an extremely bright child. Although I was introverted, I had been having sex with neighbourhood boys for nearly three years. I had heard many sermons in the local Pentecostal church (which I attended with my grandmother) about the evils of sexual activity, as well as many pointed remarks about homosexuals.

Gay liberation was a popular topic for the media in the seventies, which featured such remarks as "they are less than dogs" and "death is too good for them." I guess at some point I realized it was me they were talking about. I despaired for many months, feeling that my existence was a cosmic joke.

One day, when my parents were away, I consumed whatever I could find in the medicine cabinet. I awoke a day later at home, still intact. I confessed my attempt to a teacher I had had years earlier, who quickly, in conjunction with my horrified parents, arranged an appointment with the only psychiatrist at the regional mental health branch (serving I don't know how many tens of thousands of people). Trained in Europe, he spoke good French and Polish and poor English. English was my only tongue. I broke down and honestly confessed to not wanting to live, and also to my frequent sexual encounters with boys. The linguistic haze was exacerbated by the large wooden desk separating us. I was excused, and my mother was brought in.

I have no idea of the content of their conversation, but three days later I was withdrawn from school and found my cry for help in sorting out my sexuality answered. I was being taken by my parents to the Provincial Psychiatric Hospital in Campbellton, some 100 kilo-

metres from my hometown. Upon arrival, my father stayed in the car and my mother and sister took me inside, documentation in hand. We were seated in the admissions office.

The first question of the interrogator is still clear: "Is it sex, drugs or alcohol?" I don't know if I was sent or

went of my own accord to the outer office after that. My mother and sister, teary eyed, came out. I remember no last embrace as they left. I was promptly told that they had signed papers allowing insulin and electroshock to be administered without informing the family.

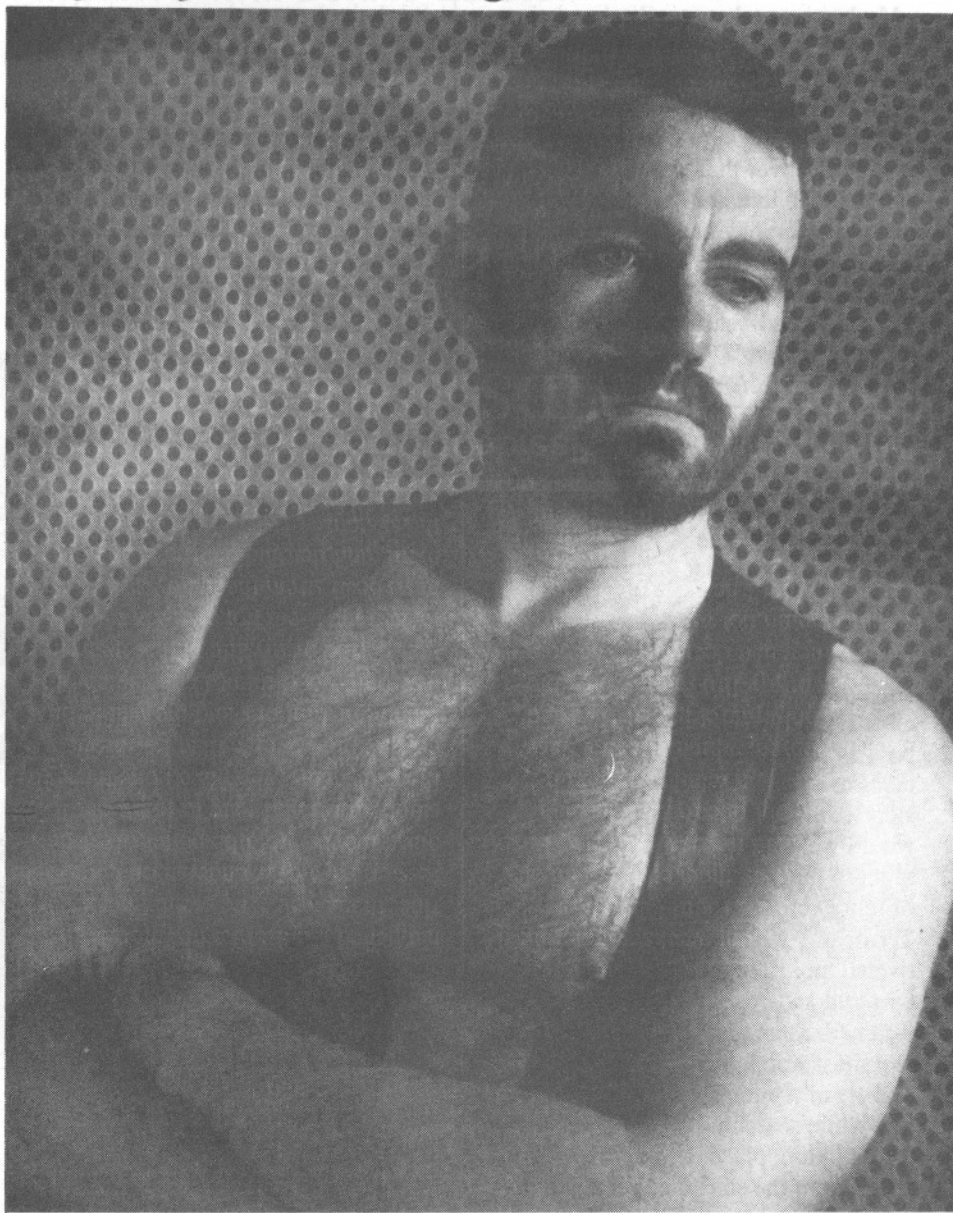


Photo by David Hawe

My bag was taken, my broken being searched. I was led through numerous locked, heavy doors to the admitting ward, where you were supposed to stay only a few weeks for assessment. I was to discover that, due to lack of space, some inmates had been there nearly a year. My bag was searched by the employees. They seemed fascinated that a fourteen-year-old should have a copy of *The Bolshevik Revolution*.

In a matter of minutes I received my first pills in my little paper cup. It was an open ward with what looked like World-War-Two metal-frame beds. I don't know how many dozens of males, from boys in their early teens to elderly men, slept *en masse*. I would wake in the night to the screams of fellow creatures. Terror was what motivated me. I did as I was told and watched, as an animal must watch the muzzle of a hunter's gun while searching for its hiding place. I heard from the staff that yet again my prison had not met the minimum standards set by the Canadian Psychiatric Hospitals Association for full accreditation. A week passed, and no psychiatrist came to see me.

The little paper cups arrived with regularity, and I dutifully swallowed. I had seen the result of suggesting that you did not need it today. Jean-Claude,

fair-haired, several years my senior and gay, one evening simply said he wasn't hungry and didn't feel like eating or taking his pill. He wasn't feeling well. The staff insisted. What had been a simple request to forgo a meal escalated, as my heart pounded, into the arrival of additional staff, a quick

sons for the transfer. Perhaps I was not seen as dangerous. I do remember the same locked doors, and within hours a psychiatrist spoke to me in my drugged haze. I recall nothing of that conversation — only the results. I was asked to lie on my stomach for what would be the first of many injections, for what seemed like countless days. It hurt to sit. I remember being fed, as I was unable to feed myself.

I still have visions of stories overheard in the halls — of restraint, and of uncooperative patients, like the gentle Rolande, having another electro-shock treatment. I honestly don't know if I received shock myself, though permission had been granted. I left the hospital under my parents' care some weeks later, very peaceful, with prescriptions safe in my mother's purse.

Now, years later, I can recall only disconnected scenes and images of my life before being institutionalized. Four years of regular drugging and visits to my first psychiatrist finally ended. I guess they had achieved suc-

cess. My memories were scattered and I was broken, it seemed, of lustful urges.

More than five years passed before I, in full terror, touched another man to try to recapture my humanity. I continue with that struggle to deprogram myself, to honestly feel, to love and be loved.



restraint, injection and confinement alone in a room. I learned later that Jean-Claude was an orphan whose foster parents had dumped him because of his sexuality, and that he continued to be detained because there was nobody to release him to.

Some days later I was transferred to the psychiatric ward of a hospital in the same town. I never learned the rea-

Activist on the Air

An interview with Bonnie Burstow

The following is excerpted from a CKLN-FM radio interview with anti-psychiatry therapist Bonnie Burstow, broadcast in Toronto on December 19, 1989:

Interviewer: 1973 was a very important year. My understanding, from talking to you, was that that was the year when you could no longer be locked up for being gay.

Burstow: No. People are still being locked up for being gay. That was the year when homosexuality as a psychosis was removed from the *Diagnostic and Statistical Manual of Mental Disorders*. But in fact, they didn't stop pathologizing gayness. You can find people who are psychiatrized and locked up for being gay right now.

Interviewer: As a dyke I'm having difficulty responding to this. I hope my mother's not listening to this show — she'll have me locked up.

Burstow: Psychiatry is at its most dangerous when kids are doing things that their parents don't approve of, so you're quite right.

Interviewer: If I were younger I'd be a lot more scared of her than I am.

The whole process of coming out and discovering your sexuality and who you are — to have that viewed as a problem that you can be locked up for . . . how many people are aware of that?

Burstow: Very few.

Interviewer: I saw a story in *Phoenix*

Sheila was originally locked up for being a lesbian. And after every electroshock they would ask her, "So, do you not want to be cured of being a lesbian?" And she would answer, "No," and she'd get another electroshock. And this was in the eighties. This is after it's supposedly no longer a pathology, right?

Then they wanted her to accom-

modate more to the female gender role, and were asking her to put on a dress. She did put on a dress. And finally, as one way of rebelling, she slashed herself. And then they could come down like a ton of bricks, because she'd done something self-destructive, which was proof —

Interviewer: Is this something that lesbian and gay groups should be working on, in concert with anti-psychiatry groups? What response should the community be making to this? Because just to let it go by . . .

When we talked earlier, you said that a lot of people seemed

to think after 1973 that everything was okay. Clearly, it's not okay.

Burstow: That's right. For the most part it was as if psychiatry was no longer a danger. So what you started seeing was gay groups using psychiatrists as consultants and so on, without understanding that they were bringing in people for whom the word gay meant psychiatric turf.



Bonnie Burstow (right) confronts shock doc Joel Jeffries. Photo by Konnie Reich

Rising [Vol. 5, No. 1] in which a dyke was locked up and was given electric shock. She said they thought that would make her wear dresses and she would become normal.

Burstow: That's Sheila Gilhooly. She and Persimmon Blackbridge came out with a book called *Still Sane* [Vancouver: Press Gang, 1985], which documents Sheila's psychiatrization.

Hospital Days

by B.K.

Monday morning merry-go-round
two doctors ponder the sociogram
who gets to walk the grounds this week?
who shares a room with whom?

Claire hasn't left her bed all week
– all month if the truth be told –
a moan escaping from the sheet
– the only sign of life I meet

who gets to leave the ward today?
and who has come to stay?

Sue's back again in her same old room
not ten days since she left
they brought her in as a stretcher case
the sign of shock still on her face

do you all enjoy the sun in the park?
do you go to do your supervised art?

Diane hoards pills and razor blades
to save for a rainy day
she smiles and draws a happy face
tears blotch the paint across the page

was everyone there at the bingo game?
did you stay and dance to the tunes?

Mike nods and hums to the Bee Gee's wail
his shifting eyes are veiled
"One more hour and my life will be through . . .
I've just gotta get a message to you"

let's end on a positive note for today
does anyone have anything to say?

Debra slit her wrists last night
before she ran away
she came and shared her misery
but asked me not to say

A sex worker's experiences in therapy

Merchants of Love

by Gwendolyn

The following is excerpted from Gwendolyn's multimedia show, *Merchants of Love*, which she has performed at the Toronto Fringe Festival and in Ottawa in 1989, and then in England in May 1990, to great acclaim. The sequel to *Merchants of Love*, called *Hardcore*, will be part of Toronto's 1990 Fringe Festival.

Once upon a time, every night, I would light a candle and pray: Please, dear god, dear goddess, please let me let go of this anger. Make the anger go away. Lit a lot o' candles. Still pissed off.

Might as well tell ya, cause the truth will out. I'm a professional bad girl. Painted lady. Could you tell? That's a fancy way of saying: sex trade worker. I'm a stripper by trade. Which means I push pussy to sell beer. I am a stripper; I have been a prostitute. Used to work in a self-serve body-rub parlour – where the guys just rub themselves. They paid me to watch. Ah, the sweet life of a professional voyeur . . . Some people get paid just to listen. Well, not listen . . . be there, sort of.

For those of you who might be sitting here wondering, "Where are we? What

the heck is going on?" this show is called *Merchants of Love*. There are two sides to the story: gettin' paid for

Yes, we are a service industry. We sell hard-ons. We sell comes. What?

I'm sorry sir, we do provide companionship, but if you're looking for love, call the 50-minute hour. Thank you.

If you're lookin' for love, call the sliding-scale facilitators – counsellors, therapists. There been a few that broke my heart, I'll tell ya. They pretend to love and care for you, right? Suck you in. After they get your health insurance number. Fist full o' dollars. Get out your empathy. If you're too poor to pay, you stay on the waitin' list.

Back in the days of the G-string. Yeah. That was back when I had my mid-life crisis: *You're 27 years old. You're not getting any younger. What are you going to do with the rest of your life?* I don't know! I never expected to live this long!

[*"Choice Boredom"* movie begins.]

She lived in the rich part of town, where money grows on trees. She had a swimming pool in her back yard. She had a box of Kleenex on her table. She liked to drink tea with milk, no sugar.



Photo by Konnie Reich

bein' laid, an' the flip side – payin' somebody to fuck me over.

Brrrrinnnggg.

Sex trade . . . may I help you?

She liked cats. Just like me. Her name was Choice Boredom, and I loved her. Choice was a counsellor. She was also a wife. And she was a mother, with two teenage daughters. Most important of all, Choice was an actress. A professional actress.

I got her name by phoning the Women's Referral and Counselling Centre. You just phone them up, and they give you the numbers. And Choice was the first one I called. Choice said, I don't know any strippers, but I would like to meet you.

She was a big blonde, with a deep, sexy voice. Once I complained, 'cause she was away a lot. Like, how can you run a business if you're not there? She said, I don't do this for the money.

Then why am I paying you? I know. I'll feel better if I pay. It's more like real life.

Choice was my very first therapist. I was crazy about her. Yeah, I knew she saw other people. But I wanted her to like me special. I didn't know that much about therapy, so I went to Coles Notes, to study up. There's a lot you gotta learn. Lot of books to buy. Therapy books are in the psychology section. Right next to the books on the occult. Some of the books are on the self-help shelf. Therapy don't care about your social or political reality. You're crazy (or just not perfect).

Choice wanted to talk about how I experienced kindergarten. In the meantime, in the present tense, I was experiencing one fuck of an education. We were sucking up to bosses, and sucking off cops, to keep out of trouble.

Therapy says, learn to be happy, wherever you are. We're into awareness here, dear. Not politics. And just remember, you're a good person.

So you stay in the now, and talk about the past.

We talked a lot about my time on the street. Stuff I barely remember. Choice

said, I can understand you doing it once, because you're hungry. But what I can't understand is why would you do it again.

'Cause you get hungry again. But I wasn't gonna tell her.

Be careful with the therapist. Don't give the whole story. Never met one who could handle too much reality. Therapy is like religion. You come hoping for acceptance.

What you get is a lot of self-righteous condemnation.

Therapy is not a gift. You got to pay for it. Pretty package. That's it. [movie ends].

I spent a lot of time, and a lot of coin, trying to hip up a straight. I hope if they throw me in jail, she'll be there – a respectable middle-class lady – to stand up for me.

All my therapists have been ladies. Ladies first.

I'm an impulsive, compulsive, anything-for-a-

laugh kinda gal. I had one doctor who said I was a borderline personality. Which is kind of funny, 'cause in school they said I had too much personality. I scare them off. It's a pattern with me. A rejecting mother. A rejecting lover. A succession of rejecting therapists.

I had a lady therapist in Rosedale. She said, you think you're so tough.



"I don't do this for the money." "Then why am I paying you? I know."

You think you're so tough. Well, you work with me, young lady. You'll lose that hard exterior.

I don't think I'm so tough. But being easy is hard work.

I figured, I'll give the lady another chance. I went back the next week. She said, I'm good with middle-aged, middle-class women who drink in the afternoon when their husbands are at

the office. I can't work with you. Everything about your life is illegal.

Then she told me how she was having an affair with a married man. He was a taxicab driver, and he was much younger than she. And how she's been feeling kind of depressed lately. So I paid her, and left.

"Do you sometimes feel like you can't go on? Don't fight it. I understand you. You're a lot like me."

Doubt it!

"When you feel you're all alone, Standing at the edge . . ."

Yeah, you'll be there to give me a push. (Uh-oh. We're headed for commitment.)

"You're not alone. I have 30 clients a week. And they're all scared and stupid, just like you. Only some of them don't know it yet. You're getting better. You know you're sick."

Hmmm. Is there a therapist in the house? Are you covered by health insurance? Can I talk to you after the

show? My insurance number is 32-28-32 Do you love me yet?

The feminist therapist said, If you felt good about yourself, you wouldn't do the things you do. You wouldn't let men use you. We need to work on building your self-esteem.

The stripper said, I don't wanna do that. It's my money; I'm payin' you. I got plenty of self-esteem. And none of your tacky put-downs can take that away from me.

She said, I give you a lot of power.

You don't give me nothin'. I take what is mine. I won't take this shit. Look, I want you to like me. But what we have here and now is a case of mistaken identity. You see me as you. You would not like sex work. But I do. I do. I like gettin' applause every time I bend over. I like the girls. I like the men. Some more than others. The business has been good to me. Read my lips. I like doin' the things I do.

She said, You think you like it, that's part of your oppression.

Lady, I know what I think. You see me as a victim. Or worse, a traitor. You see the men who like gynecology-in-motion as the enemy. But, we're not all the same. If you could see them through my eyes. . . .

She said she didn't know if she could see me again. She didn't know if she could reconcile her feminist politics. Yeah, well . . . that's a tough one. What she gonna do? Toss a coin? While she's busy reconciling, I'm gone.

Strippers stand accused of objectifying women. I object, too. And defy the presumed privilege to deny my experience. To define my experience. My fine experience.

When I'm on stage, I'm a whole person. If all you see is the hole, you look like the ass.

All right. I admit that every now and again I succumb to public pressure.



"I'll feel better if I pay. It's more like real life." Photo by Rogde

It's the voice of some long-lost therapist, nagging: Why don't you get a job? Get a real job.

As if what we do is not work, right?

Well, I got a job. Hey, I scored. Just like winning in the lottery, right? A real job. Gosh. Long hours, minimum wage, no overtime pay. I felt so decent. It was great — 'cept I worked five weeks and never got paid. When I asked for my money, the boss beat me up. Shoulda got the coin up front.

This was in Vancouver. I live in Toronto, right? Real job! My therapist supported and encouraged me to quit stripping. Make a clean break. Get out of town. Bad advice. Sold all my costumes; gave 'em away. Said goodbye to all the girls.

"Good luck, Gwendolyn. Don't let us catch your ass back here."

Got out of the business. All the way over and out to the other side of the world. Vancouver. Suicide capital of Canada. Never rains, but it pours. So what happened was, I lost the job. Boss beat me up. I felt really bad. Yes, there were witnesses. No, I didn't call the cops. Called my therapist. Long distance. My ex-therapist. She said, What did you do? Why would the man hit you? Don't press charges.

Check the writing on the wall: For a good time, call 911. Don't worry, Lady, I don't want my day in court. I know I'm guilty; I have a past.

See, I lied to get the real job. If your whole work history has been in the sex trade, who's gonna recommend ya? What would you put?

Gets along well with others. Significant others. Men who pay.

An' what would they say?

Very oral and discreet. Quite well-known downtown.

Last job: Bob.

I found myself alone in Vancouver, broke and peer-less. There was a beer strike on. All the bars were running dry. Couldn't fall back on stripping;

"You'll get your cheque." Ah, sweet lady, your words . . . like music to my ears. You'll get your cheque.

'Cept I didn't get the cheque. Turns out I hadn't been in the province long enough. See, I was too stupid to lie. Honest isn't eligible.

Oooh. Bitter.

So I cut up my arm, for something to do. Not to hurt myself or kill me. Just sort of my personal comment on all the red tape and all the red blood, falling through pictures. Concentrated pain. And then, the old numb-de-numb again.

The lady psychiatrist said, What happened? And I said, I was experiencing an emotional holocaust. She smiled and wrote that down.

It's funny what people find funny. Then she said, We have a job for you. Would you like to work in a sheltered workshop? And I said, What do you do there? She said, You paint signs.

This made me hopeful. I had always been interested in communication.

How much does it pay?

It pays a guaranteed welfare cheque, ten cents a day, plus tokens for the bus.

Tokens, eh?

Yeah, I have always felt really ashamed of asking for help. Like, I don't take nothing from nobody, okay? I paid my own way, even when I was a kid on the street. I sold what I had. I didn't ask for handouts. But now I had fallen into the picture. I saw reality a little more clearly.

The government owes me an apology! You can't live on the puny, tight-fisted little monies they allot you. Can't live, eat, and pay rent.

**Your therapist
will never
validate your
experience. If
she hears you,
she fears you.**

nobody wanted dancers. So, I did something I regret — 'plied for welfare. Oh, the shame of it all. I just applied. I didn't get it.

The lady welfare worker said strippers are considered self-employed; strippers can't get welfare.

How am I considered self-employed? I don't own a strip club. I can't say, Gee, think I'll go downstairs to my bar, take off my clothes.

The only way I'm self-employed is if I stand on the street corner.

First, number one, welfare worker comes to your home. Makes a home visit. Looks in the cupboard. It better be bare. Tea is a luxury. Drink water from the tap. T for trap. No T for me. I'm home free.

"You feel you're at the brink."

I don't think I'm at the brink.

"You feel you're at the brink."

I don't think I'm at the brink.

"You feel you're at the brink."

Are you listening to me? I don't think I'm at the brink.

"I hear you, hear you, hear you. You have all the answers within. Listen to yourself - 'I don't think. I'm at the brink.' Don't think. Just feel, feel, feel."

(Deep breath)

"Good! With someone like you, breathing is very important."

Wow.

Here's to you and here's to me. If by chance we disagree, fuck you. Here's to me.

When you're up against the wall, it's hard to lie back and enjoy it. So I did what I know. I went on the street. Worked the street. I hadn't done it since I was sixteen. And I'm just talkin', like, five years ago. And I got back on my feet a lot better, wearin' high heels.

Old street lady seen me on the stroll. Gave good advice. She said, Take care of yourself, girl.

And I hope none of you ever falls into the hands of the agents of social control. The helping agencies.

There's a new kid at work. I like her. She reminds me of me when I was young. She's going to her very first therapist. I said, So how's it goin'?

She said, Okay. But there's a problem I have to work through.

Oh, yeah?

Yeah. My therapist doesn't understand me.

Story of my life. And your therapist will never validate your experience. If she hears you, she fears you.

I remember one therapist said, Oh, you're a drug addict. Simple. Stop stripping. Then you won't need drugs. Anyone would take drugs if they had to face a crew of drunken brutes every night. You use drugs to blot out the reality of a painful environment.

Yeah, right.

That's why I got high every time I seen her.

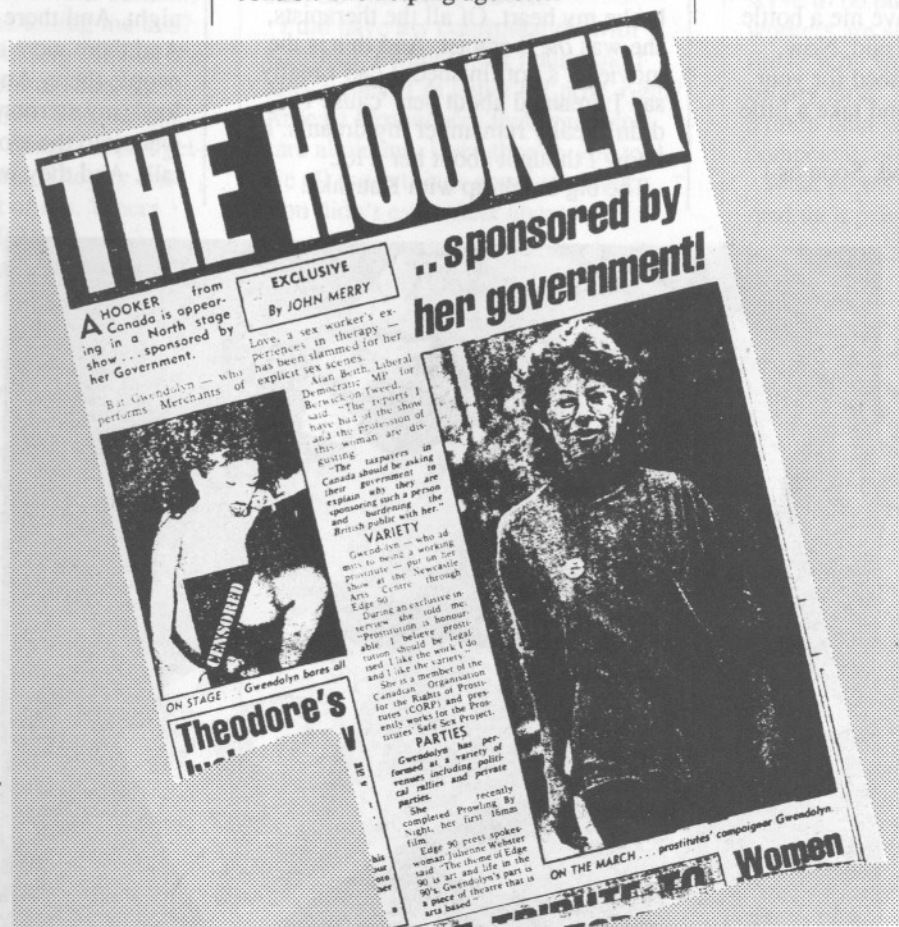
There are chemi-

cally dependent people in every walk of life. Maybe we should all stop working. Just say no to the landlord.

Therapy is just a substitute for a good drug. Who said that? Some loco shrink. Yeah, a therapist is not a fairy godmother. Wishin' it don't make it so.

["Addiction therapy" slides begin.]

Went to a lot of professionals, for help with addiction. There was a doctor that



You can't reform me. I sweat too much to be a lady. You're looking at a proud and practising exydisiast. Stripping has been a blessing. But it's not for everyone.

Dope was not good to me, but I know the attraction. But there is one old habit I'll never stop kicking. I can't believe people still stand by therapy.

dabbled in acupuncture. And then there was the homeopathic doctor. Homeopaths, they treat like with like.

So you're addicted to hashish. Well, hash is a derivative of cannabis sativa.

So the good doctor gave me a bottle of liquid cannabis. She said, Now, whenever you feel the need for your drug, go to the bottle, and take a little drop.

Funny how it happened. Soon as I left her office, I felt the need for the drug. So I took a little drop. But just a drop didn't do nothing. So I downed the whole bottle. Wssshhhhhh. Caught a mild buzz. But it weren't enough to cure me.

Well, the one I really want to bitch about is the lady therapist who said, Every time you get a craving for your drug, just squeeze your little finger. Just squeeze your little finger. And the craving will be gone.

Sometimes I have to pinch myself to see if I'm really here. If I really believe it will help, it will.

Sure, whenever I get a craving for some money, I just squeeze some little finger. Squeeze my ass. See if it's real.

Hostile? I'm paying you 30 dollars an hour to help me with an addiction, and all you can say is, squeeze your little finger. I'm not being hostile. I'm being ripped off.

If I really believe you'll drop dead, Will you, *please*?

I'm not some little finger, but I could squeeze you. [end of slides]

["Katrinka" movie begins.] This is about Katrinka Eatwind. Katrinka broke my heart. Of all the therapists, she was *the* therapist. And this is the movie. It's not finished. I can't really say I dreamed about her, 'cause I didn't really remember my dreams. I know I thought about her a lot.

The big break-up with Katrinka.



Photo by Rogde

What happened is, I'd been telling her I was off my dope. I was trying real hard to stay off it. I'd been off maybe five or six weeks. And I'd been telling her I was real worried about how hung up I was getting on her. I told her, Okay, I'm not in love with you, but I think about you all the time. And I want to be with you. She would never deal with it. She'd always say, You won't get hung up on me.

Addiction is an obsessive disorder, right? So what was happening, I was transferring my obsession with my dope to Katrinka. And she came in one day, and she said, "I was at a party last night. And there was reggae music. And there were all these coloured people there. And the music was so loud, my sternum was vibrating. So we went into the women's washroom to talk. And they were smoking drugs in

there. And then back on the dance floor, they were smoking drugs there, too. And when I left the party, I realized that I was quite high. And I'd only had one drink. I realized I'd gotten high on the drugs that the people were smoking. Just from breathing it in the air. And it was quite marvellous. It was so much fun. I walked all the way home. I completely forgot I had a car, and I walked all the way to my home in Rosedale. Which was about five miles. And I

was so glad I was going to see you today. Because there was no one else I could tell this to."

Well, at the time, this felt really great. Wow! Katrinka got high on dope! Wow! I could get her some dope. Like, okay, I probably couldn't smoke it with her. But I could maybe get a little piece of hash and say, well, here you go, Katrinka. Just check this

out, if you want to check out high. Maybe I'd have to show her how to roll it. Or maybe she'd smoke it in a pipe; then she wouldn't have to smoke it with tobacco.

But after about a day of this bullshit, I realized, Why is she telling me this? She has no business telling me that she got high the night before. Like, she knows I'm off my dope. Why would she tell me that? My friends aren't gettin' high in front of me. They're not talkin' drugs in front of me. Where does this bitch get off?

I come to these sessions and I listen to her talk about her trip to Club Med. In a six-week period, she goes to Club Med for two weeks. She comes back and tells me, for two weeks in a row, about the good fuck she had down there, with some guy on the staff. And then she doesn't show up for two weeks. Because she's gone back down there to get laid.

Is this any of my business? Is it any of my business that she left her husband because he was lousy in bed? Like, what does that have to do with me? Like, why does she tell me these things? Why did she tell me about the dope?

I was so pissed off. I was so hurt. I'd gone to her for two years, and I never missed a week. I was so upset that I didn't go. I never called or nothing. I missed two sessions in a row, and I never called. And I was sure that she would phone me. Or that her office, her secretary, would call. Or maybe I'd get a personal note, right?

Dear Gwendolyn, Where have you been? You always came, every week, for two years. And you didn't show up the last two weeks. Is everything okay?

Nothing. No note. No phone call. I kept my phone plugged in. I hung around, to see if she'd call. Didn't hear from her at all.

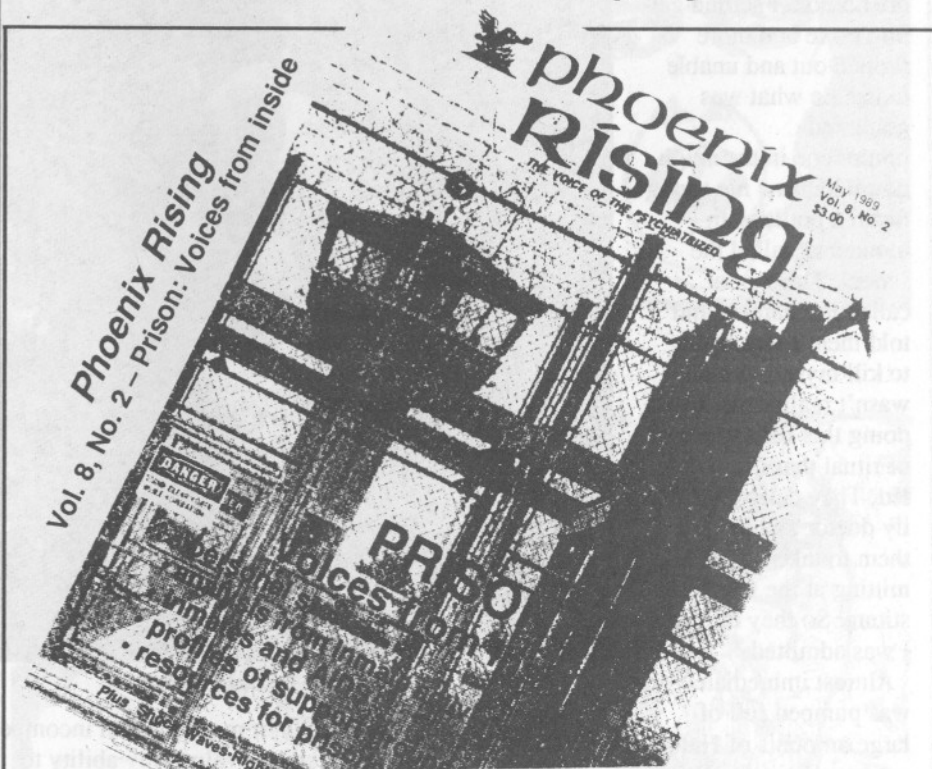
Finally, I phoned her secretary, and her secretary said, Oh, yes. You. Gwendolyn. You've lost your place. It's nothing personal, but the doctor has a two-year waiting list. And you didn't call. So you're off the list.

I did have my confrontation with Katrinka. I went to her house and I said, I guess I'm better off now, right? At least I know now that you didn't care about me. Even though you told me all those things about yourself. You didn't even *think* about me.

Katrinka said, But I *did* think of you. I heard of a woman found dead in a ditch, and I thought of you.

Why would I be found dead in a ditch? Because I'm a bad girl and I deserve to be punished? Or because sex workers are always supposed to be victims? Why would I, an honest whore, be any more likely to be found dead in a ditch than you, a lazy, arrogant, incompetent, no-good quack of a doctor?

What pisses me off is their power. And their privilege.



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School of Hard Knocks

by Ryan Hotchkiss

Adapted from an interview conducted by Irit Shimrat for "Analyzing Psychiatry" (see Page S40).

The event that precipitated my getting locked up was trying to fill a bottle with my own blood behind a suburban high school in the winter of 1976.

I was extremely distressed in that period of my life. My parents were breaking up; I was confused about my sexual orientation. I started getting more and more flipped out and unable to handle what was going on.

Someone in the neighbourhood saw me trying to fill a bottle with blood and called the school. The school called my parents and told them I was trying to kill myself, which wasn't really true. I was doing this for some sort of ritual that I'd invented. They called our family doctor and he told them to take me to admitting at the Clarke Institute. So they did, and I was admitted.

Almost immediately, I was pumped full of large amounts of Haldol, which is an antipsychotic. I collapsed. I couldn't breathe. There was a flurry of activity; they said later on that what had happened was they'd overdosed me. They'd thought that I needed more of it. They didn't realize that I didn't have any resistance to that kind of drug. I felt as if there was a great weight on my chest and that I just couldn't get any oxygen. So I said something like, "What are you trying

to do, kill me?" And this was interpreted as paranoia.

I was always on antipsychotics, Thorazine particularly [Thorazine is the brand name of chlorpromazine]. Thorazine tends to deaden everything. It's sort of like being under water, if you can imagine how moving under water would be. The simplest things became extremely difficult to do, plus it made me drool and it made me feel crazy.

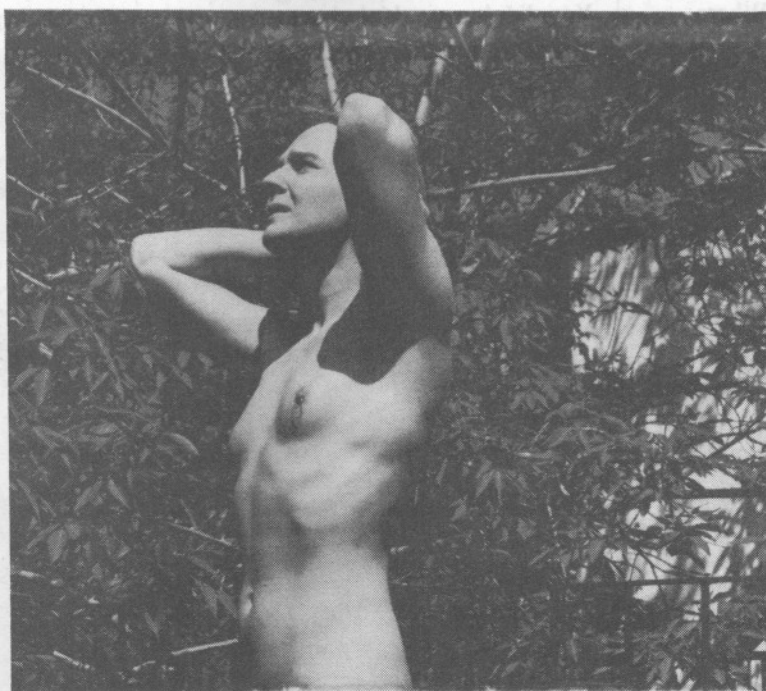


Photo by David Henderson

Specifically, it made me feel incompetent. And since I valued my ability to put thoughts into words, being unable to do that was a real blow to my ego. It made me feel really bad about myself. I felt I was becoming stupider and stupider, and eventually I'd just sort of be this little slug off in a corner somewhere, totally unable to function. And I was terrified that the drugs were damaging my brain permanently, because I had seen a little bit of the effects of

long-term anti-psychotic use, like tardive dyskinesia, in the other patients.

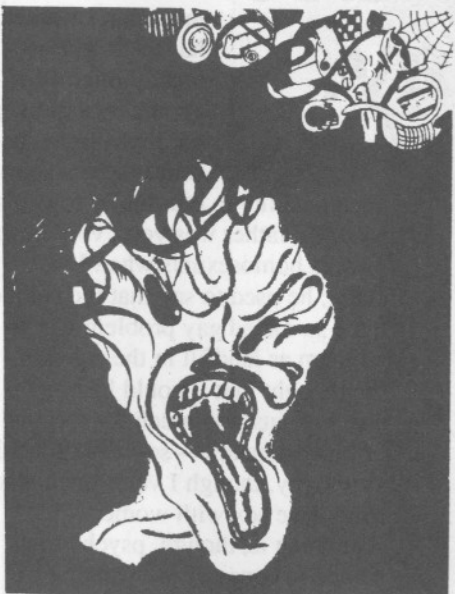
At first I didn't know the drugs were dangerous. I was never told of any of the effects. When I got severe muscle cramps and had to shuffle around the halls all the time, they gave me a drug called Cogentin, which was supposedly to combat the "side effects." Cogentin has its own side effects, on the other hand. My vision got so blurry that I couldn't focus within four feet, so that meant I couldn't read. Words appeared to jump around on the page.

Eventually I noticed that the only people who ever got out were those who agreed with the staff, who agreed that they were sick but said they felt much better now and would be able to handle life when they got out. They didn't question the staff's authority, and didn't ask what the side effects of the drugs were.

So I learned to play the game, to mask my emotions. I lied. They were very concerned about the way in which I saw things. They thought that when you look at a blank wall, you should just see white, and the fact that I saw colours and swirls

and things that weren't supposed to be there really freaked them out. So I told them I didn't see those things anymore, and they let me go.

I was released taking a great deal of chlorpromazine a day – about 200 mg. I tried to go back to high school, but it's extremely difficult to think and function on chlorpromazine. And I got really depressed, because I felt that this was a lifelong sentence imposed on



Drawings by Ryan Hotchkiss

me; that I would never be capable of doing the things I had wanted to do because I was supposedly schizophrenic and incurable.

My parents and all the people around me treated me as if I were made of cut glass; they treated me like a crazy person.

They were very concerned about little changes in my mood. If I expressed distress about something they would go rushing to the phone to ask the psychiatrist if that was a relapse, or if I was about to go psychotic again.

My school friends avoided me. My teachers were very patronizing; they seemed to consider it exotic to have a real schizophrenic in their class. I got very depressed, and told people that, so I got locked up again.

At this point, I was told that schizophrenia was a permanent, life-long illness, that I would have to take medication for the rest of my life, and that there was no reason to continue with high school, far less go on to post-secondary education, because schizophrenics were basically not capable of functioning. I was really saddened by this and I burst into tears, and they took that as further evidence of my insanity.

I was institutionalized about seven times in all. Sometimes I was voluntary, which is supposed to mean you can leave when you want to. But it rarely works that way in practice. I witnessed this and had personal experi-

ence with this. When you tried to leave, when you said, okay, I'm checking out now, very soon they held up a little piece of paper, a form from the Mental Health Act, and you were committed. It was the same thing with refusing medication. Supposedly if you

you're searching for an identity. And here they had given me one. I knew what I was: I was schizophrenic. I was a mental patient and I was incurable. I didn't have to search any further.

They were more comfortable with the idea that I was schizophrenic than with the fact that I was gay.

My family was upset when I originally told them that I was gay, when I was about thirteen. They seemed a lot more comfortable, afterwards, with the idea that I was schizophrenic than with the fact that I was gay.

While I was locked up, of course, I no longer considered myself gay. I no longer considered myself a sexual being anyway, because the drugs really do affect your interest in sex.

I always knew that I was attracted to women, that I wanted to have sex with women, though I had a great aversion to calling myself gay, because there was so

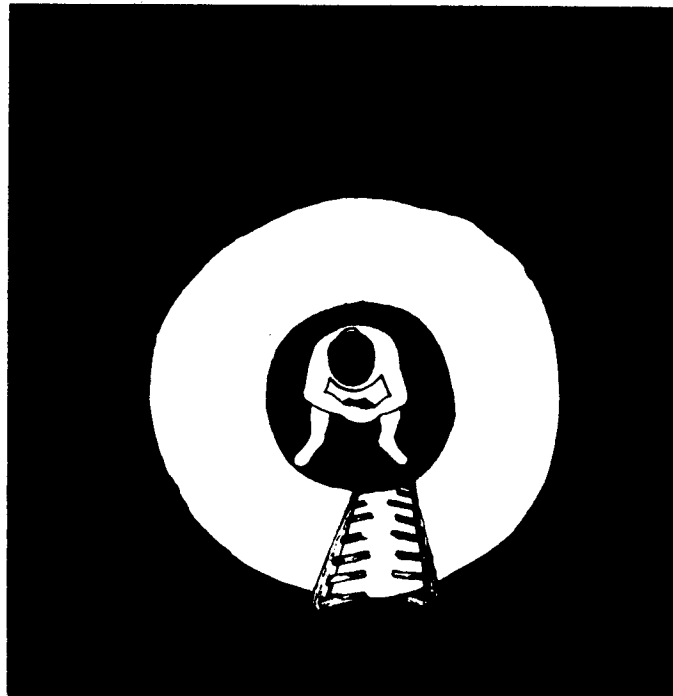
were voluntary you could refuse. But when I tried it, six big orderlies were called and they held me down and injected me with it.

I think one of the most damaging things that happened is that I was taught how to be a mental patient. When you're inside an institution, normal human emotions are taken as symptoms of whatever pathology they've decided that you have.

And I believed that I was schizophrenic. It was interesting; although I was distressed by that, I was also pleased. Because when you're a teenager,

much hostility in our family towards gays. My father was very, very hostile towards homosexuals when I was young; he used to say that the solution to the so-called gay problem was to use them as landfill in the suburbs. The thought that I would be one of them was just too much for me, and for him, to handle – so I didn't label myself gay, though I very much wanted to have sex with women.

The thing is, though, psychiatrists seemed to consider my wanting to have sex with women a rejection of my femininity. I've since looked at my



Drawings by Ryan Hotchkiss

psychiatric records, and that comes up fairly often.

Some of the records were pretty funny. In one interview that I had with the psychiatrist, she mostly commented on my appearance and wrote that I wasn't wearing makeup again, and that obviously I was still having trouble with my femininity. Some of these people have very stereotypical views of what male and female are.

I stopped getting locked up when I was in my late teens. I went to an alternative high school, and a lot of the people who were teaching there were sort of radicals – activists from the sixties. One of them, who'd done a lot of acid, explained to me what my problem was – that when I started to hallucinate, I would get scared, and then the hallucinations would get worse. It became a sort of cycle. The more afraid I got, the worse and scarier the hallucinations got, and what I really needed was to get over my fear. The problem wasn't what I was seeing, but rather my fear of it – my fear of losing control. And so he acted like a "trip guide" a few times when I stopped taking chlorpromazine while I was at that high school. When things became too heavy, he'd let me sit under his desk, or we'd go out for drives. And I think what it was, was that I developed real friendships, real closeness with people, and that really helped.

As the years went on, I became less and less enthralled with psychiatrists. I started to realize that they didn't know any more about human behaviour than the average grandmother does; that

**My life no longer
fit into these
neat little boxes
that middle-class
psychiatrists
invent to classify
the world.**

they weren't capable of solving the problems that I wanted solved. I was looking in the wrong place. I started to see psychiatrists for what they were – professional people, paid to be there, who believed in a certain model of the world, which I was increasingly calling into question. They believed in the medical model of mental illness, that there are these identifiable diseases, mental diseases that people have that you can treat with drugs. I started to think that that wasn't the case.

After I stopped taking the neuroleptics I still saw a psychiatrist for a while because I thought she was different

from the other psychiatrists I had seen in the institutions. But one day I told her that I was really excited because I'd fallen in love with a woman, and how great this woman was. I was explaining what this woman was all about, and that she was a prostitute – an escort – and what kind of relationships she had with her clients, and how much good she did. And the psychiatrist got really sarcastic, and explained to me that my falling in love with a prostitute was a symptom of my self-destruction.

I was flabbergasted that a woman who I'd thought was so intelligent could be so dogmatic, so bigoted. I walked out that day, and I never saw a psychiatrist again.

At that point I realized that I didn't want to see my life in terms of symptoms or syndromes, and that my life no longer fit into these neat little boxes that middle-class

psychiatrists make up to classify the world. That the little boxes are really sexist and racist and classist.

But I'm actually glad about what happened to me, just because I know I can go through things like that and come out in one piece. That makes me feel good about myself.

In Memoriam

by François Lachance

Chris Ingold committed suicide in 1987. Chris was disowned when he came out to his family. Chris discovered recreational drugs and leathersex.

He once O.D.ed and was locked up. Chris was caught in the revolving door of the psychiatric establishment. Because of his homosexuality and because of rumours and speculation about his HIV antibody status, he was treated as a pariah both within the hospital and within the small community of Kingston.

I remember Chris once saying to me that he remembered me distinctly, because I had been the first person to talk with him on the park cruising grounds. I remember Chris helping at dances. I remember a very bright scientist. I remember his politeness. I remember an uptight man with a WASP background coming from a family where his father and his father's father before him had been chemists: the burden of that tradition and the support it gave him.

Chris was in a sense intellectually starved and this made him a bit socially awkward. I remember his pride in his leather drag. I remember how liberating it was for him to be naughty, risqué, a taboo-breaker.

I don't want to remember his fingers stained from the chain smoking he took up after being incarcerated. Or the stink of his sweat because of being doped up on antipsychotics, antidepressants, and other pharmaceuticals. But

it's part of the story and explains why he could never regain the concentration to finish his Ph.D. thesis. Bloody doctors didn't have enough wit to realize they were pumping medication into a chemist who had designed his own drugs.

Chris had a long way to come back. We knew he might not want to. He knew that support would wear thin. He knew that the system would impose its will, shape him into a good boy.

Chris and I last talked on a bright sunny summer day by the lake at Kingston. He looked good, rested, smiling. I was leaving the city. He was soon to be released – or at least I hoped my conversation that day with his shrink might hurry that along. I don't remember the words. I do remember the even-keeled tone.

Chris, through his altered states, had discovered the fascination of making meaning. He hadn't quite learned to shut off this meaning-making capacity at will, and was prone to over-reading, connecting signs and significations in a dizzying logic. The shrinks tried to rob him of the surreal. He would not surrender. He was too cogent to be deluded.

My friend is gone. A resistor. A flaming faggot, like me. His suicide was clear. A final act to mark his right to make life choices. He would be proud of that interpretation.

Narrow Escapes

by Irit Shimrat

Phoenix Rising editor Irit Shimrat's story, adapted from "Analyzing Psychiatry" (see Page S40).

I went completely out of my mind in 1978. Everything in my life went wrong all of a sudden. I didn't get into the program I wanted in university; my father told me he was getting remarried and that I wouldn't be able to live with him anymore; and I got dumped by a man I thought I was in love with. For a long time I thought that was the whole problem, but later I realized that my going crazy had been coming for a long time. I now believe that it was the result of trying to live as a heterosexual, and having no education or role model to convince me that anything else was possible.

The first hints of my craziness coincided with having my first boyfriend at fifteen; I started hurting myself in various ways and feeling really confused and fucked up. And it got worse with every boyfriend I had. I didn't have that many, but I stayed with each one for a long time because I didn't want to hurt their feelings by breaking up.

When I finally went off the deep end, it was more interesting than anything else that had ever happened to me. I had amazing hallucinations. I remember being in the Ross Building at York University. My father was a professor there and I was upstairs in his office, and I thought I heard the music of the universe downstairs. I don't know what that meant, but that's what I thought. So I went down to the "bear pit," which was a small area slightly lower than floor level, with benches around it. And there was a band – at least, in my mind there was a band –

playing this fantastic music that was telling me something important. It was incredibly beautiful. But it wasn't quite right. I went up to the drummer, or maybe the keyboard player, and told her to go slower. She did, and it was even better. The next thing I remember is that the band was gone, and the bear pit was ringed with people I didn't know, sitting on the benches. I went up to each of them and held their hands and said, "It's okay. I'm your mother, and it's okay." And each one believed me and felt better.

Then I borrowed a pen from someone and walked around the library writing on the walls: "Rejoice, brothers and sisters. God is dead."

Later that day, my father drove me home. Sitting in the car, I told him I could make traffic lights change by thinking about it, and then the lights were green all the way home.

That night I held a clock to my ear and heard the voice of god telling me

what I should do with my life, and god was the collective unconscious of women. Unfortunately, I don't remember what they said.

I think I got locked up the next day. I had broken my glasses because I'd decided that my vision wasn't "bad," just different, and that there was nothing wrong with that. My brother told my father I had done this, and my father had me put away by taking me to my family doctor, Dr. Genesove in North York, who told me that I should sign myself into the psych ward of the local hospital – North York Branson Hospital.

I don't know how I was put in isolation. I remember signing the papers and going to the hospital, so obviously I had been cooperative. And then somehow I stopped being cooperative, probably when they wanted to give me drugs. They put me in a tiny room (I later found out it was called "the quiet room") with nothing in it except a bed.



Photo by Konnie Reich

(Later on, they took the bed away and left the bare mattress, without any sheet on it, so I wouldn't do anything naughty.) They ripped my clothes off and stuck me in the ass with a needle, very painfully and roughly, because I was struggling to get away from them. I still have welts on my ass from this. Then they tied me to the bed with restraints, naked, and left me in the dark.

Until then, my insanity had been the most wonderful, fascinating experience of my life. At this point it became terrifying and horrible. I lay there twisting my body into weird positions, thinking they must want something from me and there's not much I can do, so maybe this is what they want. Maybe if I twist my wrist far enough they'll let me out. Eventually they removed the restraints but still left me locked in there, and then I started doing things like sticking my finger up my ass and painting magic symbols on the wall with shit in hopes that that would make the door open. Needless to say, this kind of behaviour did not get me out of isolation any faster.

The "major tranquillizer" they put me on at Branson, Haldol, made me very, very sick. I was nuts when I went into the hospital. But when I came out I was very ill. There was always part of me twitching – my hand or my foot. My face convulsed. I couldn't shit. It hurt to sit still and it hurt to move. It was kind of an impossible situation. I remember running after Dr. Kaplan – the person I'd been told was my doctor, who I didn't seem

to ever have any contact with – in the hall, and pulling on his sleeve and saying, "I want to get out of here. When can I go home? Can I have my clothes? Can I have my shoes?" And he would say, "Look at you! You're shaking! You're crying! You're obviously not ready to go home. You're not well."

I wasn't allowed visitors at this time, I guess so that the people who were

watching non-threatening shows on TV, like game shows. Apart from that, I slept and I ate. I gained 60 pounds. And that's about all I did.

I got off the drugs after a few months and started trying to put my life back together. That summer something wonderful happened: I had my first woman

lover. I told everyone who would listen that I was gay, and felt that everything made sense now and that my problems were solved. But she left me, and I didn't know any other lesbians, and I felt that I was thrown back into the ugly world of heterosexuality. I ended up going nuts again.

My friends were worried about me because I'd stopped eating and sleeping. They insisted on taking me to Toronto's Mount Sinai Hospital (or Mount Cyanide, as I came to call it), where I had been seeing a shrink for half-hour sessions of staring and silence some months earlier. I was very frightened, since the most horrible thing that had ever happened

I discovered other lesbians in Toronto, found the radical queers and made a lot of wonderful friends.

supposed to care about me couldn't see how sick the drugs were making me. So I had no contact with anyone except the people in the hospital. Eventually, I learned to shut up, so they started giving me "privileges" and then let me out. I guess I got locked up about the beginning of September and they let me out around Christmas, still on enormous doses of Haldol: twelve pills, four times a day. I was capable of

to me was being hospitalized, and I didn't want it to happen again. So I freaked out in the emergency ward – a bad idea. I sat in a wheelchair and started wheeling away from the doctors that were chasing me. Of course they caught me, and it was the same routine again. They put me in restraints, they put me in isolation, they shot me full of drugs, and I was paralyzed with terror for days. Eventually I got out into the

general population of the ward and was heavily drugged with Nozinan (another "major tranquillizer"), which made me extremely sick, as Haldol had done.

I remember that one day the person who was supposed to be my doctor, Roxanne Bukhari, found out that I was smoking marijuana and hauled me into her office and screamed at me: "How dare you medicate yourself!" Another time, someone gave me a historic romance I didn't want to read. One of my fellow inmates was banging her head against the wall that day, as she sometimes did, and was getting the attention of all the nurses. I wanted some attention too, so I took my historic romance and set it on fire in a metal garbage can in the middle of the room. There was an emergency meeting the next day where I had to apologize to all the patients for endangering their lives, which I don't think I'd done by setting a fire in a metal garbage can in the middle of the room. Still, I was in big trouble, and they decided they didn't know what to do with me at Mount Cyanide – that there weren't enough "activities" to keep me busy there. So they sent me to the Sheppard Pratt Hospital in Towson, Maryland – a kind of country-club setting. In the States, people who have Blue Cross health insurance and get

locked up for going crazy go to one of these fancy hospitals for a year and then, when their Blue Cross runs out, they're put in the state hospital to scrub floors and rot.

ing locked up. I was able to escape quite easily, since this was a low-security facility. So I ran away in October of 1980 and came back to Toronto.

That was the end of my relationship with psychiatry. For a few years I went to therapists because I still wasn't happy and everyone said I needed professional help. But the therapists were unable to do anything for me.

Eventually, I discovered that there were other lesbians in Toronto. I found the radical queers – and made a lot of wonderful friends. I started having excellent sex with women, and moved in with Chris Bearchell, my lover, who is the best person I've ever met. I also found the antipsychiatry movement and discovered, through becoming the editor of *Phoenix Rising*, the joy of wreaking revenge on the bastards who had almost succeeded in ruining my life: psychiatrists and their lackeys. Finally, I realized that anyone worth knowing has at one time or another been called crazy

by a lot of boring people.

Clarke Institute of Psychiatry



Photo by Konnie Reich

When I had been in Sheppard Pratt for a few months, I was told I'd have to stay there indefinitely. However, the person in charge of me, Dr. Kiernan, who was otherwise a complete goof, allowed me to go off my "medications" when I asked to. So the only thing wrong with me was that I hated my life and was miserable because of be-

Straightening Gay Clients

by Jennifer Chambers

In the 1970s it was allowed that homosexuality could be categorized as a mental illness only when a lesbian, a gay man, or a bisexual felt unhappy about her or his sexual preference. But most mental health professionals are still prejudiced against people who are not heterosexual, and this prejudice affects their practice. Even mental health professionals who have accepted, at least superficially, the legitimacy of lesbians and gay men often still believe that bisexuals are "sick" and should be brought to the point of having a "real" identity.

I first noticed that the mental health profession was not value-free in its reaction to my love life when my psychiatrist asked me how I felt touching my lover's breasts. I replied, "How do you feel touching your wife's breasts?" Later he told me I was hostile. Both psychiatrists I saw during that time admitted when challenged that they would be happier if I were in a heterosexual relationship.

I soon found out that these weren't isolated cases of prejudice. In 1985, Jack Williams, director of the counselling centre at the University of Waterloo, addressed the workers at the York University Counselling and Development Centre on the topic of "straightening gay clients."

Williams felt that gay and bisexual men might want to change because they wanted a "normal" life – a wife, a

house in the suburbs, and so on; because they felt different and alienated from the larger culture; or because they did not like the homosexual culture they had encountered (mainly in the bars).

Williams's method for "straighten-

ing" a gay or bisexual man was to have the man wear an elastic band around his wrist. The man was to pull the band whenever he felt attracted to another man. He was also supposed to develop his attraction to women by picking isolated body parts that he liked, such as bums in tight jeans, and

to focus on these parts when looking at women (a scheme with obvious limitations). Williams tried encouraging a man to have delightful fantasies about being naked with another man, walking towards him, starting to feel sick, vomiting, shitting, falling in the shit, etc. This didn't work either.

He observed that all the men he was working with felt distant from their fathers, and thought this might be true of men who were ambivalent about their sexuality. I asked whether he knew how most men felt about their fathers, and he admitted that he didn't.

I asked Williams whether he would use the same methods on a Jew or a Black person who did not want to be attracted to other members of her or his own ethnic or racial group. He said he supposed he would have more problems with that.

It appeared to me that most of the counsellors and students at the Counselling and Development Centre did not find what Williams was doing acceptable, but never said so directly.

The professional validation of self-hatred is a result of the assumption that people who are having difficulty "adjusting" are the problem.

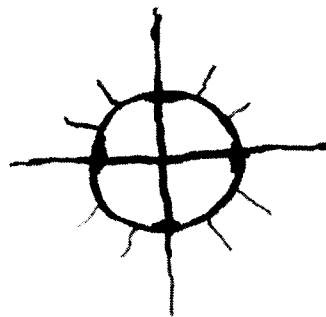
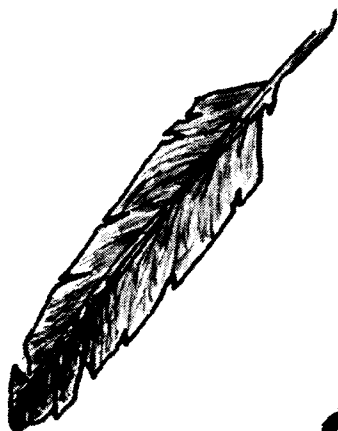
This kind of thinking ignores the possibility that the real problem is the society we are expected to fit into.



Doctor's Favorite Color

by Chrystos

Her office blue enough to break you accusations in her indigo
velvet throw pillows her coarse royal blue hopsacking couch
her teal tweed carpeting where hours of my mind unreeled without
catching anything She bought paintings of misty
flowers which evaporated in a delicate smoke of wounds Wouldn't
hang mine which leaned ashamed in her coat closet Innocent
desk containing alphabetical files of our nightmares her extra
nylon stockings & fastidious letterhead Crane's best rag
pale blue kid finish with navy engraving Those windows watched
the bay where we'd waited for my father on rough docks
when he left left again left
Somewhere else we waved a white tablecloth to him over sharp
bridge railings his dark ant body far below on deck passing
under us the wind beat my coat through my knees blue with cold
I stared out her mirrors my father floated in every ship as he
listened to the complaints of officers in white duckskin
gold braid snakes She wanted me to re-enact what I couldn't
feel handed me Fisher Price toy dolls to show her what it
was like when my uncle took off my flannel pajamas to make
me a real woman at 12 I explained my mother hours
of her voice repeated in mine while the baby blue
telephone silently blinked for help Doctor A told me being
Indian didn't matter Said I had Character Psychosis
Doctor A she had her nose carved down changed her last name
joined the Unity Church wore blue contact lenses dyed
her hair blonde as can be carefully denied her Jewish father
My visions she assured me were part of my sickness
a tunnel my eyes couldn't light So busy being not
who she was born how could she see me as her desperately
thalo blue curtains kept their stiff folds She listened bent
forward on her Prussian blue velvet chair to eat with her eyes
the rose I saw glistening in multi-colored radiance on her exit
door Cheeks cold with confusion I touched nothing
The state sent her forms in triplicate white pink & blue
which cured me at their expense She said I lived as though
I had no skin my heart hemophiliac waited when she was late
with the tear-streaked patient ahead of me Shivered
her door opened she leaned with a smile *Come On In*
Blue birds of happiness wheeled in her teeth my stomach
empty her voice cooed *How Are We Today*
inferring a relationship I didn't swallow Her sympathy
like cheap perfume in a crowded elevator I had no room
for her explanations of my overdoses Drugs she ordered
that boiled me in passivity Her thin unwatered
philodendron whose brown strangling roots revoked my life
laid me out in double solitaire with a taste of antiseptic
Moans through her black leather padded door Scuttle
of metal instruments in the sterilizer of the office down



the hall My breath held itself against time clicking
her turquoise clock in random mockery I didn't tell her
 the trouble was I wouldn't live
if I was a chronic undifferentiated schizophrenic thing
my skin apostasy Her room aborted Her voice pulled
me through azure walls I was open to stars & coyote howls
 She suggested I go to the day care center
 where we danced in a circle with scarves
 trying to be planets rotating around the sun
or strung wooden beads with dull awls or accepted
 paper cups of yellow & blue pills at the end
 of long silent lines She committed
me times when I didn't make sense to her
dangerous mystery I was so quiet & so loud Cadet blue
she had no smell dry as anesthesia my throat couldn't swallow
her face I was acid-etched in a red sky She was nowhere
 in sight as she spoke said she wanted
 to help me



in honor of Sheila Gilhooly

A History of Psychiatric Homophobia

by Bonnie Burstow

Note: Homophobia is the irrational fear of homosexuality.

1869

Hungarian physician K.M. Benkert invents the term "homosexuality." He argues against the legal repression of lesbians and gay men. Their unfortunate conduct is not their fault, says this "humanitarian psychiatrist," because the urge is congenital (inborn). Also in 1869, psychiatrist Karl von Westphal diagnoses a lesbian, labeling her "condition" as "contrary sexual feelings." He concedes that the "condition" does not necessarily indicate insanity.

1886

In Germany, Richard von Krafft-Ebing publishes his highly influential book *Psychopathia Sexualis*, which refers to homosexuality as a "physiologically based psychiatric pathology" that can be attributed to a congenital weakness of the nervous system.

1905 to 1934

In a variety of books and letters, Freud takes issue with the psychiatric claim that homosexuality is an illness, giving it the dubious dignity of the label "arrested sexual development" instead. Freud is consistently more respectful of gay men than of lesbians, linking the existence of lesbians to penis envy – woman's refusal to accept that she does not have a penis. Freud does not advocate treatment, as he does not consider homosexuality a disease. Most psychiatrists in Freud's time and for some time afterward, however, disagree, using electroshock, drugs, lobotomy, and "aversion therapy" to "cure" it.

1952

The first edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is released. In it, the diagnostic label "homosexuality" is listed as one form of "sexual deviation" under the general psychiatric category of "Sociopathic Personality Disturbance."

1958

The American Psychiatric Association (APA) holds a series of panel discussions on homosexuality, largely at the instigation of Charles Socarides, who supports and promotes the disease theory.

1965

Edmund Bergler – a New York psychoanalytic psychiatrist – reverses the psychoanalytic position and declares homosexuality a disease. He maintains that there is no such thing as a healthy homosexual; that every self-proclaimed bisexual is really a homosexual trying to establish an alibi; that homosexuals obliterate the personalities of their love objects; and that homosexuals suffer from deep inner depression. "Scratch a homosexual," writes Bergler, "and you find a depressed neurotic."

1962

On the basis of a study using 100 gay male "patients" and 100 heterosexual "patients," American psychiatrist Irving Bieber and his associates conclude that heterosexuality is the biological norm and homosexuality is a pathological deviation. They consider only male homosexuality, which they attribute to a pathologically close relationship with one's mother. They see the "condition" as curable.

1968

Socarides publishes his influential work *The Overt Homosexual*, stating that homosexuality is a form of "mental illness," and declaring psychoanalysis the "treatment of choice" for homosexuals. Also in 1968, *DSM II*, the second edition of the *DSM*, is released. Homosexuality is now listed as a full-fledged personality disorder.

1969

The gay liberation movement is born.

1970

The gay liberation movement begins to fight back against psychiatry. On May 14 in San Francisco, gay activists dis-

rupt the annual meeting of the APA. They appear unexpectedly at a session on "aversion therapy," interrupt all speakers, list and denounce psychiatric crimes against lesbians and gay men, and call Socarides, Bieber, and their supporters "pigs." Similar confrontations are staged at meetings of the American Medical Association, at an east coast nurses' seminar, and at the national conference of American psychologists held in Los Angeles. Shrinkers begin to consider removing homosexuality from the *DSM*. Socarides objects to the trend towards liberalism, and calls the defenders of homosexuality tragically misguided.

1971

As a result of the confrontations, five gay activists – two lesbians and three gay men – are invited to participate in a panel on "Life-Styles of Nonpatient Homosexuals" at the annual APA meeting in Washington, D.C. All five speak out against the pathologization of lesbians and gay men. A gay activist in the audience seizes the podium, outlines the implications of the disease theory for lesbians and gay men, and denounces the company marketing "aversion therapy" technology.

1972

At the annual meeting of the APA, a gay psychiatrist, wearing a mask to conceal his identity, speaks at a session on homosexuality. Meanwhile, in a meeting of the Social Concerns Committee of the Massachusetts Psychiatric Society, Dr. Richard Pillard urges the Committee to adopt a resolution stating that "homosexuality *per se* should not be considered an illness and APA nomenclature on this subject should therefore be altered."

1973

The Social Concerns Committee of the Massachusetts Psychiatric Society passes the 1972 resolution and psychiatrist Robert Spitzer – a member of the APA Committee on Nomenclature – begins a series of meetings with gay activists.

The Committee on Nomenclature subsequently agrees to a presentation by members of the Gay Activist Alliance (GAA). Psychologist and GAA representative Charles Silverstein methodically demonstrates the flaws in each and every psychiatric theory on homosexuality.

The Committee on Nomenclature subsequently passes a resolution that homosexuality *per se* should not be considered a psychiatric disorder. At the same time, it invents a new homophobic diagnosis – “sexual orientation disturbance” – intended for people who experience discomfort regarding their sexual orientation. (And how many lesbians and gay men do not experience such discomfort – given a homophobic society?) Gay activists seem unaware of the implications of the new category, and they hail the outcome as an unqualified victory. The APA board of trustees accepts the resolution. Socarides and Bieber respond with a petition demanding that the matter be put to a referendum of the APA as a whole. The board agrees.

1974 to the present

The referendum passes. Gay activists rejoice, thinking that all is well. Psychiatrist Thomas Szasz attempts to point out their naiveté, maintaining that the gay community has been co-opted. He suggests that the change is nothing but an attempt to get gay activists off psychiatrists’ backs – a successful attempt at that. He points out that homosexuality is still being pathologized, al-

beit under a new name. No one, however, seems to be listening.

Gay men and lesbians continue to be locked up, shocked, drugged, and subjected to behaviour modification because of their sexual orientation. Psychiatry, nonetheless, is considered progressive and non-homophobic, due to the APA resolution; psychiatric backup becomes a standard feature of lesbian and gay counselling organizations.

Lesbians and gay men are still locked up, shocked, and drugged for their sexuality.

1980

DSM III is released. “Sexual orientation disturbance” is renamed “homosexual conflict disorder.”

1987

With the release of *DSM III-R* (revised), the game of hiding psychiatric homophobia behind new names continues. Discomfort about one’s sexual orientation now appears under the general category of “Other Sexual Disorders.” Such discomfort also figures as a symptom of “borderline personality disorder,” as does engaging in casual sex – even though casual sex

is a widely accepted practice in the gay community.

1988

Phoenix Rising solicits funds from the Lesbian and Gay Community Appeal to publish a lesbian and gay issue. Psychiatry, sadly, is seen not as a problem for lesbians and gay men, but as a resource. The request is denied, and *Phoenix* is advised to turn to the Toronto Counselling Centre for Les-

biens and Gays (TCCLG) for guidance. (TCCLG frequently consults lesbian and gay psychiatrists.)

1989

Psychiatrists at Johns Hopkins University in Baltimore, Maryland, give electroshock to people with HIV (Human Immunodeficiency Virus, the virus commonly associated with AIDS), and publish an article in the June issue of the *American Journal of Psychiatry*, recommending electroshock as a treatment for the depression “caused by the virus,” seemingly unaware that it is natural for people facing a life-threatening

illness to be depressed. For some unknown reason, the article mentions the sexual orientation of the “patients” so treated. Thomas Szasz responds in the December issue of *Reason*, pointing out that the psychiatric establishment is using AIDS to continue its assault on the lesbian and gay community (see Szasz interview, Page S6).

1990

Despite having received no specific funding for it, *Phoenix Rising* publishes its first lesbian and gay issue. The fight continues.

“Analyzing Psychiatry”

**A three-hour radio documentary presented by Irit Shimrat.
Broadcast on *Ideas*, on CBC-AM, April 1990.**

What listeners wrote in response to “Analyzing Psychiatry”:

“So many people on your program described their situation the same as I would. I thank you for showing people the terrible tragedies that occur in our hospitals.”
– an ex-inmate

“As I was listening . . . I felt as though I was living under the psychiatric dictatorship. Who are we protecting by having a psychiatric system where patients have no say in their own well-being?” – an ex-inmate

“I am writing after hearing only half of the first hour . . . the concept of anyone needing treatment was totally rejected . . . where is the balance?” – a psychiatric nurse

“I am taken aback by your speaker’s bold pronouncement that schizophrenia is of neither genetic or chemical origin.”
– a member of an inmate’s family

“I found the program informative; it has raised some insight for my situation here in this facility.” – an inmate

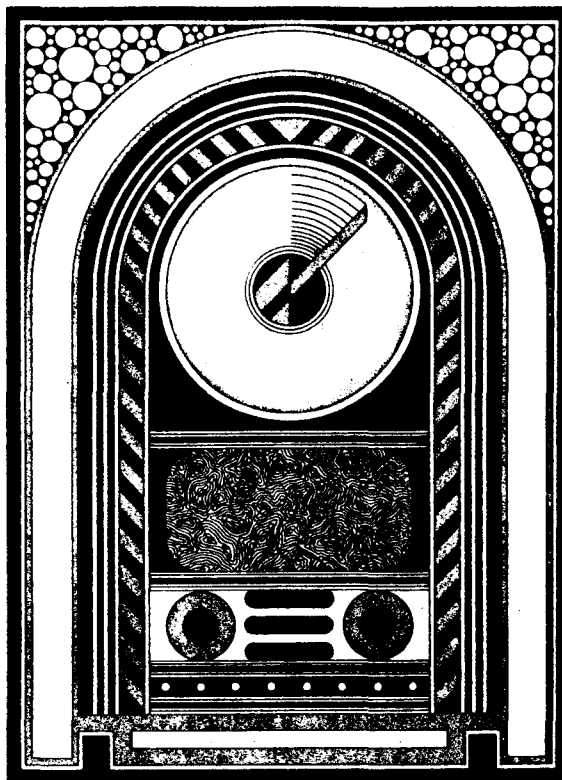
“I was quite surprised and saddened [by this] one-sided and angry assault on alleged psychiatric practices . . . I heard very extreme and exaggerated statements, and unfounded statements.”
– a psychiatrist

“I listened to Analyzing Psychiatry with gratitude because it gave affirmation to my own growing conviction that something is tragically awry in the psychiatric treatment responses to persons in mental or emotional pain.” – a therapist

“I’ve had diarrhea for months. . . I’ve had kidney problems too . . . but none of these counts a whit when it comes to my mental stability. . . Taking pills, no problem. . . Your program ignored me. . . You should be ashamed of yourself. I only wish that nobody bothered to listen.”
– a person on lithium

and knew that the valium prescriptions she introduced me to at 15 belonged in the toilet, not in me. . . After your series, I *know* I did the right thing. I am so happy to be the one who got away! Thank you.”

“I too am a survivor of electroshock and powerful and dangerous drug therapy. Your program is appreciated.”



“I have been out of mental hospital for 20 years now. Your descriptions and facts apply for today as much as then. Our family had another member spend six months of her life going through the same bondage and the same horrors as I did.”

“Your program on our mental health system was great. I felt that it will create more understanding in the community. I have a friend who is gradually being destroyed by this system.”

“My mother darned near drove me crazy trying to make me comply with her standards of normalcy. Somehow, I knew I must never let her talk me into going to see the “nice doctors”

**Transcripts (\$7), and audiotapes (\$12) are available from:
CBC *Ideas*, Box 500, Station A, Toronto, ON M5W 1E6.**

SHOCK WAVES

Demonstrators zap the shock shrinks

Confronting the Clarke Institute

On May 14, 1990, about 40 angry protestors demonstrated against electroshock in front of Toronto's Clarke Institute of Psychiatry.

The demonstration was co-sponsored by *Phoenix Rising* and the Ontario Psychiatric Survivors' Alliance, and endorsed by Resistance Against Psychiatry.

For the past couple of decades, the Clarke has generally inflicted about 1,000 shock treatments on about 100 inmates every year, without informed consent. Inmates are told only that ECT (electroconvulsive "therapy" — the official name for shock) is "safe and effective." In fact, it is not safe: it is known to cause brain damage and permanent memory loss. Nor is it effective. A shock "treatment" consists of sending an electric current of between 130 and 175 volts through your brain in order to cause an epileptic-like seizure. Like any traumatic head injury (e.g., going head first through a windshield or get-

ting hit over the head with a baseball bat), it makes some people feel giddy

or "euphoric" for a while after it happens, which admittedly is more fun than being depressed. But when that effect goes away, many people who have shock feel just as bad as they did before, or worse.

Many people are surprised to learn that electroshock is still administered in most psychiatric wards in general hospitals in this country, and in virtually all provincial hospitals. In Ontario, between April 1, 1988 and March 31, 1989, 9,850 shock "treatments" were administered in the psychiatric wards of general hospitals alone. Hundreds of inmates in Ontario's ten provincial psychiatric institutions were also given shock.

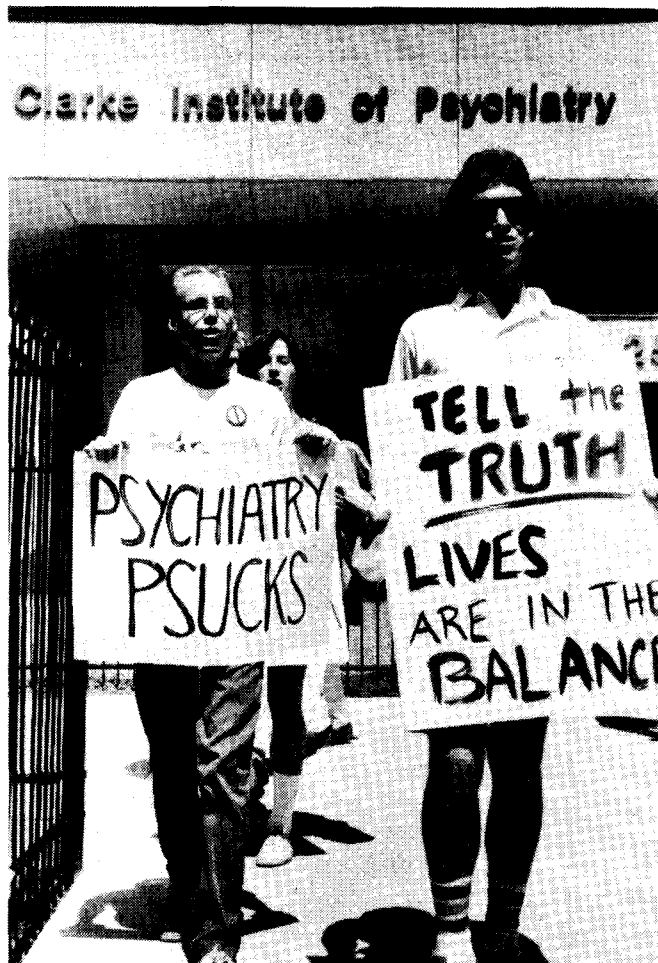
As we protested in Toronto, hundreds of psychiatric survivors in New York City were demonstrating against electroshock during the annual meeting of

the American Psychiatric Association. This was just part of a united series of protests against forced psychiatric treatment, coinciding with the North American Support-In to Celebrate the Human Spirit, a festival organized by U.S. activists. The themes of the Support-In were letting people know about alternatives to psychiatry, and speaking out about psychiatric oppression.

On March 28, 1989, fellow psychiatric survivor Jack Wild and I were convicted of "trespass" charges that were laid during a May 1988 anti-shock protest at the Clarke (see *Phoenix Rising*, Vol. 8, No. 1).

We were each fined \$53.75, and had to pay an additional \$100 each in order to be able to appeal the judge's decision. Our appeal will be heard in September 1990.

At the time of our arrest, Jack and I were sitting peacefully on the floor with arms linked near an elevator on the Clarke's



Denouncing the Clarke. Photo by Konnie Reich



Don Weitz (right) confronts shock doc Joel Jeffries outside the Clarke. Photo by Konnie Reich

Freedoms. They argued that the Clarke was not exempt from the Charter – that, in fact, the Charter directly applies to the Clarke, because it is a public hospital and routinely carries out government functions such as involuntary commitment (incarcerating people labeled mentally ill against their will, without a court trial or hearing). They also argued that in using the Trespass Act against us, the Clarke and the police violated our rights to freedom of expression and freedom of association, which are supposed to be protected

under the Charter, and also the rights of the inmates.

“Affective Disorders Unit,” where a lot of inmates are given shock. Nurse Janice Walsh had told us that we couldn’t hand out copies of our shock facts pamphlet and couldn’t see any “patients,” even though we were there during visiting hours. When the police arrested us, we went peacefully.

NDP health critic David Reville, who is a psychiatric survivor, made the following statement in the legislature: “Two former psychiatric patients who tried to hand out information on electroshock therapy to patients at the Clarke Institute of Psychiatry were arrested and charged yesterday. If Mr. Weitz and Mr. Wild are found guilty, I think the Ministry of Health should pay the \$53.75 fine. If the Ministry of Health had got its act together and produced information about electroshock therapy for patients, Mr. Weitz and Mr. Wild would not have to be doing it. This is another case in which this government is asleep at the switch” (*Hansard*, May 3, 1988).

At the trial on February 3, 1989, before Provincial Offences Court Judge Bruce Young, our lawyers, Pat Case and Bill Sullivan, launched a constitutional challenge to part of Ontario’s Trespass to Property Act, assert-

ing that its use against Jack and me violated our freedoms as guaranteed in the Canadian Charter of Rights and

Aftermath

With “therapeutic” fury
search-and-destroy doctors
using instruments of infamy
conduct electrical lobotomies
in little Auschwitzes called mental hospitals.

Electroshock specialists brainwash
their apologists whitewash
as silenced screams echo
from pain-treatment rooms
down corridors of shame

Selves diminished
we return
to a world of narrowed dreams
piecing together memory fragments
for the long journey ahead

From the roadside
dead-faced onlookers
awash in deliberate ignorance
sanction the unspeakable –
silence is complicity is betrayal

Leonard Roy Frank

I testified at the trial that the shock information Jack and I had tried to hand out to Clarke inmates was not only free and public, but a necessary public service, because there was no psychiatric patient advocate at the Clarke to provide this information. (The Ministry of Health's twelve psychiatric patient advocates work only in the government's ten public psychiatric institutions – there are still no advocates in any other psychiatric facility in Ontario.)

In her testimony, Walsh tried to justify her refusal to let us talk to the inmates by stating that neither of us asked to see any particular "patient" and that we couldn't name any current "patient," which is true. However, Walsh also claimed that giving the "patients" our shock information, which she never bothered to look at, was "against hospital policy." In fact, however, no evidence that the Clarke had any policy specifying a ban on distributing alternative shock information was produced in court.

We were not surprised by Young's ruling, in which he expressed his concern about the fact that we didn't automatically obey the law and leave the ward "when requested to do so."

The shock pamphlet that Jack and I were prevented from handing out is entitled "Electroshock Facts: Your Right to Know the Truth About ECT." Copies are available for \$2.50 each, including mailing and handling charges, from Phoenix Rising, 394 Euclid Avenue, Toronto, Ontario M6G 2S9. Please make cheque or money order payable to Phoenix Rising.

Don Weitz

PHOENIX PHARMACY

The "new, improved" antidepressant Prozac When a new drug is deadly

According to the March 26, 1990 issue of Newsweek magazine, Prozac is the newest antidepressant on the market, and is being lauded as a major breakthrough in the treatment of depression. So new, in fact (it hit the U.S. market in 1987), that as of May 1990, it hasn't been listed in the Compendium of Pharmaceuticals and Specialties (the CPS, which outlines the purpose, effects, and side effects of prescription drugs). Its long-term effects, beyond six weeks of use, have yet to be documented in any source. It is attractive because of its allegedly minimal (read: undocumented) side effects relative to other antidepressants, and the fact that dosages needn't be monitored. (The same dosage is taken every day from day one.) Despite the fact that the manufacturer, Eli Lilly, only endorses its use for depression, doctors are prescribing it for obesity, eating disorders, alcoholism, and so-called obsessive compulsive behaviour. Today, Prozac (the generic name of which is fluoxetine) is being prescribed more than all the other antidepressants combined, even though it costs nearly twice as much and its long-term effects are unknown. Prozac is taking on the role of the wonder-drug of the 1970s – Valium – a panacea for all our ills.

Uninformed, suicidal, and terrified of re-experiencing the hell of being committed, I sought help from a psychiatrist to whom I had been referred during my first and only psychiatric admission. She was well liked by staff on the psych ward at the hospital where she worked, and was apparently skilled in cognitive therapy. The first time I met her, she wrote a prescription for Prozac. "Start taking it right away. It's suicide-proof and there are virtually no side effects." That was March 19, 1990. Three weeks later, I spent a night in the emergency ward of another hospital, being treated for a life-threatening allergic shock reaction to Prozac.

I saw this doctor once a week after I started taking the drug. Concerned about possible reactions to Prozac, I asked many questions. She was never able to answer such inquiries as "How does it work? What class of antidepressant is it? If it's not a tricyclic, an MAO inhibitor, or L-tryptophan, what is it? Why does it take so long to start working?" Meekly denying knowledge of how the drug worked, she jotted down my concerns, ostensibly to ask the representative from Eli Lilly. She did, however, try to lead me to think

that it was ridiculous for me to try to understand how the drug affected me.

I still wasn't getting the message. Each week I arrived with more questions about changes in how I was feeling. I'd been told I could expect slight nausea for the first three or four weeks. But my reports of incapacitating drowsiness and impaired concentration were discounted; she felt that these could not possibly be caused by Prozac. Confused, I told myself that the other, less disabling side effects I was experiencing (dry mouth, change in taste perception, sweating, increased appetite, inexplicable anxiety, nervousness, abnormal dreams, vague changes in visual perception, and difficulty falling asleep) but didn't report, were also not related.

Paying some heed to my better judgement, I kept looking for answers. Although the current *CPS* did not carry any entries under Prozac, I did find two newly published drug handbooks containing comprehensive lists of side effects. I was alarmed and confused, because what the doctor had been saying was inconsistent with this material. Despite the fact that I was having effects such as those listed, I decided to distrust myself and believe her.

I continued taking Prozac until one night it almost killed me. I started developing a rash. Within a couple of hours it turned into a severe case of hives. When my breathing became severely laboured and I started feeling faint, I got myself to the emergency department of the closest hospital.

The intern on call knew less about Prozac than I did. She did, however, recognize the signs of anaphylaxis – a life-threatening allergic reaction. She administered a fast-acting antihistamine, wrote me a prescription for another antihistamine – which was very potent and heavily sedating – and strongly suggested that I immediately

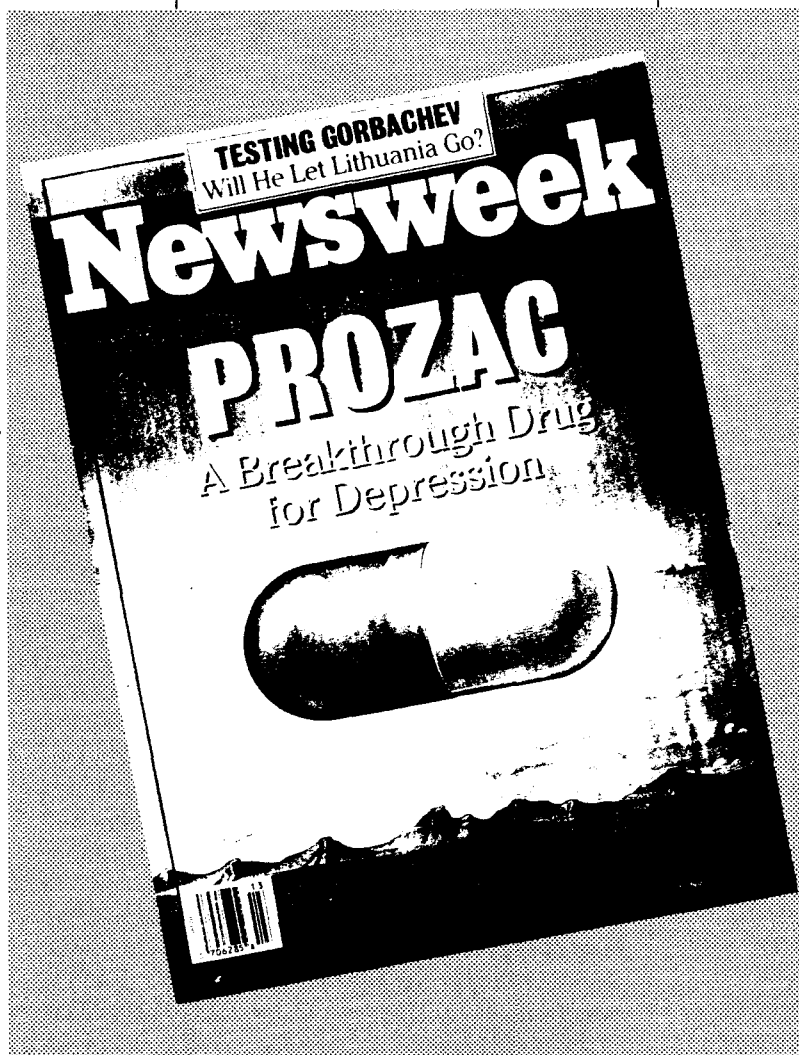
tensify the negative side effects of Prozac. My right hand swelled to double its normal size. My hands and feet were burning. I kept getting more hives until they covered my body, inside and out, from head to foot. The swelling and burning continued for a couple of days, and the hives didn't go away until six days after I'd stopped

taking Prozac. When the swelling gradually went down, I was left with severe joint pain, especially in my upper body and hands. At the same time, the Prozac interacted with the sedative effects of antihistamines. This left me unable to stay awake for several days.

I did manage to call the doctor the following night, only to find that she was on vacation. The replacement she had arranged rudely informed me that they did not practise psychiatry and that if I had a problem I should go to a mental hospital.

When the doctor returned, I contacted her to cancel all of my subsequent appointments. She asked me what the problem was and I told her that I had had a life-threatening reaction to Prozac. Her response was, "I don't believe you. If you did have such a reaction, you would be calling me from the hospital!"

Angry, sore, itchy, and scared, I approached an addiction counsellor I knew at the Addiction Research Foundation (ARF) for support and validation. She arranged for me to see one of the doctors at ARF's walk-in clinic to talk about my concerns. This doctor kept me waiting a long time. When I finally explained my situation to him, he told me that Prozac was safe, and



stop taking Prozac and call my psychiatrist in the morning.

Antihistamines are the prescribed treatment for allergic reactions, but not when the reactions are due to Prozac! I was to learn the hard way what the literature says and what any competent physician should know about mixing antihistamines and Prozac – even Prozac that is still in the body after you stop taking it. Antihistamines in-

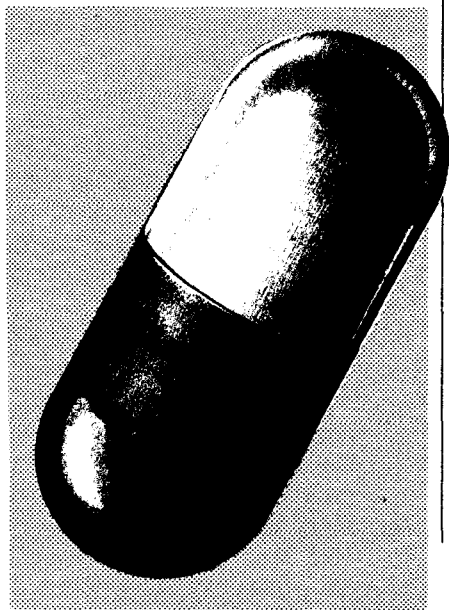
implied that I was crazy, misinformed, or both.

Recently, I got the manufacturer's review of the research on Prozac from a pharmacist at ARF, who was also skeptical of my account of my experience. This material detailed more than 30 different types of common adverse reactions, including allergic, neurological, behavioural, gastrointestinal, respiratory, endocrine, hematological, musculoskeletal, and urogenital reactions, most of which I had endured. A further three times as many adverse reactions were reported as being "less frequent" or "rare."

Interestingly, 15 percent of the 4,000 patients who received Prozac in North American clinical trials had their treatment discontinued due to such adverse effects. In another pre-market study, 4 percent of 5,600 patients given Prozac experienced allergic reactions similar to mine. I wonder how many more had their reactions discounted, as I did, and never showed up in the statistics.

For me, the major issues are that, despite the fact that the side effects I experienced are known and documented, I was not informed of them; that what I did report was discounted; and that the treatment I got for the adverse reaction was in itself dangerous. Had I been warned of the possible lethal reaction to Prozac, I would never have started taking it.

Anonymous



An interview with Peter Breggin

The hows and whys of psychiatric drugs

The following is excerpted from "Analyzing Psychiatry" (see Page S40).

One of the main groups of drugs used by psychiatrists is the neuroleptics – they're also called the major tranquilizers; they're also called, falsely, the antipsychotic drugs.

In Canada, the trade name of the original drug is Largactyl. Chlorpromazine is its chemical name. You also have brand names such as Mellaril, Stelazine, Nozinan, Navane, and Haldol.

These are the drugs that are used to control unruly, outraged, hurt, and suffering human beings. They have no specificity whatsoever for the so-called disease of schizophrenia. They have no specificity at all for any human problem.

They subdue vicious sows in veterinary medicine. If you shoot a dart of this kind of drug into a lion, he becomes docile. This isn't taught to medical students, because it's such an embarrassment. Medical students are being taught "these drugs are for schizophrenics." No one bothers to mention that they have a mighty powerful place in veterinary medicine. Although in veterinary medicine, the tendency is to use them for only a few weeks at a time, because they're considered too damaging to animals.

These drugs are used in any institution where you're trying to control people. In institutions for the developmentally handicapped, in nursing homes, in children's homes, and even in prisons – anywhere where institutional control is the priority – large percentages of people are on these drugs.

So how do these drugs work this miracle? They do it by producing a

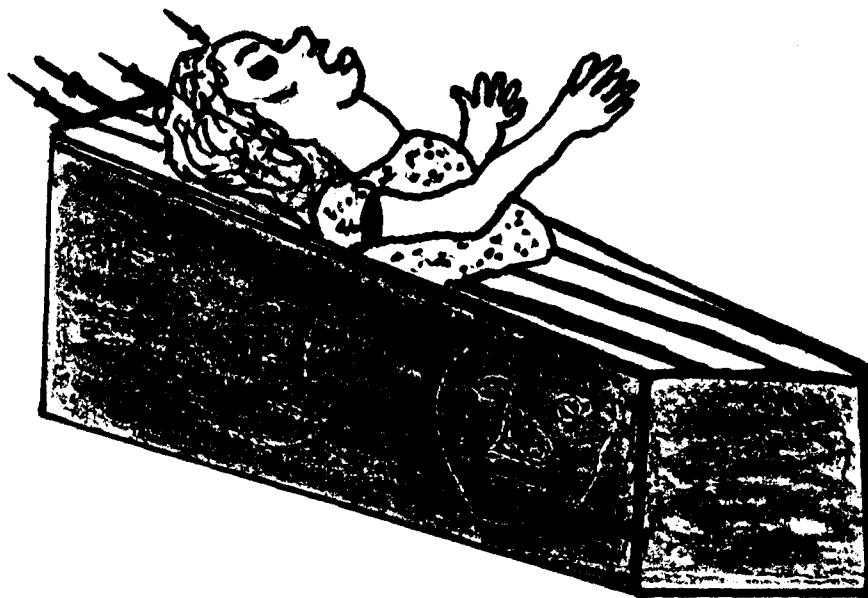
chemical lobotomy. The dopamine pathways from deeper in the brain to the emotion-regulating centres and to the frontal lobes are impaired, often permanently. And so there's really no way of getting around the fact that this is a chemical lobotomy; it's just that psychiatry avoids it and says, "Ah, we're balancing imbalanced biochemicals." Which is simply a pack of nonsense. We're lobotomizing people.

What is the effect of a lobotomy? Its primary effect is to produce apathy, disinterest, lethargy. It defuses people, makes them more docile, more easily controllable.

You can't put this sort of a toxin into a human being's brain without causing damaging effects. We have so many varieties of damage that it's difficult to catalogue them.

Let me talk about three categories. Once you get the things I'm going to talk about, the odds are they're going to stay with you, and they're untreatable.

One is tardive dyskinesia. "Tardive" means delayed in appearing. It's now well known that the use of neuroleptics for several months to a few years produces, in a large percentage of people, permanent disabilities of all the voluntary muscles. It can involve something as simple as the tongue, the lips, the mouth, or the eyes. When you see a street person grimacing on the street, you tend to think, "Ah, this street person is crazy, look at them grimace." They actually have tardive dyskinesia. Take a look at some street people in the next week or two. If you see ten street people on any given day, you're likely to see a couple of them with odd



Drawing by Douglas Robinson

twitching, posturing, contortions of the body, or tremors, and overwhelmingly these are going to be due to tardive dyskinesia. So at the least it's disfiguring and at the most it can result in the flailing of arms and legs, difficulties, breathing that can risk your life, and difficulty speaking.

According to the American Psychiatric Association [APA] task force on tardive dyskinesia from 1980, at least 10 to 20 percent of patients will get more than minimal disease. Now, this is from a trade union that defends psychiatry. The real statistics are bound to be worse. Of long-term patients and older patients, according to the APA, at least 40 percent will get more than minimal disease.

We have studies that show that if your mother goes into a nursing home, where in the United States the odds are 50 percent or more she'll get these drugs, the odds are also that she has a 40 percent chance – four in ten – of getting tardive dyskinesia within two years. Just two years in a nursing home. So when your mother begins to deteriorate and get funny facial movements and twitch and get lethargic and apathetic, you may think that she is simply heading towards her demise from natural causes. In fact, she's being killed by the drugs.

Why do I say "killed"? Because the drugs reduce the ability to respond to internal signals of pain and discomfort, because they lobotomize and make you apathetic. Particularly in old people, they are bound to increase the fatality risk.

So tardive dyskinesia is one of the kinds of permanent disorders you can get. You can also get tardive akathisia. It drives you to endless activity. It too can be mild – you just can't sit still; to severe – you have to stand up and jump up and down all the time and wear out your shoes. That literally happens in hospitals.

What happens to children in hospitals is that they are called hyperactive – that is, they're resisting, rebellious, anxious, frightened over being hospitalized. Nobody wants to do activities with them, so they are drugged, and then they develop tardive akathisia, which makes them look as if they're still active. And then, in a vicious circle, they get more and more drugs, and more and more permanent akathisia. I've been involved in a couple of legal cases where this has happened to youngsters.

Then we get tardive psychosis. In fact, Canada has been one of the research frontiers in the understanding of tardive psychosis. Guy Chouinard and

Barry Jones have found that 30 percent of routinely treated patients, after several months to a few years, will develop a psychosis caused by the drugs. And as their own papers say, these are largely irreversible, untreatable psychoses, which then result in more and more drugs being given to suppress the psychosis, worsening the psychosis in another vicious circle.

We're talking about very serious outcomes from taking these drugs. If we put together tardive dyskinesia, tardive akathisia, tardive psychosis, and tardive dementia, we're looking at more than half our patients suffering from one kind or another of serious brain disease when they are treated long-term with these drugs.

In the past ten to fifteen years, psychiatry has increasingly used the medical model, where fake diagnoses are made up, fake brain diseases are invented, and fake treatments that suppress the brain are employed.

Along with this we have a call for more involuntary treatment. This is that whole package of biological, authoritarian psychiatry. The reason for this is financial.

In the 1970s, psychiatry came under increasing stress from competition

throughout the world, from social workers, psychologists, nurses, counselors, and family therapists. Often these people are women who are willing to work for prices that are not quite so outrageous as those charged by psychiatrists. Many of these women have a feminist orientation, so they're far more able to help in the liberation of women to become more themselves and to face the issues of being chained and controlled in this society. And the doctors can't compete with this.

Well, psychiatry was really on the rocks financially, and the APA, the National Institute of Mental Health, and other leading organizations decided to make believe that human disturbances are biochemical. Of course, they didn't say, "We'll make believe." They said, "We're in trouble. We'll promote our medical image. And in order to do this, we'll need some funding. Where are we going to get the funding from?" They couldn't even get enough funds from the psychiatric membership to support the psychiatric association. So, they went to the drug companies.

You can trace this process in the minutes of the APA. You can see it in publications and documents of all kinds. Psychiatry is now so totally dependent on the drug companies that we have a virtual psycho-pharmaceutical complex, similar to the military-industrial complex.

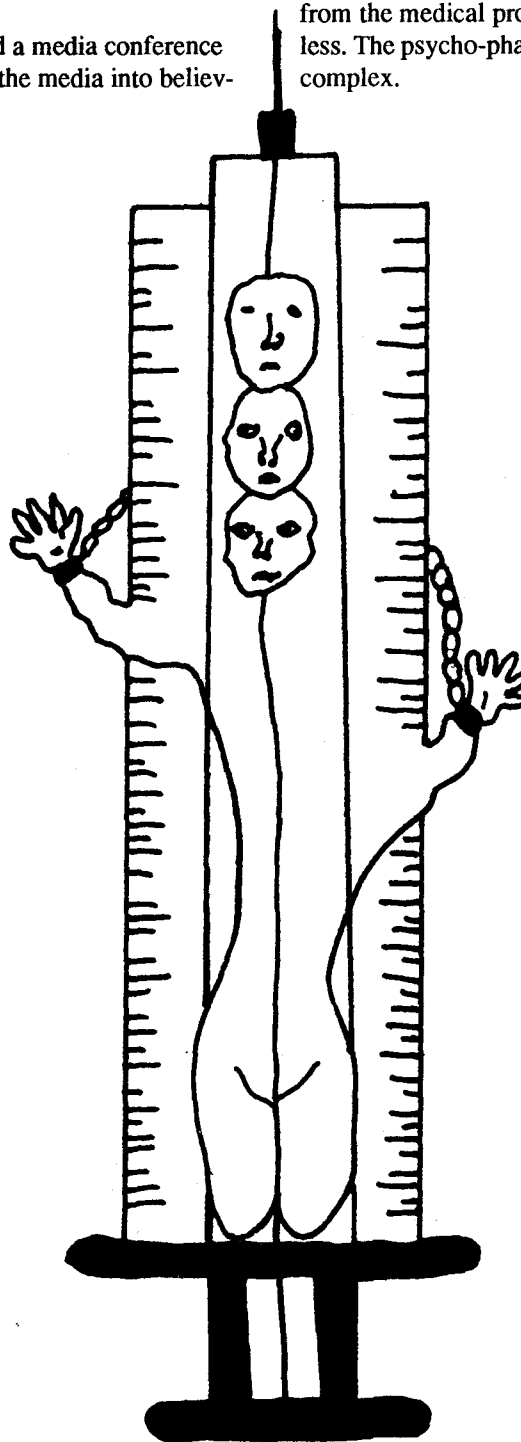
All the major psychiatric journals are supported by the drug companies. Just imagine that. All the research and educational journals are supported by the drug companies. But it's worse than that. That drug company support is far more than the journals even need, so that money spills over and supports the associations. And that's only the beginning. Psychiatrists hold conventions that costs millions of dollars. How much do the psychiatrists pay for these conventions? One percent, two percent; some very fractional amount. The millions are put up by the drug companies.

Even the seminars you've got to take to keep your medical licence are paid

for by the drug companies. Recently, I was giving a talk at a medical centre and I found out that it was unusual to have me there because I wasn't on drug company money. Even the travelling professors who lecture at the medical centres are on drug company money.

When they hold a media conference on how to snow the media into believ-

ing this medical nonsense, the drug companies pay for it. When they want to have an outreach program to get regular medical doctors to stop distrusting psychiatry, the drug companies help by paying for videos and paying for conferences to get more referrals from the medical profession. It's endless. The psycho-pharmaceutical complex.



Drawing by Douglas Robinson



Drawing by Douglas Robinson

RAP submits brief on psychiatric drugs to Toronto Board of Health

In May 1990, Bonnie Burstow and Don Weitz, on behalf of Resistance Against Psychiatry (RAP), submitted a brief entitled "Psychiatric Drugs: A Public Health Hazard" to the Toronto Board of Health. In the brief, Burstow and Weitz explain that psychiatric drugs that are

regularly prescribed to thousands of Torontonians are dangerous substances the administration of which constitutes a public health hazard. They detail the effects of neuroleptics (also known as "antipsychotics," "phenothiazines," or "major tranquillizers"), antidepressants

(which are even more dangerous than neuroleptics), and lithium (an extremely toxic drug intended to control people's moods), and explain that all of these drugs work by destroying people's ability to think, concentrate, create, remember, and feel. These are not side effects, but are primary and intentional effects of psychiatric drugs. Furthermore, all of these drugs cause irreversible neurological illnesses when used over a long period of time.

In the short term, the brief explains, neuroleptics, antidepressants, and lithium have all been shown to cause lethargy, dizziness, heart and stomach problems, and, ironically, "mental" problems such as "mania," delirium, confusion, and hallucinations.

Finally, the brief points out that the use of neuroleptic drugs is known to cause Neuroleptic Malignant Syndrome, which is characterized by high fever and coma, and is often fatal.

Burstow and Weitz point out that psychiatrists routinely fail to tell people about the drugs' damaging effects, and commonly prescribe combinations of drugs (a practice known as "polypharmacy") without regard for how the drugs interact.

The brief further explains that, whereas supporters of biological psychiatry claim that psychiatric drugs save lives by preventing suicide, in fact, a large number of psychiatrized people kill themselves by overdosing on these drugs, often because they find "the life to which they had been reduced by psychiatric drugs not worth living. . . . Still more people die because of the unintended effects of psychiatric drugs - in the case of the antidepressants because of their extreme toxicity, and in the case of polypharmacy, because of impossible combinations, and more generally, because of the tendency of psychiatrists to prescribe and administer drug dosages which far exceed the maximum dosage recommended in the *Compendium of Pharmaceuticals and Specialties*." People also die from taking

neuroleptics because these drugs suppress the gag reflex, which can result in people choking on their own vomit.

Burstow and Weitz point out that there have always been safe alternatives to drugs: "People in crisis need safe places to go where people will talk to them and spend time with them."

The brief ends by recommending to the Board of Health that it launch a campaign to educate the public about the risks of psychiatric drugs; that it create a list of doctors who are willing to help people get off of psychiatric drugs and make this list available to Torontonians; that it provide the public with information on safe withdrawal from psychiatric drugs; and that it negotiate with the government and with advocacy groups for the purpose of creating withdrawal centres.

On May 31, Burstow and Weitz, together with ex-inmates Steve Attell, Jack Wild, Jim Spencley, and Irit Shimrat, spoke to the Board of Health in the Council Chamber of Toronto's city hall about the dangers of psychiatric drugs. Unfortunately, what they had to say was contradicted by the shrinks, Canadian Mental Health Association

people who'd been damaged by psychiatric drugs, and some Board members were quite moved. One of them publicly admitted, after the presentations were over, that she had been given psychiatric drugs herself some years ago and suffered an adverse reaction. She'd assumed that the reaction was part of being "crazy" until a nurse explained that it was caused by the drugs.

There have always been safe alternatives to drugs. People in crisis need places to go where people will talk to them and spend time with them.

You can get a copy of "Psychiatric Drugs: A Public Health Hazard" (which is 37 pages long, including an appendix on how to safely withdraw from psychiatric drugs, and another on psychiatric deaths) for \$3.50 (including postage and handling) from Resistance Against Psychiatry, 441 Clinton St., Toronto, ON M6G 2Z1. Please make cheque payable to Resistance Against Psychiatry.

members, and Ontario Friends of Schizophrenics representatives who spoke after them. Still, it was the first time the Board got to hear the stories of

The Journal of Mind and Behavior

(Volume 11, Numbers 2 & 3, Spring/Summer 1990)

CHALLENGING THE THERAPEUTIC STATE:

CRITICAL PERSPECTIVES ON PSYCHIATRY & THE MENTAL HEALTH SYSTEM

Edited by David Cohen, Ph.D., Université de Montréal

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RIGHTS & WRONGS

Ontario's latest authoritarian scheme Outpatient commitment

The Ontario government is currently considering implementing a piece of legislation called "outpatient commitment" or "compulsory community treatment."

This means that if you are released from a mental hospital or psychiatric ward you must stay on your medications or they can lock you up again. The means of checking up on you would probably be blood or urine testing. This is a grotesque abuse of human rights and should be stopped.

Liberal Member of Provincial Parliament Shirley Collins (Wentworth East) first proposed the idea of outpatient commitment in 1989, suggesting legislation that would "return a person who has been involuntarily hospitalized to the community without cancelling the involuntary hospitalization order so that patients could live independently in the community, under medical supervision, but be hospitalized quickly when illness strikes. Similarly, outpatient involuntary medical treatment orders should be made available, along with outpatient facilities for the administration of medicines" (*Hansard*, July 13, 1989).

In the same excerpt from *Hansard*, New Democratic Party Member of

Provincial Parliament David Reville (Riverdale), who is a psychiatric survivor, spoke against Ms Collins's point, calling outpatient commitment "independence with a leash." Since Reville's remark, the proposed legislation

The report that recommended the leash law is a guide to increasing the power of mental health professionals outside of hospitals.

has been referred to by many as the "leash law."

Outpatient commitment is written into a discussion paper on community mental health legislation drafted by the government in response to the Graham Report, or "Building Community Support for People." The Graham Report was written in 1988 and has the trappings of a liberal approach to improving "mental health" practices, but is actually a subtle guide to increasing the

power of "mental health professionals" outside of hospitals.

Consultations on the government's discussion paper were held throughout Ontario in April and May 1990. Many survivor activists who attended these consultations not only spoke against outpatient commitment, but also advocated for more money to be spent on survivor-controlled groups in the community. We need safe, non-medical alternatives where people in crisis can seek to regain control of their own lives.

The public hearings were meant to suggest that people could still influence the course of mental health legislation as of spring 1990. However, in January – prior to the start of these hearings – Gilbert Sharpe (director of the Legal Services Branch of the Ministry of Health) spoke to the Canadian Bar Association, saying that "a statute

governing community mental health facilities is being developed by the Ministry of Health. The legislation, which will be based primarily on the recommendations of the 1988 Graham Report, is expected to provide a mechanism to ensure that patients remain on medication after being discharged from hospital and while living in the community. The expectation is that this legislation will assist in minimizing the revolving door syndrome. . . ." (minutes of the Health Law Section meeting, January 31, 1990). This suggests that some politicians and bureaucrats are assuming that outpatient commitment will become a reality.

If you want to keep this from happening, let the government know. Write to The Honourable Elinor Caplan, MPP, Ministry of Health, Minister's Office, 10th Fl., 80 Grosvenor St., Toronto, ON M7A 2C4 (or call [416] 965-2421). If you write to Caplan, send a copy to NDP Health Critic, David Reville, Legislative Bldg., Room 348, Queen's Park, Toronto, ON M7A 1A2.

Angela Browne

Swain case challenges "not guilty by reason of insanity" system

In 1983, Owen Swain was charged with assaulting his wife and two children. At his first trial in 1985, he pleaded not guilty to the assault charges and strongly objected when the Crown prosecutor tried to introduce evidence of his alleged insanity. District Court Judge H. O'Donnell allowed the "insanity defence" and ruled Swain "not guilty by reason of insanity."

Swain's lawyers argued that Section 542(2) of the Criminal Code, which allows the "insanity defence" and automatic, indefinite sentencing to psychiatric institutions under a Warrant of the Lieutenant Governor (WLG), without a sentencing hearing, violated Swain's constitutional rights under the Canadian Charter of Rights and Freedoms. Nevertheless, O'Donnell ordered Swain indefinitely incarcerated in the Queen Street Mental Health Centre. Swain then appealed this decision to the Ontario Court of Appeal, but lost in September 1985.

Owen Swain asserts that he was never "insane." He was incarcerated both in Queen Street and in the Penetanguishene Mental Health Centre. He was finally released in 1986, and has been fighting against the injustice perpetrated against him ever since.

On February 19, 1990, Swain's lawyers, Clayton Ruby and Marlys Edwardh, and Gwen Brodsky – lawyer for the Canadian Disability Rights Council, which was an intervenor in the case – appeared before the Supreme Court of Canada. They made strong arguments that Swain's Charter rights were seriously violated by the relevant section of the Criminal Code. Seven of the court's nine justices heard the case; their decision should be announced sometime in 1990.

This is the first time the Supreme Court of Canada has had the opportunity to apply the Equality Rights section of the Charter to people with disabilities, and particularly to those labeled as having a "mental disability." Furthermore, the WLG, which authorizes the implementation of Section 542(2) of the Criminal Code, is finally being challenged. (This is an indirect challenge, since it's not the WLG itself that is under attack, but the legal procedures surrounding it.)

The WLG/insanity-defence system is cruel and unusual punishment and

The WLG and the "not guilty by reason of insanity" defence are part of a system of cruel and unusual punishment that should be abolished.

should be abolished, not reformed. The powerful constitutional challenge launched in the Swain case is a beginning. (See *Phoenix Rising*, Vol. 8, No. 2, for more details about the Swain case.)

Don Weitz

WLG update

In 1973, Tom Burke was found not guilty by reason of insanity in the death of his wife and was promptly ex-

iled to Oak Ridge, Canada's infamous psycho-prison, under a Warrant of the Lieutenant Governor (WLG). After surviving seven years of abuse, he was deemed "well" enough to be released on the condition that he return to his native Scotland. There were no restrictions placed on Burke's activities, and he was to be under no supervision. The only condition specified in his warrant was that if he ever returned to Canada, he should report to the Queen Street Mental Health Centre to advise them that he was in the country.

In 1980, Burke returned to Scotland and proceeded to get on with his life. He remarried, had a child, and worked steadily for the post office.

The Review Board continued to hold annual hearings on Burke, without any information about how he was doing.

In 1988, the chair of the Review Board wrote Burke in Scotland, asking if there was any reason that his warrant should not be vacated. Burke admitted that he was experiencing some marital difficulties that potentially could end in divorce, but stressed that, outside of these pressures, life was pretty "normal."

The Review Board altered his warrant so that he would be incarcerated immediately if he ever set foot in Canada again. No one notified Burke of this change.

On February 14, 1990, Burke came to Toronto for a one-week visit with rela-

tives. The first thing he did when he got there was to report to Queen Street to let them know he was in town. And, of course, he was immediately locked up.

Tom Burke spent three months in what appears to be illegal custody. He had committed no crime, other than belonging to a tiny group of people who are frequently denied due process of law. On May 18, the Ontario Supreme Court ordered Burke's immediate

release. He very quickly left the country.

Why did it take two Review Board hearings, the launching of a civil suit for false imprisonment, and a presentation to the Supreme Court of Ontario to free a man who had committed no crime? Why does due process not apply to WLGs? And, most importantly, why doesn't anyone seem to care?

The saddest thing is that Burke was actually treated better than most people with the misfortune to find themselves in the WLG system. The horrors endured by these people must not go on. Everyone reading this should get informed, get angry, write letters, and put an end to the injustice. No more Tom Burkes!

Randy Pritchard

For more information about the WLG system and what you can do about it, contact Randy Pritchard or Jeff Jefferson at the Ontario Coalition for the Humane Treatment of Psychiatric Offenders, 1339 King St. W., Toronto, ON M6K 1H2.

Oak Ridge inmates fight forced drugging

Two psychiatric inmates in the Oak Ridge Division of Penetanguishene Mental Health Centre in Ontario have flatly refused psychiatric drugs for the past three years. Their psychiatrist, Russell Fleming, wants to drug them by force. Both inmates, who wish to remain anonymous, have been incarcerated in Oak Ridge for several years under WLGs. Fleming believes that both need "neuroleptic medication" and are "incompetent" to make treatment decisions. The Official Guardian of Ontario has been acting as the substitute decision maker for one of the in-

mates and has acted on his wishes (expressed while competent) by refusing all psychiatric drugs on his behalf. The legal issues in both cases are identical.

On January 26, 1989, after Fleming applied to the Review Board to forcibly treat one of the inmates, the Board ruled against the inmate by ordering "a course of neuroleptic medication." On February 3, the inmate took legal action, filing a "Notice of Appeal" in the District Court of Ontario at Barrie. The appeal challenges the constitutionality of the Review Board's decision and of Section 35a of the Mental Health Act, which allows review boards to make treatment orders. Both inmates assert that forced drugging, as allowed in the Act for involuntary and "incompetent" inmates, violates Section 7 of the Charter, which guarantees a person's "right to life, liberty and security of the per-

The forced drugging of inmates is a massive intrusion into personal security.

son," and Section 15, which guarantees the equality rights of all Canadians.

According to lawyer Carla McKague, who is representing both inmates, forced drugging is a "massive intrusion" into a person's security and safety. McKague states that forced drugging "constitutes discrimination on the basis of mental handicap."

District Court Judge Peter Tobias in Barrie has not yet ruled on the cases, but should do so soon. If his decision is unfavourable, it will no doubt be appealed to the Ontario Court of Appeal, and possibly all the way to the Supreme Court.

Don Weitz

Rights group speaks out against injustice

The Canadian Disability Rights Council (CDRC) is a national advocacy coalition for people with disabilities. Although it is only two years old, the CDRC has already had an impact on inmates' rights (see "Inmates fought to exercise fundamental rights," *Phoenix Rising*, Vol. 8, No. 2).

According to the CDRC's Statement of Principles, at least 50 percent of the people in any organization belonging to the CDRC must be disabled. Members promote the interests of disabled people and abide by the following principles: promoting equality of opportunity and rights for disabled people; working towards the full economic and social participation of disabled people; gaining self-determination and independence for disabled people; and ensuring direct representation in decisions that affect the lives and liberty of disabled people. All significant decision-making functions in CDRC are controlled by disabled people who are directly accountable to major organizations of the disabled in Canada.

This information is from CDRC's newsletter *Right On!*, Vol. 1, No. 1, Fall 1989. Write to CDRC, #926, 294 Portage Ave, Winnipeg, MB R3C 0B9, Attn: Yvonne Peters, National Coordinator. Or, call (204) 942-4625.

Inmate kills himself in Penetang

On February 18, 1990, 29-year-old Glen William Hepburn jumped to his death while incarcerated in the regional hospital of Penetanguishene Mental Health Centre.

According to an article in the February 23, 1990 *Toronto Star*, Hepburn "crashed through a window on a locked ward . . . and fell five storeys." An autopsy and police investigation have been carried out.

An inquest has been scheduled to begin on May 30, 1990. The presiding coroner is Dr. Herman Jilesen. No location has been announced yet. (It took *Phoenix Rising* almost two months to find out the name and age of the inmate and the date of the inquest, none of which was either mentioned in the *Star* or revealed by the Penetang administration.)

Another prisoner death

Mark Buhagar should be alive today. He was only 30 when he died on November 8, 1989.

Buhagar died in Toronto's Don Jail, only nine days after his arrest for trying to steal a car, and eight days into his imprisonment. The cause of death, according to the coroner and coroner's jury, was "septic shock, result of gas gangrene brought on by streptococcus pyogenes infection."

How can a healthy young man, who showed no visible signs of a serious infection when he was arrested, die from gangrene shortly after being imprisoned? It seems that prison doctor Michael Klar, nurse Elizabeth Yale, and guards Joseph Forsythe and Carl Lindo weren't sharing medical information about Buhagar. Another reason is

that medical care at prisons like the Don Jail is generally substandard.

Buhagar was a nobody as far as prison staff were concerned; he was stigmatized and invalidated as "crazy." He had a psychiatric history that included years of being "assessed" and labeled "schizophrenic" at the Clarke Institute of Psychiatry and "treated" at other psychiatric institutions. The recommendation of the jury that was most emphasized by the press was for a "separate maximum remand centre," or heavy-duty prison, for "dangerous mental patients" like Mark Buhagar. It is classic to blame the victim rather than getting rid of the chronic overcrowding and brutality in our prisons.

**To respond to
to his death
by creating
a heavy-duty
prison is
classic victim-
blaming.**

Inmate wins minimum wage

Bruce Fenton was a slave labourer in British Columbia's psychiatric "gulag" for almost sixteen years — until December 7, 1989. That's when BC Supreme Court Judge William Davies ruled that Fenton had the right to be paid B.C.'s current minimum wage of \$4.75 an

hour. Until then, Fenton, who was incarcerated in the BC Forensic Psychiatric Institute in Port Coquitlam, was being paid 29 cents an hour for his labour. For many years, he had put in 60 hours peeling potatoes, stripping furniture, building planters, and doing other work, for \$17.50 every two weeks.

Institute lawyer Harvey Groberman argued that Fenton's work was "therapeutic" and exempt from the BC Employment Standards Act, which allows non-profit or government-run institutions to pay "patients" or "clients" far less than the minimum wage. (This is also legal in most other provinces, including Ontario, where the Queen Street Mental Health Centre pays inmates a maximum of 60 cents an hour in its "industrial therapy" program.)

Fenton's lawyers, David Mossop and Jim Pozner, successfully argued that the Institute and its workshop program violated his constitutional rights — particularly his right to equality as guaranteed by the Canadian Charter of Rights and Freedoms — by paying Fenton less than the minimum wage. His was an obvious case of economic exploitation and discrimination based on "mental disability."

The BC Supreme Court decision is retroactive to 1980, so the province's government owes Fenton thousands of dollars in back pay.

Fenton won a victory not only for himself but for thousands of other inmates and prisoners in BC who

have been exploited for many years. His case should inspire similar court challenges everywhere in Canada where economic exploitation is taking place in sheltered workshops and industrial and occupational "therapy" programs.

NETWORK•NETWORK•NET

Ontario Survivors' Alliance Formed

The founding meeting of the Ontario Psychiatric Survivors' Alliance (OPSA) was held in Toronto January 27, 1990. Those who attended decided that allies who haven't been locked up are welcome to join, but only psychiatric survivors can vote. Several people volunteered to form a steering committee. At present, about a third of the steering committee members live outside of Toronto. OPSA is in the process of becoming incorporated as a non-profit organization.

Among our objects of incorporation are the following: to develop and implement alternatives to psychiatry, to sponsor and organize educational activities for psychiatric survivors, to make representation to the government for the enactment, repeal, or amendment of legislation dealing with mental health issues; and to assist in the development of local support groups for psychiatric survivors. OPSA is trying to get funding for a psychiatric survivors conference for people from all over Ontario (to be held *outside* Toronto) that we hope to put on in the winter of 1990.

The organization submitted a brief to the Toronto District Health Council's public hearing on community mental health legislation (see Page 26), in which we responded to the question "Should the legislation include provisions for outpatient commitment?" as follows: "Outpatient commitment is meant to coerce people to stay on their medications under threat of rehospitalization. It does not take into considera-

tion the possibility that medications can do more harm than good. Outpatient commitment, also called involuntary community treatment, absolutely must not be introduced under this or any other legislation. People will not end up getting their act together if the basis of their 'treatment' is coercion."

OPSA's first newsletter came out in May 1990. In it, we included a slightly shortened version of our brief to the Committee, and three stories from psychiatric survivors about the "Our Turn" conference (see Page 7).

OPSA can be contacted through Irit Shimrat, 3107 Bloor St. W., Suite 201, Toronto, ON M8X 1E3. Or, phone (416) 234-9245.

Ottawa

OAPP, formerly the Ottawa Association for Psychiatric Patients, has changed its name to Ottawa Association for Psychiatrized People, in order to more adequately reflect the group's anti-psychiatry position. Congratulations to OAPP on this decision!

OAPP provides a self-help support group and information and advocacy concerning welfare, housing, and patient rights. The group also offers free paralegal services, since lawyers in Ottawa are not adequately defending the rights of psychiatrized people in hospitals.

OAPP paralegals will help members appeal committal decisions; help members insist that hospitals provide patients with necessary information about their diagnosis and treatment so that they can defend themselves in competency hearings; advise members that they are entitled to appeal incompetency decisions in district court within ten days, and assist in the appeal process; make arrangements for patients to have "substitutes" who can decline medication, shock treatment, etc., on their

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behalf while fighting an incompetency order; and assist in processing complaints and taking court action in response to incidents of abuse by hospital staff.

OAPP has been effective in lobbying and advocating for rights, but regrets that the group does not have enough funding to continue to offer its crisis intervention services to non-members.

If you live in the Ottawa area, are or have been a victim of psychiatry, and want to start fighting back, you will find membership in OAPP helpful. Group members share their time, energy, and resources to try and build a better community, free of psychiatric abuse. To apply for membership, phone Sue Clark, OAPP coordinator, at (613) 728-1498.

Niagara region

Activists for Real Alternatives. Contact: Angela Browne, Box 161, St. Catharines, ON L2R 6S4. Or, phone (416) 688-5598.

Thunder Bay

A chapter of OPSA has been formed in Thunder Bay. Contact: Peggy Seward-Maling, 218 Leith St., Apt. 208, Thunder Bay, ON P7C 1M8.

Brockville region

Survivors in Action. Contact: Sheryl Pedersen, 224 Arthur St., Gananoque, ON K7G 1B2.

O N T A R I O

Cambridge

Cambridge Active Self-Help (CASH). Contact: Annette Bauman, c/o CASH, #5, 13 Ainsley St. S., Cambridge, ON N1R 3J9. Or, phone (519) 623-6024.

Toronto

OPSA – Metropolitan Toronto area. Contact: Irit Shimrat, 3107 Bloor St. W., Suite 201, Toronto, ON M8X 1E3. Or, phone (416) 234-9245.

Resistance Against Psychiatry (RAP). Contact: Bonnie Burstow, 441 Clinton St., Toronto, ON M6G 2Z1.

Attention WLGs!

If you or someone you care about is being psychiatrized under a Warrant of the Lieutenant Governor in Ontario, contact: Randy Pritchard, Ontario Coalition for the Humane Treatment of Psychiatric Offenders, 1339 King St. W., Toronto, ON M6K 1H2.

For contacts elsewhere in Canada, get in touch with OPSA at 3107 Bloor St. W., Suite 201, Toronto, ON M8X 1E3.

REVIEWS

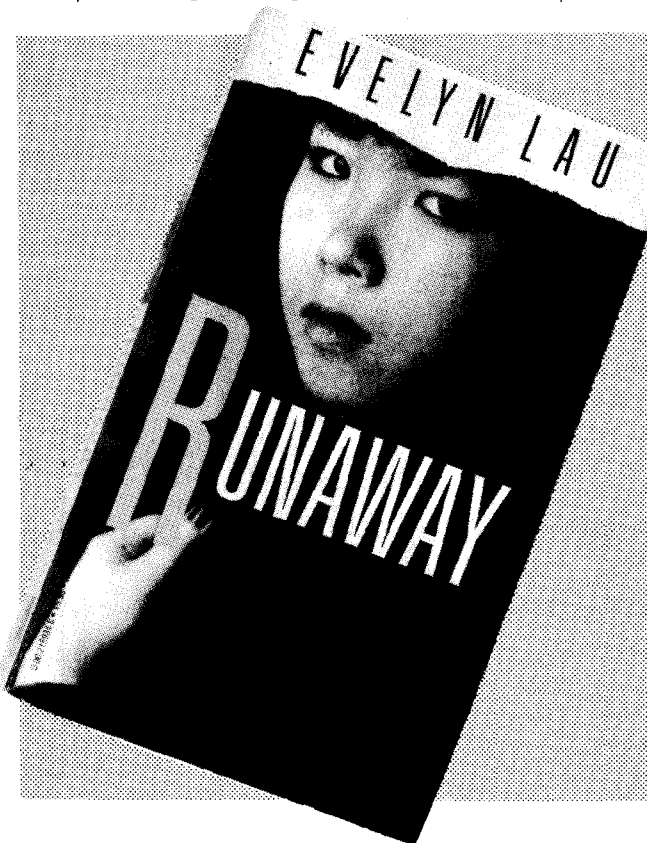
Young Canadian writer experiences the shrinks **Diary of a street kid**

**Runaway: Diary of a
Street Kid**
Toronto: Harper &
Collins, 1989
\$5.95, paperback

Evelyn Lau is fourteen years old when she runs away from home. She never wants to live with her parents again. To escape them, she tries to kill herself. Her attempt backfires, and Lau is sent to a psychiatric hospital. She spends a day in the Quiet Room and three days in the Psychiatric Assessment Unit. The experience – though brief – will haunt her for years. There is only one thing worse, she thinks, and that is home. “I tell the nurse I’m not going home and that’s it . . . I would almost rather stay in the psych ward scumhole than live at home. . . .” After four days, Lau is released into her parents’ custody. Between the psych ward and the house, Lau escapes, and she describes her adventures of the next two years in *Runaway*.

While in the Psychiatric Assessment Unit, Lau writes in her diary: “Here the patients talk incessantly about food, complaining loudly if there is not enough on their trays, snatching bits from

their neighbor’s meals. Medication is pumped into these people until they shuffle listlessly through the days, sightless, tuned inwards to the dances in their heads. Even now, I want to be the Prince who awakens these Sleeping Beauties from their drugged apathy. Let them scream! Let them fight! Together we could shatter the glass and tumble into the streets underneath the blue sky; what is beyond this world inside a paperweight.”



For the next two years, Lau sees her psychiatrists once a week. At one point she says, “Therapy sucks; the more I go, the crazier I get; why not just forget about it? Shrinks screw me up more than I can screw myself up. I rely on them too much and as a consequence explore and analyze myself too much, thus getting more involved in my problems and less with the outside world.”

One day Lau has an insight into her feelings about the psych ward. “Childhood events are becoming more lucid. I remember my fascination with small, bare, locked places – I would shut myself in a closet or bathroom and stay there, wondering, ‘Would I rather live here, never to go out again, or continue the way I am (with my parents)?’ The answer was always the same: I’d rather live in a closet.

“Maybe this is why my memories of the Quiet Room have become obsessive; it was, in a way, a fulfillment of my earlier fantasies of freedom. I realized this last night while I was in the bathroom, locking the door and looking around: ‘Would I rather live here . . . ?’ Then I saw what I was doing.”

For a while Lau tries hooking, but she spends all the money she makes on drugs, and besides, she doesn’t like sex or men very much. She makes several attempts to change her life, but the lure of the street wins out each time. As the book ends, she has a new boyfriend, and hopes he will be the key to her future. In the epilogue we learn that she is off the streets and off drugs (although a few paragraphs later she admits she’s still struggling with the drugs). One thing’s for sure: she’s not planning any visits to the psych ward.

Edna Barker

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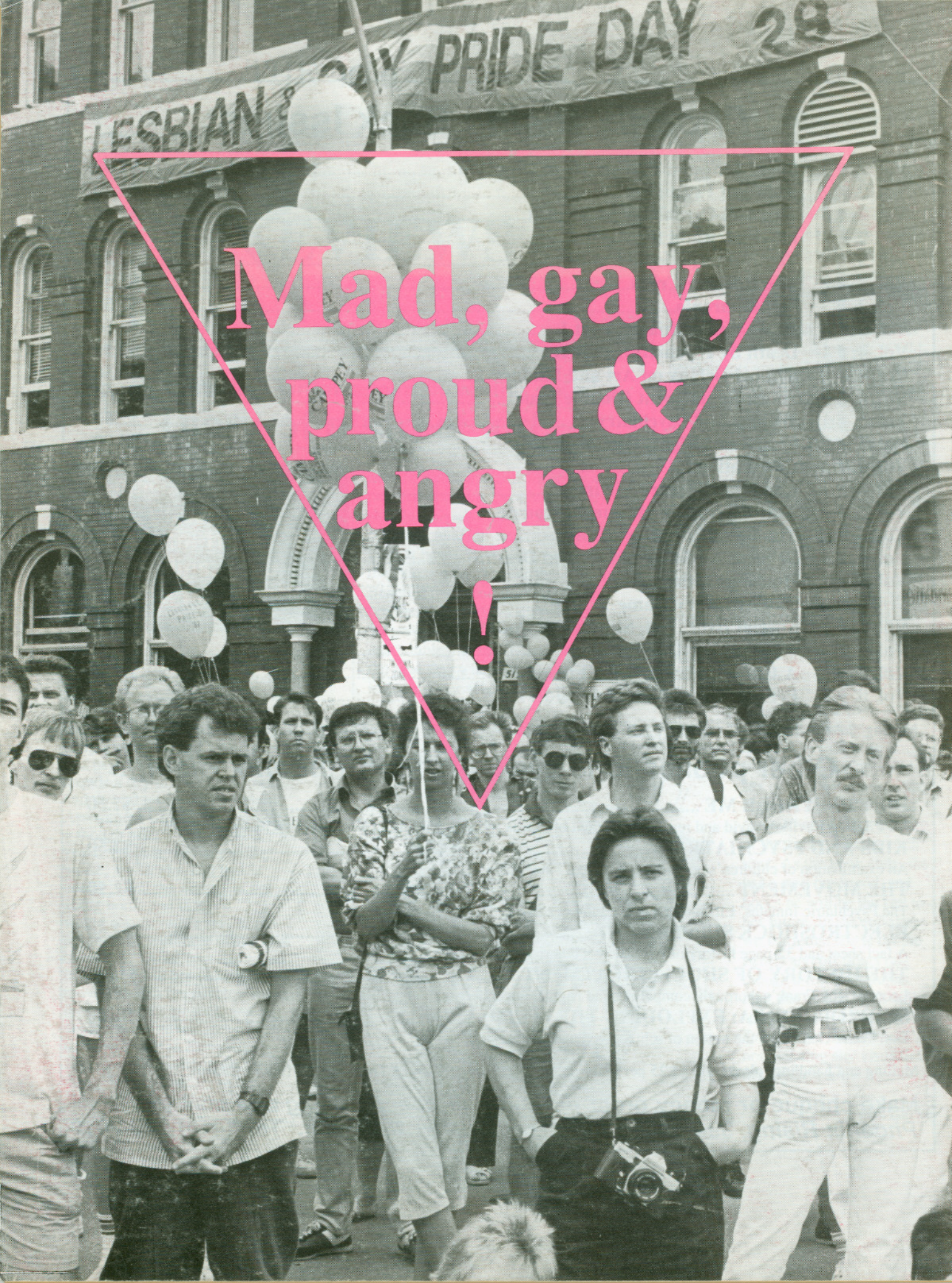
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