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**ELECTROSHOCK ECT  
BRAIN DAMAGE AS THERAPY**

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democratic psychiatry, psychology,  
and community development

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editors@asylumonline.net.

Send creative writing to [william.park@talk21.com](mailto:william.park@talk21.com)

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Associates on behalf of contributors

**Executive Editor:**

Phil Virden: [tigerpapers@btinternet.com](mailto:tigerpapers@btinternet.com)

**General Editors:**

Prof Alec Jenner and Lin Bigwood

**Business Manager:**

Peter Bullimore

**Members of Asylum Collective:**

Jim Campbell	David Harper
Tamasin Knight	China Mills
William Park	Ian Parker
Dina Poursanidou	Sonia Soans
Helen Spandler	Phil Thomas
Pauline Whelan	Lauren Wroe

**Design:**

Old Dog Graphics

**Administration & Distribution:**

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**Cover Images: Front and back covers, Mary Maddock:  
Protest against shock treatment**

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*Asylum* magazine is a forum for free debate, open to anyone with an interest in psychiatry or mental health. We especially welcome contributions from service users or ex-users (or survivors), carers, and frontline psychiatric or mental health workers (anonymously, if you wish). The magazine is not-for-profit and run by a collective of unpaid volunteers. Asylum Collective is open to anyone who wants to help produce and develop the magazine, working in a spirit of equality. Please contact us if you want to help.

The views expressed in the magazine are those of the individual contributors and not necessarily those of the Collective. Articles are accepted in good faith and every effort is made to ensure fairness and veracity.

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# EDITORIAL

## Phil Virden (Executive Editor)

Most of the material for this issue was gathered together by Cheryl Prax who campaigns against electroconvulsive therapy (ECT). Included are pieces which discuss the bio-electrical realities, the so-said efficacy, the harmful 'side effects', and the social and judicial aspects of this controversial psychiatric

treatment; mixed in are a number of accounts of what it is like to be subjected to shock treatment. The reader can judge whether ECT should be permitted – as a useful 'last resort' – or opposed – as always a barbaric and harmful means of psychiatric coercion.

But first we must announce the death of a founder of this magazine.

## PROFESSOR ALEC JENNER 1927–2014

FA JENNER, MB, ChB, PhD, FRCP, FRCPsych, Emeritus Professor of Psychiatry (Sheffield), Professor Visitante (Concepción, Chile), was a psychiatrist, an academic and a manager for fifty years. The sad news of Alec's death is mitigated by the fact that we can celebrate the positive energy which he poured into a long, busy and productive life in genuine and ever-thoughtful service to those who suffer from intense emotional or mental distress.

After qualifying in medicine, Alec was recruited to an academic post in psychiatry due to his expertise in research biochemistry. By 1967 he had been appointed Professor at Sheffield University, and found himself managing the psychiatric services for the whole of the Trent Region – a population of six million. Meanwhile, he had carried out the first double-blind UK trials on Librium and Valium, and became Honorary Director of the UK's Medical Research Council Units for Chemical Pathology of Mental Disorders, and for Metabolic Studies in Psychiatry. Professor Jenner was also instrumental in a number of institutional reforms. In particular, he initiated the Phoenix House Drug Addiction Rehabilitation Unit at Sheffield (the second biggest in the country) and, in response to the appalling provisions for the elderly at the time, set up a psycho-geriatric service (now known as 'specialist service of old age') for the city. He was the first Western psychiatrist to draw attention to the political use of psychiatry in the Soviet Union.

Alec was very modest and always encouraged others to come forward and express their views. Consequently he is something of an unsung hero. However, aside from Laing and Cooper, in the UK he was perhaps the most influential psychiatrist of his generation. Since he had trained in chemistry, he probably understood better than any other psychiatrist of his time the actualities of the biochemistry and genetics of mental disorder – and demonstrated the absence of evidence for either kind of cause, or cure. Whilst he carried out and supervised key UK drug trials, he also did much to promote the idea of social psychiatry, both in changing the focus of the services within his 'domain' to include the voice of the patient and by inspiring a fair number of the next generation who



passed through his university department and went on to make their own careers based on a profound scepticism of the so-called medical model of mental illness.

Although believing in the medical model when young, in the light of the accumulating evidence Professor Jenner came to advocate social psychiatry and a biographical approach to understanding and responding to anyone with disabling emotional or mental disorders. By the 1960s it was clear to him that there was no proof that the great majority of such conditions were due to 'inherent' biochemical abnormalities; instead, so as to discern causes and be able to offer help, psychiatry had to learn to listen carefully to the stories and back-stories of the distressed.

In 1986, his vision, organisational skills and financial assistance proved vital in setting-up *Asylum* magazine, and to keeping it going; he was also a regular contributor. In retirement, concerned with the topic which had always intrigued him the most, he at last found time to review the research and literature and come to his own conclusions. This resulted in a book: Jenner, FA et al (1993) *Schizophrenia: A disease or some ways of being human?* Sheffield: Sheffield Academic Press.

**Phil Virden**

*In the next issue we hope to publish a few memories of Alec. Three contributions can already be viewed on the Asylum website, along with extracts from a fascinating interview:*  
**ALEC JENNER – IN HIS OWN WORDS**

Electroconvulsive therapy is the application of two electrodes to the head to pass electricity through the brain so as to cause an intense seizure or convulsion. This always damages the brain, resulting each time in a temporary coma and often a flat-lining of the brain waves, which is a sign of impending brain death.

After one, two or three applications of ECT, the trauma causes symptoms typical of severe head trauma or injury, including headache, nausea, memory loss, disorientation, confusion, impaired judgment, 'loss of personality', and emotional instability. As routine treatment progresses, these harmful effects worsen and some become permanent.

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Electroshock 'therapy' was discovered in a slaughterhouse in [fascist] Italy. Before being killed, hogs were knocked out by a jolt of electricity to the head. After a while, if they didn't die, the animals woke up and, on wobbly legs, were able to walk around. In 1938 two psychiatrists learned about this and immediately tested it on an involuntary patient. The patient wasn't knocked out by the first jolt, and struggled from the table screaming 'Murder!' So the doctors gave him a bigger jolt. When he woke up, the man was docile and no longer complained. A miracle treatment was born and the two psychiatrists became famous.

Modifications have been used since the 1960s, but they are not safer. The changes make it harder to cause a seizure. As a result, modern ECT requires even stronger and more damaging doses of electricity.

\*\*\*

Why in the world would medical doctors get so excited about a jolt of electricity that knocked out a hog without killing it? This was the era that originated lobotomy – slicing up, burning or poisoning the highest centers of the human brain. It was also the era that originated insulin coma therapy – putting patients into a coma with overdoses of insulin that destroyed cells, in great batches throughout the brain. Doctors were looking for new ways to inflict damage on the patient's brain without completely destroying its function.

In those early days, many psychiatrists voiced the opinion that brain damage was good for 'the mentally ill'. It certainly made patients more docile and hence easier to manage in huge state lockups. Only more recently, in response to criticism, did shock advocates begin to claim that the treatment was 'harmless' and 'corrected biochemical imbalances'.

In fact, shock treatment damages the brain through a variety of mechanisms:

It causes grand mal seizures that are much more intense and destructive than those spontaneously experienced by people with severe epilepsy. These multiple seizures (typically three per week for a few weeks or more) exhaust and damage neurons or brain cells.

The electric current by itself damages the brain by disrupting electrical function, overheating brain tissue, stimulating massive hypertension inside the brain, breaking down the blood brain barrier, and causing tiny blood vessels to spasm shut, thereby depriving neurons of oxygen and nutrients. Commonly, patients undergo several seconds

# ELECTROCONVULSIVE THERAPY (ECT)

Dr PETER BREGGIN

after ECT in which their brain flatlines – zero detectable electrical activity. When extended for minutes, this is a sign of permanent brain death. After exposure to doses of ECT smaller than nowadays used in clinical practice, animal studies have shown small haemorrhages and cell death in the frontal lobes and throughout the brain. Human studies show that former ECT patients suffer from persistent loss of mental function and dementia (Breggin, 2008; Sackeim et al., 2007).

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So ECT only 'works' by damaging the brain. The initial trauma can cause an artificial euphoria, which ECT doctors mistakenly call 'an improvement'. After several routine shocks, the damaged person becomes increasingly apathetic, indifferent, unable to feel genuine emotions, and even robotic. Memory loss and confusion worsen. The helpless victim of electroshock treatment becomes unable to voice distress or complaints, and becomes docile and manageable. ECT doctors view this as an improvement but actually it indicates severe and disabling brain injury.

ECT permanently impairs memory and causes other long-term signs of mental dysfunction such as difficulties with concentration and new learning. Memories of important past experiences are commonly impaired or eradicated, including weddings, birthdays, vacations, educational experiences, and practical and intellectual skills. Sense of self or identity may be demolished, and family members often report that their loved one 'was never the same again'. Follow-up studies show that ECT has been used to abuse women by making them docile and submissive.

Many animal studies show that ECT causes small haemorrhages throughout the brain, as well as patches of cell death. Newly discovered ECT-induced neurogenesis (growth of new brain cells) is not a benefit but instead confirms brain injury. Neurogenesis is a response to brain damage from many causes, including Traumatic Brain Injury (TBI).

\*\*\*

ECT is *not* a last resort because it does not work and can ruin recovery. ECT does not prevent suicide – but it can cause it. Controlled clinical trials show that ECT has no more benefit than sham ECT (anaesthesia without actual shock). For about four weeks – during the acute phase of brain injury – ECT blunts emotional life, after which the person remains depressed, with the added affliction of brain damage.

There is abundant evidence to indicate that ECT should be banned. Because it destroys the ability to protest, all ECT quickly becomes involuntary and thus inherently abusive and a violation of human rights. Therefore, when ECT has already been started, concerned relatives or others should immediately intervene to stop it, if necessary with an attorney.





In place of ECT, depressed and severely disturbed people need good therapy – whether individual, couple or family. Family members should participate actively in therapy with their overwhelmed loved ones.

Since psychiatric drugs commonly cause or worsen depression, anxiety and psychosis, always consider stopping all psychiatric drugs through a carefully supervised withdrawal. Becoming free of psychiatric drugs is often the start of recovery. (See: PR Breggin (2013) *Psychiatric Drug Withdrawal: A guide for prescribers, therapists, patients and their families*. New York: Springer.)

### Key Points

- ECT is not a legitimate last resort because it does not work and can ruin any hope of future recovery.
- After one or more ECTs, the brain-damaged individual becomes too docile and confused to protest or resist. Therefore family members, concerned individuals, advocates, or attorneys must intervene to prevent more extensive injury. No harm will come from stopping shock treatment, but increasing harm will inevitably occur from subsequent sessions.
- Because it causes severe damage to the brain and mind, and because it always becomes involuntary, ECT should be banned.

This information is confirmed by more than 125 scientific articles and other relevant materials. See Peter Breggin's *ECT Resources Center*, available free of charge online at [www.ectresources.org](http://www.ectresources.org). A table of contents is provided with extensive search terms such as 'memory loss' and 'brain damage'.

For the chapter on ECT in his medical textbook, see Breggin, PR (2008) *Brain-Disabling Treatments in Psychiatry: Drugs, electroshock and the psychopharmaceutical complex* (2nd ed). New York: Springer Publishing Co.

Reprinted by kind permission: article on pp 4–5: [www.breggin.com](http://www.breggin.com); Peter Breggin's Blog on pp. 21–3: *Huffington Post*, 30 Jan 2009: Electroshock for involuntary adults & children.

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- Peter R Breggin, MD**, is a psychiatrist in private practice in Ithaca, New York. He runs the non-profit international organization, 'The Center for the Study of Empathic Therapy'. He is the author of more than twenty books, including *The Heart of Being Helpful*, *Talking Back to Prozac*, *Brain-Disabling Treatments in Psychiatry*, *Toxic Psychiatry*, and *Medication Madness: The role of psychiatric drugs in cases of violence, suicide and crime*. He is also the author of dozens of peer-reviewed scientific articles, many in the field of psychopharmacology.

# ELECTROSHOCK AT BELLEVUE, AGE SIX

## Fragment from an unfinished autobiography

Ted Chabasinski

I was six years old, and so, finally, all the symptoms of my supposed mental illness – playing in the back yard making mud pies, running away from the big children when they threatened me, picking flowers from our neighbor's garden, fighting with my little sister, and especially, being born to a crazy mother – came to a head. And now I was officially a schizophrenic, proving that the disease was inherited.

And Miss Callaghan declared that I was to be taken to Bellevue Hospital, to be made an experimental animal for Doctor Lauretta Bender. She was a leading child psychiatrist of her time, and she needed foster children to try out electric shock treatment on. How interesting to see what might happen!

And the child welfare agency that was supposed to protect me was happy to provide the children.

I remember nothing of how I got there, and very little of what I actually experienced during that time. But, very unusually for a shock victim, I have a few memories, memories of events that occurred over and over.

Now, writing as an adult many years later, I can only imagine all the terror I must have felt when I was torn from my foster parents. Maybe it is merciful that I can't remember everything.

At Bellevue I slept in what seemed to me, small as I was, a gigantic hallway – cold, echoing at night with strange and frightening noises, a ceiling as high as the sky. There were windows up to the ceiling but they had not been cleaned for many years and the hallway was always dark, even during the day, even when the sun was shining. My bed, furnished with a hard, filthy, bad-smelling mattress and an olive drab blanket, was all alone in the hallway.

I didn't know why I was kept alone in the hallway. I wanted to be with the other boys on the ward. I remember vaguely being told that the ward didn't have enough room. But why didn't they put some other boy out there so I would have someone to talk to?

And there was no one to hear me cry, which might have been just as well because they said my crying was a symptom of my illness, and maybe if I kept crying I would be there for the rest of my life.

And there was no one there at night to hear me scream when the man came to rape me.

Sometimes Doctor Bender would appear during the day, coming through the elevator door in the middle of the hallway, surrounded by her protectors, many aides who

seemed to worship her, or maybe they were just afraid of her, as I was. Sometimes she would pass very close to me, looking at me, but not acknowledging me, as if I didn't exist.

And it was cold, so cold. It was a New York City winter, and I only had one blanket, though sometimes the kinder attendants would put another on my bed. But it always seemed to disappear. I would wake up shivering, and couldn't find any position that would keep me warm.

And I thought about home, about my parents and my little sister, and the nice teachers I had in school, and I wondered if I would ever see them again. Sometimes, right after the shock treatments, it was very hard to remember home at all, and all I knew was the world I knew right then, of shock treatments and loneliness and cold.

I wanted it to be over and I wanted to die.

*Row, row, row your boat,  
Gently down the stream  
Merrily, merrily, merrily, merrily  
Life is but a dream ...*

Most mornings, the boys were all marched to the other side of the hallway, to the girls' ward. There we were supposed to sing and show how happy and normal we were, but I almost never did. The attendants would try to pressure me to sing, telling me how it was a sign of my illness, and I should sing if I wanted to get better.

On the mornings when I was going to get the shock treatment, I didn't get any breakfast, so I knew what was going to happen. On those mornings, while the other children sang obediently, I would cry without stopping.

Soon, three attendants would show up and start to drag me down the hallway, to a room close to the boys' ward where the shock was given. They had learned to provide lots of staff for this as I fought so hard that it was impossible for any one person to control me.

"I won't go to the shock treatment, I won't!" I kicked, tried to bite my captors, tried to escape their grip. But they dragged me down the hallway and threw me violently onto the shock table, where several of them held me down. A rag was stuffed into my mouth and down my throat, making me choke.

And that was the last thing I would remember, until I woke up in a dark room somewhere. Often I would wake up in the same room with Stanley, a very big boy of about thirteen. I was terrified of Stanley, though I don't know why. Whatever the reason may have been is lost in the black hole that the shock had created.

I had learned to try to memorize my name, to concentrate on my name so I would remember it after the shock. "Teddy, I'm Teddy, I'm here in this room, in the hospital. And my mommy's gone ..." I would cry and realize how dizzy I was. The world was spinning around, and coming back to it hurt too much.

I want to go down, I want to go where the shock treatment is sending me, I can't fight any more and I want to die ... But something made me go on living, and to live, I had to remember never to let anyone near me again.

The man came to my bed, my isolated little bed in the big hallway, and grabbed my head and forced my mouth against his penis. Then he tore off my hospital gown and tried to turn me over. I fought back, and he grabbed me and slammed me down, hitting my head against the bed frame and stunning me ...

My bottom hurt all the time and I was bleeding. I had a terrible taste in my mouth that wasn't really there but never went away.

My father came to visit me, and I told my daddy what the man was doing to me.

I was crying, as I almost always did.

"Daddy, please make him stop. Please don't let him do that to me."

My father looked very upset. "I'll talk to the doctor about it."

He visited me again. "Teddy, you imagined it. The doctor says you imagined it."

*I imagined it. My daddy says I imagined it.*

*My daddy doesn't care what happens to me.*

*I want to die.*

Almost every night the man came to my bed in the big hallway and raped me. And then it stopped.

And then one night I heard a little girl screaming across the big hallway. I recognized her voice. She was a beautiful child about my age who I saw sometimes on the girls' ward. She was getting shock treatment too, because on the days I didn't get breakfast, she didn't either. Like me, she didn't sing – she didn't sing and celebrate our happy childhoods like we were supposed to. She was much more affected by the shock treatments than I was, and said almost nothing, just smiled vacantly.

It must have been her bed that I saw in the hallway when we were led to the girls' ward to sing and celebrate.

I heard her almost every night in my sleep. It woke me up, although during the time of the shock treatments, I never was either fully awake or fully asleep.

And even now, so many years later, she sometimes comes to me in my dreams, the beautiful little girl crying out in terror and pain.

And so, in May 1944, after being being raped and killed over and over, I was finally released from Bellevue. The little boy who had been taken there to be tortured didn't exist any more. All that was left of him was a few scraps of memory and a broken spirit. The rest was ashes in a giant dark pit, mixed with the ashes of the hundreds of other children who had been tortured and burnt alive by Doctor Bender, a leader of her profession.

That was two months after my seventh birthday – but I don't remember that birthday. I don't remember anything about the next few months, but eventually I found myself at home in the Bronx, trying to remember who I was.

I was so terrified now that I would cling to my mother, and for a while I was afraid to go out.

Finally, I took my tricycle and rode it all over the neighborhood, very confidently, as I had always done, for I knew every block. But suddenly I realized that I didn't know where I was, and I panicked. Somehow a kind neighbor got me home, but I was scared to ride my tricycle any more. I used to have a sense of freedom, that I was a big boy and could ride it anywhere. But that was gone now.

A little boy named Karl, about my age, came to our house to visit me. I was told he lived very near to us, on the corner, just two houses away. And I was told he had been my best friend. But I didn't know who he was.

And Miss Callaghan said my memory loss was a very bad sign. It meant I wasn't getting better.

# LEONARD ROY FRANK

## Electroshock Survivor and Editor



Leonard R Frank has been active in the anti-psychiatric and survivors' movement in the USA since 1972. He edited *The History of Shock Treatment* (1978) – the classic collection of information, from both sides of the debate – and the best-selling Random House-Webster's *Quotationary* (1998).

He is a member of MindFreedom

International, a coalition of more than 100 grassroots groups working for human rights in psychiatry, and also The Coalition for the Abolition of Electroshock, Texas.

He writes: "In 1963 I was forced to endure 85 shock procedures – 50 insulin comas and 35 electroshocks. As a result, my memory for the three most recent years of my life was obliterated. The brain is a terrible thing to damage, and brain damage is electroshock's bottom line. The surest indicator of this brain damage is memory loss, which is practically universal among survivors."

### ELECTROSHOCK ALWAYS

\* DAMAGES THE BRAIN \*

\* CAUSES MEMORY LOSS \*

\* SOMETIMES KILLS \*

IT IS NEVER NECESSARY

*The Electroshock Quotationary* (2006) (available free online and as an e-book) is dedicated to everyone committed to ending the use of electroshock. The Campaign for the Abolition of Electroshock in Texas (CAEST) was founded in Austin during 2005. *The Electroshock Quotationary* supports the organization's opposition to electroshock by informing the public, through the CAEST website, about the nature of electroshock, its history, why and how it is used, its effects on people, and the efforts to promote and stop its use. LR Frank regularly updates *The Electroshock Quotationary* with suitable materials when he finds them or when they are brought to his attention. He invites readers to submit original or published materials for consideration: lfrank@igc.org.

***The Electroshock Quotationary* is a comprehensive guide. It includes the following sections:**

### THE CONTROVERSY

Electroshock is also known as shock therapy, electroconvulsive treatment, convulsive therapy, ECT,

EST, and ECS. It is a psychiatric procedure involving the induction of a grand mal seizure (i.e., a convulsion) by passing electricity through the brain. It is the most controversial 'treatment' in psychiatry, and perhaps in all medicine. Proponents say it is a safe and highly effective way to address various kinds of 'mental illness' and certain other medical conditions. Opponents charge that evidence shows that it causes brain damage, and that it is used in psychiatry as an instrument of social control, sometimes administered by means of coercion or outright force, and seldom with genuine informed consent.

### BACKGROUND

Since 1938, when psychiatrists Ugo Cerletti and Lucio Bini introduced the procedure at the University of Rome, more than six million Americans and millions of others throughout the world have undergone electroshock treatment.

These days, an estimated 100,000 people in the United States undergo ECT every year. Two-thirds are women, and half are elderly. Age is not a disqualifying factor: there are published reports of individuals as young as 34½ months and as old as 102 undergoing the procedure.

A typical electroshock series for a hospitalized 'patient' in the United States costs from \$50,000 to \$75,000. A series of shock treatments may also be administered on an outpatient basis – in a hospital or in a psychiatrist's office – at considerably less expense: \$1,500 to \$2,000 per session. In the US, government or private insurance usually covers most, if not all, of the cost.

Psychiatrists who specialize in electroshock often earn \$300,000 to \$500,000 a year. This is considerably higher than the annual mean income for all psychiatrists (\$150,000). These figures suggest that, let alone world-wide, in the USA electroshock is a multi-billion-dollar-a-year industry.

To 'reduce the risk of relapse' following an electroshock series, psychiatrists often urge patients to pursue continuation (or 'maintenance') treatment. This generally involves psychiatric drugs and often includes individual electroshocks as well, administered on an outpatient basis at various intervals for six months or longer.

### DIAGNOSES THAT MAY 'REQUIRE' ECT

The most common indication for electroshock is a diagnosis of 'clinical', or severe, depression. An ECT series for depression typically consists of 6 to 12 sessions. People diagnosed with schizophrenia or bipolar disorder (manic depression) may also be subjected to electroshock, but this is less common. For these patients, a series of 15 to 25 sessions is standard.

Electroshock has also been administered to people with the following psychiatric diagnoses: alcoholism, anorexia, anxiety disorder, catatonia, drug withdrawal syndrome, homosexuality (no longer a psychiatric diagnosis), hysteria

(ditto), narcotic addiction, neurosis, obsessive-compulsive disorder, personality disorder, post-partum depression, post-partum psychosis, psychosomatic disorder, pseudo-dementia, psychosis, and substance abuse.

ECT has also been used to treat the following medical conditions: Alzheimer's disease, backache, acute and chronic pain, delirium tremens, dementia, epilepsy, mental retardation, neuroleptic malignant syndrome, Parkinson's disease, and psoriasis.

For persons said to be suicidal or in a state of depletion from lack of food (inanition), electroshock is frequently 'the treatment of choice'. For most psychiatric diagnoses, however, it is the treatment of next resort – after one or more unsuccessful trials with a psychiatric drug or a combination of such drugs.

### HOW ECT IS ADMINISTERED

Prior to the start of an electroshock series, the patient is given a psychiatric evaluation and a physical examination. A consent form – signed by the patient, a family member, or a state-appointed guardian or conservator – is almost always obtained after a psychiatrist has explained to the designated signer the nature and effects of the procedure, the manner of its administration, and why it is deemed necessary. Some states require a confirming opinion by a second physician. Some also require a judicial hearing if the patient's legal capacity to give or withhold consent is questionable, or if the patient withholds consent.

ECT is usually administered in the early morning, three times a week (Mondays, Wednesdays and Fridays). A routine is followed for each session. The patient is asked to avoid food and drink for eight to twelve hours beforehand. To prevent oral intake, each patient is usually kept under direct staff observation. During this period, tranquilisers or sedatives may be used to reduce the patient's fear of electroshock or resistance to it. The bladder and bowels are emptied just before the session, and dentures, glasses, hairpins, jewellery and the like are removed. About 30 minutes before the event, a conventional pre-anaesthetic medication called Atropine is administered, so as to dry secretions in the mouth and air passages, thereby reducing the risk of suffocation and other

complications of swallowing one's own saliva.

Shortly afterward, the patient is taken to the treatment room and put on a bed, padded table or gurney. Electrolyte jelly is applied to the two areas of the head where the electrodes are to be placed, usually the temporal areas. The jelly increases conductivity and prevents burns. An intravenous line is started, and sensors are placed on the head and chest to monitor brain and heart activity. A cuff is wrapped around the patient's upper arm to record blood pressure. The patient is then anesthetized for 10 to 15 minutes with a short-acting barbiturate, commonly Brevital (methohexital).

Once the patient is unconscious, the muscle relaxant Anectine (succinylcholine) is injected to reduce the risk of fractures, joint dislocations and damage to skeletal muscle, tendons, and ligaments. These were very common before this modification became routine during the 1950s. Anectine causes an almost complete paralysis of the body, including the respiratory system, so the patient has to be supplied oxygen through a mask (oxygenation) until the Anectine wears off and the patient can resume breathing on his or her own.

The anesthetic is not used to spare the patient pain since the shock itself, if strong enough, produces instant unconsciousness and is therefore painless. Instead, its purpose is to eliminate the sensation of suffocation that the patient would otherwise experience as the muscle relaxant gradually took effect.

ECT without anesthetics and muscle relaxants is now referred to as 'unmodified' or 'classical' ECT. The version with anesthetics, muscle relaxants (also called muscle paralyzers), oxygenation, and monitoring is called 'modified ECT'. Unmodified ECT is now rare in the USA and Europe but is still common in developing countries due to its lower cost.

Just before the convulsion, a rubber gag is inserted in the patient's mouth to prevent broken teeth and tongue-biting. Two electrodes wired to the shock machine are then positioned on the head and may be held in place by an elastic headband.

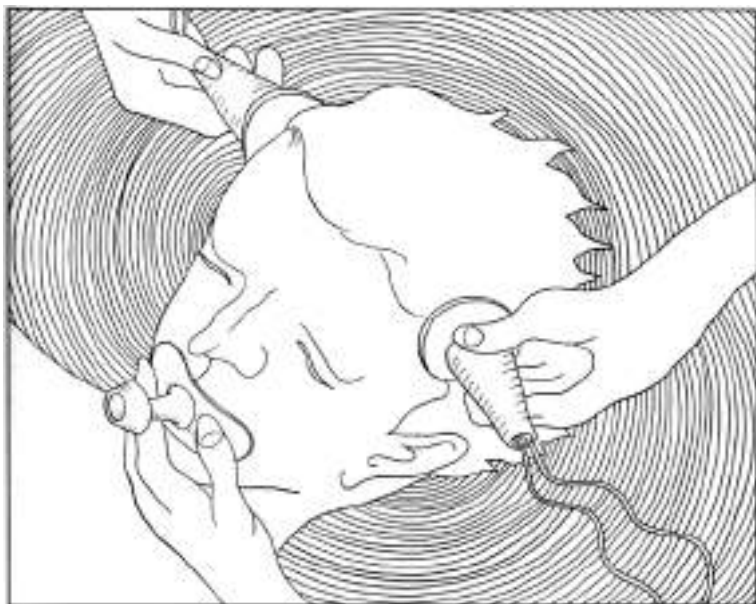
Preparations completed, the psychiatrist presses a button on the shock machine which releases the chosen voltage of

electricity – between 70 and 500 volts, or more – for the chosen time – between 0.02 and 8 seconds. The electric current penetrates the patient's skull and passes through the brain. This causes a grand mal convulsion that lasts from 30 seconds to a minute, or sometimes longer.

The patient then is







taken to the recovery room in a comatose state, from which she or he usually revives in ten to twenty minutes. Ordinarily, the patient is able to leave the recovery room half an hour or an hour later.

### THE EFFECTS

Regaining consciousness, the patient experiences one or more of the following adverse effects: headache, dizziness, nausea, confusion, disorientation (not knowing who or where one is or what time or day it is), muscle ache and soreness, physical weakness, memory loss, euphoria, increased or irregular heartbeat (especially among the elderly), brief or prolonged inability to breathe (apnea) and brief or prolonged cyanosis (blue skin from loss of oxygen).

Some of these effects may be so severe, even life-threatening, that emergency treatment is necessary. For this reason, ECT is typically given in a hospital, where such equipment is readily available.

After a session of ECT, patients may become 'agitated' (or furious) when they realize what has happened to them. Others become delirious or actively hostile, prompting the use of mechanical or chemical restraints, or both.

Within a few hours most of the immediate adverse effects dissipate. Those that don't may continue throughout the day, for several days, or longer. During the recovery period, patients are often asked to refrain from driving (or prevented from doing so), from conducting legal or business transactions, and from engaging in other activities requiring alertness and memory.

It is the longer-term (and possibly severe and permanent) adverse effects of electroshock that are most troublesome and frightening to patients and their families. The worst of these (or at least the two that receive the most attention) are memory loss and learning disability (inability to learn or retain new information). The former is called retrograde amnesia, the latter, anterograde amnesia.

A course of ECT causes a cumulative eradication of memory, which begins with recent events, learning, beliefs and thoughts, and gradually extends to the distant past.

In time some memories are recovered – usually within a month or two following the last ECT – although the memories lost during the treatment period are most often permanently erased. Most of the remaining gaps are filled only partially, if at all, through relearning. Relearning involves patients talking with people they have known, reviewing documents from their past (letters, diaries, school and work papers, home movies, newspapers, books and so on), and studying areas of interest with which they had once been familiar. Reacquisition of lost skills may be achieved to some degree through study and practice. The process of relearning is made more difficult because of the learning disability caused by ECT.

Some patients do not seem to mind their ECT-induced memory problems; they may even be largely, or completely, unaware of them. Others may welcome the loss of memories because some were so troubling and disheartening. At the other extreme are those for whom the memory loss is catastrophic, making their previous way of being, lifestyle, and work no longer possible. In between are persons who adjust as best they can to varying degrees of disability.

Physicians usually regard memory impairment, particularly when pronounced, as a sign of brain damage. Memory loss may be accompanied by apathy, emotional dullness (blunted emotion, flat affect), cardiovascular problems, spontaneous seizures, amenorrhea, demoralisation, dependency and hopelessness; reduced ability to think, problem-solve, concentrate and connect with others; loss of personality; and loss of creativity, energy, enthusiasm, moral awareness, and other elements that contribute to the individual's sense of well-being and worth.

The patient's age and physical condition, together with the intensity, duration, number, and spacing of the individual convulsive procedures, determine the severity and persistence of these effects.

### Death by ECT

Electroshock can also be fatal. Estimates of ECT-related death rates vary widely. Lower estimates include: 1 in 10,000 (see *The Electroshock Quotationary*: Boodman, 1996), 1 in 1,000 (Impastato, 1957), and 1 in 200 for those aged over 60 (Impastato, 1957).

Higher estimates include: 1 in 102 (Martin, 1949), 1 in 95 (Boodman, 1996), 1 in 92 (Freeman & Kendell, 1976), 1 in 89 (Sagebiel, 1961), 1 in 69 (Gralnick, 1946), 1 in 63, among a group undergoing intensive ECT (Perry, 1963–1979), 1 in 38 (Ehrenberg, 1955), 1 in 30 (Kurland, 1959), 1 in 9, among a group undergoing intensive ECT (Weil, 1949), 1 in 4, among the very elderly, aged over 80 (Kroessler & Fogel, 1974–1986).

Reasons for the difficulty in estimating ECT-related deaths include the following:

- There is no central tracking of ECT-related deaths.
- Some psychiatrists and hospitals under-report the

number of ECT-related deaths.

- Some psychiatrists and pathologists do not recognize deaths occurring during or soon after ECT as ECT-related.
- Families often refuse to authorize autopsies of relatives who have died during or soon after ECT.
- Professional journals are disinclined to publish reports or studies of ECT-related deaths. Not since 1957 has any journal published a large-scale study of ECT-related deaths (Impastato, 1957).
- It is difficult to determine with certainty, or near certainty, that ECT was the cause of a patient's death because multiple causes are often involved.
- Deciding whether or not a patient's death is ECT-related is difficult to establish because there is no accepted time interval between a death and the last electroshock received. For example, is it an ECT-related death only if the patient dies within a few minutes of undergoing ECT, or may the interval be a specific number of hours, days, or weeks, or up to a year?

### DOES ELECTROSHOCK WORK?

Opponents charge that ECT is demonstrably harmful and has not been proven effective (even by psychiatric standards) for any more than a month or two. However, some patients who have undergone electroshock, their families, and psychiatrists assert that the procedure is helpful. In evaluating their reports, opponents urge consideration of the following:

- Patients may feel better because of the well-known placebo effect. Any treatment offered by a doctor, along with the suggestion that it will work, may have the effect of making a patient feel better – at least for a while.
- Patients may say they feel better (even when they don't) for a variety of reasons: it's expected of them, they want to please their psychiatrists or relatives, or they fear that speaking truthfully would result in further ECT or other sanctions.
- Due to ECT-induced memory loss, patients may forget what had been bothering them; as a consequence, they may feel less troubled and complain less to others.
- Due to ECT-induced memory loss, patients may forget their ideas, beliefs, and forms of conduct that others had found objectionable, including resistance to being confined in a psychiatric facility and subjected to electroshock. This phenomenon may be called 'the brainwashing effect'.
- Family, friends, psychiatrists, and hospital staff may feel sympathy for ECT patients and give them more consideration and better care.
- Patients who believe the claims of psychiatrists and agree to undergo ECT may give up so much self-respect, health, memory, intelligence, money, skills, or

faith that they refuse to admit to themselves or others they are worse off after ECT.

- ECT-induced brain damage may be so severe that patients are unaware of their losses.
- ECT-induced brain damage may result in a brief period of euphoria during which the depression seems to lift, so for a time patients may indeed feel better.
- After ECT, patients typically become dependent on others, more docile, more cooperative, and easier to get along with as they recover from the treatment.
- Because ECT deadens the emotions, patients whose everyday lives are filled with tension, anger, sadness, and misery may experience temporary relief.

### WELL-KNOWN ELECTROSHOCK PATIENTS

LR Frank lists more than forty, from A to W: e.g., philosopher Louis Althusser, singers Connie Francis and Judy Garland, writer Ernest Hemingway (committed suicide as soon as he got out of hospital), actress Vivien Leigh, humorist Spike Milligan, writer and illustrator Mervyn Peake, poet Sylvia Plath, lyricist Dory Previn, songwriter Lou Reed, singer, actor and human rights leader Paul Robeson, fashionista Yves Saint-Laurent, physician Mark Vonnegut (Kurt Vonnegut's son), singer Tammy Wynette ...

*By kind permission, the above article is from: [www.endofshock.com/102C\\_ECT.PDF](http://www.endofshock.com/102C_ECT.PDF)*



# ECT & MY LOST LIFE

JAMES OAKES

I was enrolled at a university when they began: once every three weeks I would get an electroconvulsive therapy session. I remember very little about what was happening to me then. I did not remember – as my father later told me – that I drove an Oldsmobile during some of that time. He showed me a picture, but I had no memory of it.

Recently I visited some friends who told me that they were selling an apartment building. I asked them where it was, and they told me, duh, that I lived in an apartment there for over a year. But I did not remember it, back when I was 38. How embarrassing!

I only remember withdrawing from the university. When they asked me if I was going to return, with a deep sadness I said “No.”

Later I discovered that I had taken a senior level course in statistics, and made an A. I have no memory of any of the college courses. But I somehow knew that I realized I was experiencing cognitive decline, and that I could not finish that semester – just a few courses away from graduating.

At the time, I must have thought I was just getting old, but I was only 44. Later I realized that being electroshocked was destroying my brain. I must have realized this, but I must have felt that my depression was bad enough to override this realization. I just don't know and I don't remember.

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All through my memory there are holes where I don't remember the events of that time. I once went to the Grand Canyon – but I have no memory of it. I also have pictures of a trip I took with my family to Zion National Park. Not only do I not remember it, but I was surprised to see myself in the pictures, and saw that I was quite overweight then. I don't remember ever getting that heavy. There are also many happy memories that I don't remember.

Not only that time but many other times in my life have been forgotten. Since I was 20 I was a programmer for many major companies. So much of that I have only been able to piece together by looking at an old resume I found. Now I cannot write even simple programs. I have

trouble remembering facts, and my life is headed nowhere. I am disabled by my bipolar life and ECT, and I honestly feel I could never handle the demands of a job ever again. I am now 52. Fortunately, I have government help.

Somehow I remember this, but I don't remember much of anything else. My ECTs were administered by doctors who kept me returning for more because they addict you to anesthesia by very slowly injecting the propafol. I felt a wonderful high doing it that way. I do remember that I would always look forward to having that done. How dirty!

It's strange how amnesia works. I remember my high school days quite well. And I remember going to college at age 18 quite well – like yesterday. I still can write and type. And yet, after you receive an ECT you don't immediately think there is anything wrong. You retain memory of what you're doing currently with your life but it is only when you are asked (or ask yourself) what you were doing back then, or a friend says “Remember when ...”, that you realize you just cannot remember, no matter how hard you try.

Perhaps the worst thing that happens now is the ‘thought blocking’, where I think or talk and my mind just goes blank. So many times I am talking with someone and I'll say something like: “I once had a job where ... (long pause) duh, oh well, it's not important, forget it.”

I am able to write this only because I have to re-read the paragraph I was typing. But this problem leaves me with an inability to socialize, and, along with the anaesthesia, has distanced me from my old friends. Even though I tell them about what was done to me, to others I seem to be on illicit drugs or in a daze.

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All this saddens me. I am also mad about how my ECTs turned out. I estimated that I received more than twenty shocks before the final one, when this memory loss began. Yet I don't really know, because I can't remember the time when I was getting ECT. I did not know how much current was dished out by each shock, but it seemed like a lot. What damage was inflicted to my delicate brain! I was sold a bill of goods, and told this was the only way to relieve my depression.

This was all done at Cypress Creek Hospital in Houston. They still carry out ECT. We must do what we can to stop this insanity.

## ECT – The last torture in civilised society

Sharon Racklyeft

We used to set fire to witches. If they did not burn they were guilty. If they burned they were innocent. Many of these so-called witches might have been suffering from a mental disorder of some kind. But we had no other help for them so they burned.

Today in the 21st century we should know better but still we plug them in with no evidence that ECT

will do any good, but with sound evidence that it will do harm. As a survivor I know this is torture. At least the witches died but we live on, going through years of pain. Oh yes, they get signed consent, but only after we have been drugged out of our minds.

When will it stop?



## ECT: THE MYTH OF INFORMED CONSENT

Evelyn Scogin

*In 2004, at the age of 47, Evelyn Scogin had a successful career as a special education teacher. Then she found herself diagnosed with bipolar disorder and facing a life of endless drugs and electroshock. Rather than accept the diagnoses of the psychiatrist she began searching for alternatives.*

Informed consent is a legal process intended to inform the client and all concerned parties of the processes, costs, and possible risks of the procedure. Informed consent must include all of the following:

- The client or person signing the consent forms must not be under the influence of any kind of mind-altering substance. This includes any psychotropic drug patients are typically prescribed by psychiatrists. In addition the person must be able to read and understand the processes described to them, and the information must be presented to them in their primary language.
- The client must be given all of the information about their illness and all types of treatments for it. Then, in the case of electroconvulsive therapy, all of the procedures as well as possible risks and benefits must be explained.
- The client must be given time to consider the treatment. This crucial step is often skipped. In order to feel comfortable with their decisions, clients must have time to do their own research or get second opinions, and time to discuss all this with loved ones.
- After deciding, the client must feel comfortable saying 'No', either initially or rejecting the treatment at any time during the process. This means after they sign a consent form and the treatment has been started, clients have the right to revoke their consent.

These four steps are essential for the legal process of informed consent. But when we look at the consent process in relation to ECT the truth does not measure up to the myth.

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I was at a private psychiatric hospital when I was first approached by my psychiatrist about electro-convulsive therapy. I described the initial consent process with my psychiatrist, in my book: *Descent – A heroine's journey into the shadowlands of bipolar disorder*:

*What actually happened was that the psychiatrist told me*

*the drugs weren't working and the only course of treatment left to me was ECT or electroshock therapy. He told me it was painless and the only side effects 'might be' memory loss around the treatment time, but my memory would return soon after. He explained that for someone so hopelessly depressed, and with the drugs not working, this was the only treatment option left. I was led to believe that I would fully recover from the effects, and would go on to live a happy healthy life.*

I was in a psychiatric facility when this was presented to me. Since I was already under psychiatric care, I was taking multiple mind-altering drugs. Now that I am free of psychiatric drugs, I can tell you I was in no position to understand the processes being described to me. I was never told that there were any other dangers or side effects other than 'slight memory loss'. My family was aware of the treatment being offered to me but was no more informed of the risks than I was. Being at the hospital prevented me from doing my own research, and if I had asked for a second opinion I am sure whichever psychiatrist at the hospital talked to me would spout the exact same 'party line'. Feeling vulnerable and given no other option, I agreed to the treatment.

In my book I described the process of 'informed consent':

*A few minutes after we arrived, the nurse would come in and give me pills to take before the procedure. At first I was given just a couple of pills, and was told they were 'for reflux'. Later, more pills were added, but I was told the same thing. Each time I came for treatment I was given a stack of consent papers to sign and, just as when I went into the hospital, I signed them all. I am just guessing here but they probably told me what each of the forms were that I was consenting to, before my first treatment in the hospital. However, on subsequent visits, some of which I remember, the nurse just pointed to each place to sign, and I complied. One thing I do remember reading is that I was told not to sign or make contracts for several days after the treatment. Yet each time I was given this complex contract to sign. These 'consents' are important to the doctors and hospital as they are proof that I consented to everything that they did to me. I do remember that the consents and procedures were never explained to me by a doctor, only by nurses and attendants at the hospital. I still contend that I did not have fully informed consent to the procedures. After all, the doctors never told me that each time I went through the treatment they would have to increase the amount of shock, both in intensity and duration. Also they flat-out lied about my memory loss and returning to normal functioning. Plus my state of mind was severely disordered by all the drugs.*

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During this whole process I did not improve, only

deteriorated. I was unable to go anywhere alone, including to the mailbox at the apartment office. I lost all memory for the time of the treatment, and only with lots of therapy have I recovered a few of those memories. I lost memories of childhood and adulthood, never to retrieve them again. In fact, those memories are so long gone that until someone I know says “do you remember when ...”, I don’t even know that a memory was lost. For some time I had serious problems with word recall and learning new things. I had to work for years to teach myself again to write and speak coherently. I still to this day have problems with word recall, and I nearly always miswrite numbers and directions. Left and right are almost impossible for me to get correct.

After finishing ECT, friends helped me review my records and I found I was given at least thirty-one treatments in a six-month period, from January to July in 2005. The number of treatments is just a guess since my records have gaps and were not complete.

Through a review of my records I found several things I was not informed of. I was not told I had some cardiac irregularities and I should have been given a choice as to whether I wanted to continue my treatment. Research shows that patients with these abnormalities who are given

ECT are at a much greater risk of a heart attack or death. Also, my records showed that during one session I stopped breathing and when I started breathing again I still showed abnormalities. I had several physical problems during the time of my treatment. These were never addressed, and I was never told about: I had a very low potassium level, high blood sugar, high levels of blood in my urine, and anaemia, to name a few. As I write in my book:

*I have fought long and hard the last four years to recover from the effects of this abuse and rebuild my life. However, I will never recover the part of myself that was stolen from me with my memories.*

Informed consent is not secured by briefly parroting the company line, and not telling the patient about any problems cropping up during treatment. It has to be an ongoing and honest process between patient and doctor. Not only from my treatment but from talking to others who have undergone the treatment, it is clear to me that as far as ECT is concerned ‘informed consent’ is a myth: the doctors only tell patients what they feel is absolutely necessary, so as to satisfy the legal requirements. If patients like me were ever told the entire truth very few people would actually choose to go through this so-called treatment.



## SHOCK TREATMENT FOR AN EATING DISORDER?

Julie Greene

My own experience is not anything unusual, or let’s say, shocking or electrifying, but probably typical.

In 1996 I was electroshocked maybe thirty or forty times. I’d say some people count them and some don’t.

One day, while I lay on the table, about to be ‘put under’, they asked permission to switch from single-sided to bilateral.

Not really caring, I said “Yes”. After all, there was the needle, right in front of me, and all I could think of was how badly I wanted the thing to be over so I could get a drink of water.

I then recall the shock doc calling me at home and my boyfriend answering. He was, let’s say, shocked, cuz the shock doc asked him, “How is Julie?” And my boyfriend said, “She’s confused.”

The shock doc said, “Bring Julie in for more shock. She must be depressed.”

My boyfriend said, “No, Doc. You don’t understand. She’s confused from the shock treatments. Not depressed. You can’t keep on shocking her like this.”

But the doc kept insisting that my confusion was depression, and I should be brought right back in. My boyfriend was heartbroken but he felt powerless.

Even after they got it into their thick skulls that the shock was making me worse, I was confused for a full year and

a half. They mixed up this confusion with psychosis. They assumed I was a hopeless case. They treated me like a four-year-old and put me into kindergarten-like groups. I was rather put off by these insults to my intelligence. Finally, they decided that since I refused to sit in their groups, I must be incapable of being with my peers, so therefore I should go to the state hospital. They began to make arrangements.

I threatened suicide. They booted me out of their residence – which saved my life, ironically, because I was no longer doomed to the state hospital.

Within a couple of months of the confusion from shock treatments finally wearing off I began my first novel and started college. Five years later I graduated from college summa cum laude – the highest honors you can receive here in the US. I then went on to earn my Master’s degree, and have an MFA in creative writing. I have written seven books, and two are published.

My opinion, after more than three decades suffering unnecessarily at the hands of these idiots, is that there was never anything psychiatric wrong with me in the first place. I have an eating disorder. This is a physical condition, not a psychiatric disorder: it has more to do with malnutrition, and should be considered as such.

# ELECTROSHOCK

Mary Maddock

For nearly two decades I was a victim of what I now am aware was legalised torture.

I believe it was easier to become a psychiatric victim and be denied my right to be human because I am a woman.

I got my first bolt of electricity just three days after giving birth, on the 30th of January 1976. I continued to be electrocuted for the month of February and until the middle of March: twelve more times, while simultaneously being drugged into oblivion. The electrocution I received, without informed consent, was what is now called 'modified ECT'.

My capacity to be myself was severely diminished. I was transformed from a 28-year-old, happy, optimistic, musical woman into a person who could not think or feel. Electroshock damaged my brain and made it very difficult to be a first-time mother to my newborn daughter. I do not remember holding her in my arms for the first time. We were separated until June. My heart was broken. When we were finally united, the psychiatric system had succeeded in returning me to my family full of fear and suffering from the adverse effects of the psychotropic drugs I was prescribed.

In 1983 I received more sessions of electroshock, and eventually I was labelled 'manic depressive'. Unfortunately, this has now become a more acceptable label to many people by renaming it 'bipolar'. Renaming also seems to make it easier to label young children.

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Psychiatry diagnoses some human behaviour as 'mental illness', and electroshock is a major part of its toolkit. But psychiatry is fraudulent: it masquerades as a medical science but can offer very little scientific evidence for its remedies. Psychiatrists call electroshock 'treatment', but they have no idea how it 'works'. Yet every doctor is aware that electroshock produces a grand mal seizure and definitely causes brain damage – why else do general doctors regard spontaneous seizure as an emergency?

Today electroshock is on the increase worldwide. One of the main reasons given for the treatment is to prevent suicide. Really? For every male, two females are given shock treatment. And yet statistics show that significantly more men than women take their own lives.

Psychiatrists are very powerful people and their unproven beliefs are backed up by powerful companies which conduct false trials in order to convince the



public that black is white. They say that somehow today's electroshock is different from that I received in 1976 and 1983. Actually nothing has changed. I was under anaesthetic and unconscious and, as today, my epileptic fit was not visible. In fact today's 'modified ECT' may cause greater brain damage than before because more voltage is needed to cause the desired fit.

### What can be done?

The most terrible aspect of electroshock is that it is forced on innocent victims, and most commonly elderly women. The pursuit of power over others has caused untold human suffering. Psychiatry is able to destroy people's lives. CS Lewis wrote:

Of all tyrannies, a tyranny exercised for the good of its victims may be the most oppressive. It may be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end, for they do so with the approval of their own conscience.

It is vitally important that people speak out and take action to stop this barbaric practice. As well as *Asylum*, MindFreedom International and the Coalition Against Psychiatric Assault (CAPA) were an inspiration to me. MindFreedom organised a successful campaign to highlight the forced treatment of Ray Stanford and Elizabeth Ellis. It is currently running a

campaign of Actions to Stop Electroshock Human Rights Violations, and urges us to contact the World Health Organization, which says it has a new 'toolkit' on human rights and mental health. Officially, WHO opposes all involuntary electroshock – so you can ask what it is doing to make that a reality. You can use WHO's web form to comment, at: [bit.ly/who-web-form](http://bit.ly/who-web-form) or you can send a postcard or letter: WHO, Avenue Appia 20, 1211 Geneva 27, Switzerland.

At CAPA's Toronto Conference, in 2010, the following declaration was issued:

**Protest on ECT**

A PUBLIC demonstration against electro convulsive shock therapy (ECT) will be held in Cork on Sunday.

The first public demonstration in Ireland against the controversial therapy will be held on Sunday at 2pm in Daunt Square and has been organised by the human rights activist group MindFreedom Ireland.

A number of ECT survivors will address the demonstration which will also be attended by well-known disability campaigner MEP Kathy Sinnott and John McCarthy, Independent health candidate for Cork North Central in the upcoming general election.



1. WHEREAS research has established to a level of statistical significance that electroshock causes brain damage by causing seizure and through the electrical current, and indeed, that it does so in all its forms whether it be unilateral or bilateral, traditional pulse width or ultra brief pulse, whether it be called 'classical electroshock' or 'new modified electroshock';
2. WHEREAS electroshock always causes permanent memory loss;
3. WHEREAS electroshock frequently causes psychological trauma;
4. WHEREAS electroshock frequently causes permanent impairment and loss in creativity;
5. WHEREAS research establishes conclusively that electroshock is no more effective than placebo in alleviating depression or preventing suicide – the one effect which it is said to effectively address – and placebo causes none of the problems listed above;
6. WHEREAS despite decades of government committing themselves to informed consent, informed consent to electroshock remains a fiction;
7. WHEREAS electroshock disproportionately targets and discriminates against women, mothers diagnosed with 'post-partum depression', and elderly people;
8. WHEREAS many people experience electroshock as a serious violation of human rights, specifically as an assault on people's dignity and as cruel, inhuman and degrading treatment.

We the scholars, psychiatric survivors, students, and activists attending the PsychOut Conference, an international academic conference being held at the University of Toronto, May 7–8, 2010, some of whom have personally experienced electroshock and have been damaged by it, take the following position:

1. Electroshock is not a treatment which should in any way receive state financing or support.
2. We see governments as ethically obliged to stop funding electroshock.
3. We support provincial and state legislation everywhere whose purpose is to remove public funding for electroshock.

I was privileged to be present at that conference, and to present a workshop with shock recipient Linda Andre who had just published her excellent book *Doctors of Deception*. Being inspired by her work and that of Don Weitz, David Oaks and many others has motivated us in MindFreedom Ireland to hold what was Ireland's first public anti-shock protest in Cork, in May 2007. This was reported in the national press. We have since staged five more protests. The late Dr Michael Corry was a staunch ally in the campaign, which also included participation in national TV and radio programmes. Writing in 2008, Dr Corry described the use of electroshock as "... archaic, irrational and barbaric. It is a holocaust of the brain, a brutal Final Solution". In the most recent TV programme, in May 2012, MindFreedom Ireland activist Colette ni Dhuinneacha debated head to head with a representative of the Irish College of Psychiatry. She was more than able to refute his pro-shock arguments.

MindFreedom Ireland was also part of the Delete Article 59b Campaign. Organised by Dr Corry, Dr Pat Bracken and the late John McCarthy, this was to outlaw forced electroshock. It succeeded in having a private member's bill to that effect being introduced in the upper house of the Irish parliament. While the imminent revision of the 2001 Mental Health Act proposes to eliminate the word 'unwilling', regrettably it will still contain the word 'unable'. I believe this will make no practical difference.

Nevertheless, our campaign continues. Thanks to the internet, we have the advantage of a powerful tool to help us in our struggle. Our Facebook campaign to 'Stop the Forceful Use of Electro Convulsive Therapy' passed the 10,000 signature mark in 2013. The internet also facilitates the exchange of ideas, information and support, and it empowers us to combine to achieve a world in which my two granddaughters can live free from such an outdated and barbaric practice.

*Mary Maddock is 66, a retired music teacher and grandmother who lives in Cork. She is a founder member of MindFreedom Ireland and on the board of MindFreedom International. Her book, Soul Survivor: A personal encounter with psychiatry, is co-authored with her husband Jim, and was published by Asylum Books in 2006.*



# ECT ... & FIGHTING BACK

Deirdre Oliver

In 2000, after a catastrophic reaction to an SSRI, I was started on ECT by a panicking psychiatrist. Over twenty months I was given sixty-six treatments. My memory for this time is virtually extinct. However, I do remember four occasions when I withdrew consent. (Friends remember many more.) Each time I was threatened with being 'sectioned' (made an involuntary patient in a public hospital). This terrified me, and I was often physically manhandled into the ECT room. Pleading and begging got me nowhere.

Eventually, now labelled 'bipolar', I was 'rescued' by a psychiatrist from another clinic.

For me, the long term consequences of ECT were catastrophic. It took six months for me to recover well enough to begin to realise that whole sections of my autobiographical memory were gone. I have lost:

1. Memories of my children growing up: most of their achievements, graduations, sporting triumphs (they both became elite athletes).
2. My technical abilities as a successful sculptor (there were many works I didn't even recognise as mine), various successful sculpture exhibitions, solo and group.
3. The proposed publication of my first book. (I would forget to contact the editor.)
4. The first level of production of a movie series. (I forgot or didn't recognise my own work, or the producer.)
5. The first level production of a sitcom I had written. (I didn't, and still don't, remember that this was optioned by a production company which held major workshops with actors – which meant they were serious.)
6. I didn't even recall my professional acting career. (I was in *Neighbours* in the 1990's.)

Plus, plus, plus! All still lost. Nearly every time I talk to members of my family I find more that I've lost. As I tell my about-to-be-ex- but still current doctor, my life is a poorer place than it should be.

If there needs any more to be said, I now cannot write anything more than short stories because I have lost the organisational skills needed to produce a 75,000 word novel. Neuropsychology tests document this. But because I won prizes for my short stories, my current psychiatrist – who loves my creativity – says I haven't lost anything! So keen was she that three years ago she attempted to wipe that out, too, by persuading me to have twenty more ECT treatments. Why did I let her? I don't know. I've written nothing since.

I cannot 'get over' my rage and misery. Having ECT was, for me, like being raped, violated and demeaned. I feel terrible guilt and self-loathing that I couldn't stop it happening, that I 'allowed myself' to be treated that way. In fact I WAS once raped, and the helplessness and horror of that event was not as bad as ECT. I guess 86 times is a lot to get over.

As for the 'life-saving' effects of ECT, there is little

evidence to support this. In fact, in my case, I nearly died four times during ECT and four times after it. I spent a lot of time on life support. The ongoing anguish of suicidal thinking persists today. Yet in the preceding fifty-eight years of my life I made no attempt to commit suicide.

I think I fitted the bill as an extremely competent, high-performing, popular, well-liked woman, before ECT. Now, after losing so much of my life to psychiatry, that woman no longer exists. Since the beginning of 2013 I am about to dump the whole profession. This might seem strange when I tell you that back in the '70s I was a very good psychiatric nurse. I believed in the profession. NO MORE!

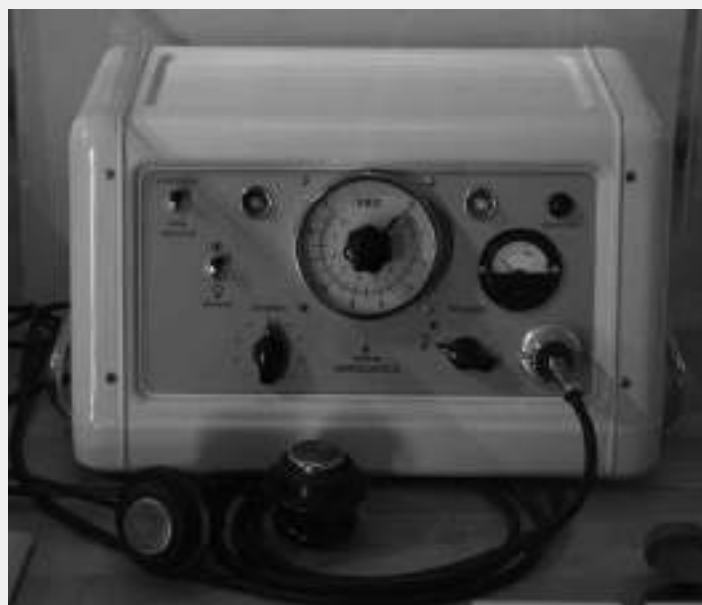
I now suffer from a severe post traumatic stress disorder.

- People should know how devastating ECT is.
- After ECT, people should realise that their awful residual distress may include PTSD which requires a specific type of help a bit different from normal depression (though this is a significant feature of PTSD).
- Psychiatrists lie about ECT, as well as about a lot of the drugs. Doctors should be prosecuted for incompetence if they claim ignorance of the appalling effects.
- I want somebody, anybody, to join me in setting up a lobby group to ban ECT, here in Australia and world-wide.

The lobby group should aim to include any doctors who also have issues with ECT. It is their voices that will do the most good.

A few years ago I actually did a telephone survey, ringing up fifty psychiatrists to ask if they ever prescribed ECT. I counted those who said 'hardly ever' as 'Yes', and those who said they did when young but never since as 'No'. Out of forty-eight responses, twenty-five said 'Yes' and 23 said 'No'. Where are these dissenting experts when we need them?

We have to remember that 'in order for evil to triumph, it just needs the good people to stay silent'.





# WHY IS ECT STILL IN USE?

Lin Bigwood

It is difficult to view ECT as anything other than a degrading spectacle, even though psychiatry cloaks the procedure in clinical benevolence. The doctor is invariably male and the patient is most likely female. The whole procedure smacks of sadomasochistic perversity, with the white-coated and all-powerful doctor and his white-coated attendants zapping electricity through the temples of a prone and unconscious form. As she convulses, nurses are supposed to gently hold the patient down. Then, just like general nursing, as the patient ‘comes round’ the nurses are required to reassure her and remind her who and where she is. However, in this case the patient not only has to recover from general anaesthetic but also from a blast of electricity through the brain. Patients experience headaches, loss of memory and depersonalisation, all of which can persist for days or longer.

For the so-called mental illnesses, there is no evidence in recovery rates to show that *any* medical intervention is significantly more effective than placebo. This is not surprising since any such disorder is *actually* caused by problems of living. It seems to me that when a medical treatment ‘seems to work’ on a patient’s emotional or mental malaise, rather than a genuine medical effect this is *just as likely* a placebo effect or the result of rest and recuperation or unintended (and unrecognised) psychological and social factors. Most psychiatric treatment is *a medical charade* which raises everyone’s hopes – only to dash them in the many instances where patients do not recover.

Discovery of the ‘efficacy’ of the major tranquillisers, the anti-depressants and shock treatment were each purely accidental. Unlike physical medicine, there is no theory to explain why any of those treatments ‘work’. There is no theoretical basis for shock treatment. All that is known is that it destroys brain cells. Just like with the widely used psychotropic drugs, for ECT there is good evidence that placebo works just as well as the ‘active agent’.

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As theory goes, in the 1930s it occurred to a certain psychiatrist that since there were apparently no epileptic schizophrenics and no schizophrenic epileptics the two diseases must be mutually exclusive. This led him to suppose that inducing fits in schizophrenic patients might

‘drive out the schizophrenia’. Initial experiments were with unpleasant drugs which induced convulsions. The psychiatric profession settled on insulin coma therapy. This brought the patient close to death. Against the experience of World War I, this did not seem barbaric. Of course, some patients did in fact die – and after a while, too many to justify the treatment.

Meanwhile, electricity was always fascinating to the medical profession. In the 19th century a few psychiatrists had already used shocks from electric eels to treat mental disorders, and later they used mechanically generated electricity. It fell to two psychiatrists in fascist Italy to happen to hear that pigs fitted before they died when being slaughtered with high voltage electrodes to the head. At first the use of electroshock with schizophrenic patients seemed curative since it exacted greater compliance. The technique became popular in the UK and USA when psychiatric services were overwhelmed with shell-shocked, battle-fatigued personnel during the Second World War. However, many ECT patients sustained fractured vertebrae and there were a questionable number of fatalities before muscle relaxants were introduced, in the 1950s.

Therapy as overt attack on the brain was very popular from the 1920s until the 1960s. A quite indiscriminate form of barbaric brain surgery became widespread during this period. Known as leucotomy or lobotomy, the idea was to sever nervous connections between the frontal lobe and the rest of the brain – to an extent which depended on the whim of the surgeon. (It is now known that ECT burns out brain cells in the frontal lobe.) As well as the risk of fatality, leucotomy causes various degrees of havoc to patients’ general mental functioning, sometimes disastrously.

Nowadays, ECT is modified by muscle relaxant and a general anaesthetic, so there is little sign of the grand mal fit. But the brain still suffers the same physical trauma. And in the meantime, since there seemed some evidence that the technique works for severe depression and none that it works for schizophrenia, by the 1970s ECT was being dropped as a therapy for schizophrenia and switched to therapy for severe depression. Insulin coma was abandoned long ago, but during the 1960s and ’70s narcosis therapy



became popular. By means of barbiturates, patients would be 'put to sleep' for maybe three weeks; occasionally they would be woken up and asked to talk about their dreams or thoughts. Since holding someone unconscious so long is a difficult procedure which in other circumstances demands the services of an intensive-care ward, the average psychiatric ward was not able to manage the situation very well, and this was also a dangerous treatment in which patients sometimes died. The few leucotomies still carried out are usually modified by the technique of inserting thin electrode probes so as to burn out more precise parts of the brain a little at a time, thereby monitoring a progressive assault on the brain tissue. However, none of these aggressive techniques has ever offered any unambiguously clear proof of cure. And it has long been known that placebo ECT registers the same efficacy as active treatment.<sup>1</sup>

\* \* \*

I was a nurse tutor in the mid-'80s and some student nurses came to me with their concerns for a young woman on an admission ward who was on 'maintenance' ECT. The patient was diagnosed with schizophrenia and was held on a long-term Section and given shock once a week, month after month. They wondered why she was being given that treatment at all, since ECT was initially used for schizophrenia but had fallen from favour when it did not seem to work for that diagnosis. (Nowadays it is generally used for severe depression.) The patient was terrified, fiercely resisted the treatment and was forced to submit. She continued to cry even under the anaesthetic.

The student nurses told me that they were very worried since the treatment seemed to do the patient no good and much harm. They also thought notice should be taken of her home circumstances. She would sometimes have home leave for an afternoon, and when she returned she always had a hand-written note which anyone would think had been written by someone with a serious mental health problem. The note was a report by her father on his daughter's behaviour during the home visit. I saw one. It was written in typically psychotic style, with a bizarre and inappropriate use of quotation marks, capitals and underlining. The content concerned the most mundane details of his daughter's behaviour. The student nurses realised that the father was fairly mad. All the same, this was ignored by the psychiatrist who determined that long-term weekly ECT was the appropriate treatment, against the patient's will and in the face of her pleading and tears.

\* \* \*

Every psychiatric nurse is expected to participate in the ECT procedure, at least during training. It is true that there was a decline in its use from the 1970s until about 2000, but now it appears that it is on the rise again. How could this be? There are a number of reasons but I suppose most add

up to the intuitive feeling amongst some family members, patients, and psychiatrists and psychiatric workers that electroshock is certainly a kind of *real medical intervention*.

Patients often complain about all the sitting around and chatting in psychiatric facilities. They say nothing is being done to make them better. Compared to the general air of relaxation and informality (or pointlessness), ECT seems like a real medical intervention with immediate effects. Shock treatment has a big placebo value. It is delivered by means of technical-looking apparatus in a clinical setting. All the staff wear a medical uniform, the patient is given a general anaesthetic and the whole thing has the appearance of an operation in a real hospital. The patient is given surgical-sounding reassurance beforehand: 'You are going to have an anaesthetic, you might feel groggy afterwards, but it will be no worse than a trip to the dentist ...'. As she convulses, nurses are supposed to gently hold the patient down. The mild convulsions are reminiscent of a shallow orgasm. Then, just like general nursing, as the patient 'comes round' the nurses are required to reassure her and remind her who and where she is.

However, in this case the patient not only has to recover from general anaesthetic but also from a blast of electricity through the brain. A desperate patient can take a lot of comfort from the idea of being an important individual case served by a team of experts who all seem to know what they are doing and use a lot of complicated-looking medical apparatus. But it is difficult to view ECT as anything other than a degrading spectacle, even though psychiatry cloaks the procedure in clinical benevolence. The doctor is invariably male and the patient is most likely female, and often old. The whole procedure smacks of sadomasochistic perversity, with the white-coated and all-powerful doctor and his white-coated attendants zapping electricity through the temples of a prone and unconscious woman. Patients experience headaches, loss of memory and depersonalisation, all of which can persist for days or longer.

ECT is a sickening procedure and there is no evidence for its efficacy.



1. See Phil Virden's article in this issue, p. 25.

# SHOCK IS PERSONAL & CRIMINAL<sup>1</sup>

Don Weitz

Carla McKague, Sue Clark-Wittenberg, Wendy Funk, Wayne Lax, and Mel Starkman are good friends – five of many Canadian shock survivors who have publicly and courageously spoken out against electroshock and want it banned. Their doctors lied to them, saying their ‘cognitive impairment’ was minor or temporary, or never even informed them of the common and serious risks of permanent memory loss and brain damage.

Carla is one of my closest friends. We lived and worked together for several years on *Phoenix Rising*, the only anti-psychiatry magazine in Canada. She is brilliant, widely respected lawyer who once specialized in mental health law but took a Master’s degree in mathematics. In the early 1960s, around the time of her divorce, Carla became understandably depressed and consulted a psychiatrist at Hamilton Psychiatric Hospital. After talking with her for only twenty minutes, he prescribed a series of fifteen shock treatments. Carla suffered permanent losses in memory, intellectual and musical abilities. In 2004, interviewed by Dr Bonnie Burstow, she said, “Huge chunks of my life are still missing. I’m not as smart as I used to be.”

Wendy is an author and pianist. About twenty years after undergoing more than forty involuntary shock treatments (in Lethbridge, Alberta, in 1989), she still cannot recall thirty years of her life. She has no memory of raising her children: the electroshocks totally erased those precious memories. They also ruined her promising social work career and dashed her hopes of going to law school. In 1998 Wendy published a gripping autobiography about her experiences of hospital, shock treatment and the courageous struggle to reclaim her life: *What Difference Does It Make?: Journey of a soul survivor*.

In Kenora, Ontario, Wayne Lax was subjected to at least eighty electroshocks and countless doses of psychiatric drugs over a twenty-year period (to treat alcoholism) – all against his will. Fifteen years after release from hospital, in 1992, Wayne still has major memory problems; sometimes he doesn’t recognize old friends he met in hospital.

Sue Clark-Wittenberg was 17 in 1973 when she was forcibly electro-shocked five times, in the former Brockville Psychiatric Hospital, Ontario. She was severely traumatized when nurses and attendants dragged her to the ECT room, screaming and resisting. Her heart stopped during one ‘treatment’ and she had to be revived. Today, Sue still has problems remembering, concentrating and learning. Nevertheless, she has become a powerful anti-shock activist and co-founder of the International Campaign to Ban Electroshock. She is also writing a book about her life.

Mel Starkman is a very close and long-time friend who, in Toronto in the 1960s, underwent more than thirty-eight shocks. In 2005, he told a shock panel at a public hearing organized by the Coalition Against Psychiatric Assault (CAPA) that the shock treatments terrified him and that he suffered severe and permanent memory loss. Like most other survivors who testified, he urged a total ban on electroshock.<sup>2</sup>

## Alternatives

Some people ask, “What are the alternatives to ECT?”

I feel like replying, “What’s the alternative to hitting your partner over the head with an iron bar? Stop beating her, stop shocking her!”

The fact that such a question is even asked is a pathetic commentary on the public’s ignorance. It indicates the power of psychiatry’s fraudulent medical model and of the pro-psychiatry ads in the mass media that continue to promote the lie of ‘safe and effective ECT and medication’. However, the media almost never mention the safe and humane alternatives to electroshock: peer counseling, safe supportive houses, crisis centres, advocacy groups, trauma centres and healing houses – especially for women shock survivors. Unfortunately, the last two do not exist in Canada.

When people ask me, “What can I do to help stop electroshock?” I offer these practical suggestions.

*If you’re a shock survivor, psychiatric survivor, anti-psychiatry or social justice activist:*

- Get together and network with other survivors, relatives of survivors, activists and allies
- Organize educational workshops, public forums or town hall meetings, rallies, marches, and demonstrations against electroshock in your community or city
- Organize anti-shock demonstrations at annual meetings of a local psychiatric association, the Canadian Psychiatric Association, the American Psychiatric Association, or the World Psychiatric Association
- Help organize or participate in anti-shock protests in front of ‘shock mills’ – psychiatric hospitals or mental health centres where shock is frequently administered
- Tell your shock story to a newspaper, radio and TV reporter or editor
- Write and publish your personal shock story and post or blog it on survivor and anti-shock websites: [coalitionagainstoppsychiatricassault.wordpress.com](http://coalitionagainstoppsychiatricassault.wordpress.com), [ect.org](http://ect.org), [endofshock.com](http://endofshock.com), [geocities.com/sueclark2001ca](http://geocities.com/sueclark2001ca)

*If you are a health professional:*

- Refuse to participate in ECT in your hospital, mental health centre or clinic
- Organize a support or discussion group of doctors, nurses and social workers who oppose ECT. Focus on risks and alternatives
- Be a whistleblower. See [www.allhealthcare.monster.com/benefits/articles/2824-should-nurses-blow-the-whistle](http://www.allhealthcare.monster.com/benefits/articles/2824-should-nurses-blow-the-whistle)
- Invite shock survivors as guest speakers
- Publicly question or challenge psychiatrists’ claims about ‘the safety and effectiveness’ of ECT
- Read personal accounts by shock survivors
- Urge your professional association or union to endorse or support public forums and protests against electroshock

If you are a concerned citizen, 'senior' or student, you can get involved by taking these actions:

- Write letters to the editor and op-ed pieces to combat pro-shock articles
- Help organize a letter-writing campaign or anti-shock petition; mail them to MPs or state representatives, local and national health bosses, the Minister of Health, etc
- Lobby national and international human rights organizations including Amnesty International, Human Rights Watch, and the United Nations Committee Against Torture. Urge them to publicly condemn electroshock as a serious violation of human rights, as torture and 'cruel and unusual punishment'
- Urge doctors and nurses and their professional organizations to publicly call for a moratorium or ban on electroshock
- Urge your college or university to organize public seminars or teach-ins on electroshock. Urge them to sponsor or endorse local, national, or international conferences that recommend a moratorium or ban on ECT
- Lobby local and national health bosses and health critics to introduce bills to abolish electroshock

**"ECT is a crime against humanity and must end now."**

Sue Clark-Wittenberg at the public protest,  
Mother's Day 2008, Parliament Hill, Ottawa.

Although electroshock has been regulated and restricted in some 30 of the US states and in perhaps one or two European countries, no country has officially banned or declared a moratorium on it. In Canada [and the UK] electroshock is legal and prescribed everywhere. Nevertheless, I am convinced that electroshock will be banned some day.

Achieving a national or international ban or moratorium on electroshock will take much more public education and organizing at grassroots, local, provincial, state and national levels, and many more public rallies, demonstrations and protests. Getting a shock ban demands the commitment of many thousands of health professionals, including neurologists – who know more about the destructive effects of convulsions



and seizures and brain damage than psychiatrists. It's time they spoke out: so far they've been silent.

Physicians, nurses, social workers and patient advocates must all get involved in the anti-shock movement. Health professionals, lawyers, and bio-ethicists must break their long and shameful silence to publicly denounce electroshock as a serious violation of medical ethics, particularly of informed consent and human rights. Don't wait for governments to pass 'whistleblower' laws, although that would certainly help.

Achieving a ban will also demand the personal commitment and direct action (including non-violent civil disobedience) of thousands of psychiatric survivors, anti-psychiatry activists, social justice and human rights activists and dissident health professionals who understand that electroshock is a brutal, brain-damaging psychiatric procedure, and a serious human rights violation.

**Let's start working together to end electroshock now!  
Then let's organize to get rid of the coercive,  
dehumanizing and tyrannical psychiatric system!**

*Don Weitz is an insulin shock survivor, antipsychiatry activist and writer who lives in Toronto. He has been active in the anti-shock and antipsychiatry movements for more than 30 years. With Carla McKague, he co-founded the antipsychiatry magazine Phoenix Rising (1980–1990), and with Dr Bonnie Burstow he co-edited Shrink Resistant: The struggle against psychiatry in Canada (1988). He is author of the e-book Rise Up/Fight Back: Selected writings of an antipsychiatry activist. For more than ten years, Don was host and producer of Antipsychiatry Radio, on CKLN.*

*Don is currently active in the Coalition Against Psychiatric Assault (CAPA), and is a member of the boards of Psychiatric Survivor Archives of Toronto, and the Ontario Coalition Against Poverty.*

#### Notes

1. This article is excerpted from my e-book *Rise Up/Fight Back: Selected Writings of an Antipsychiatry Activist* (2012).
2. For testimonies of these and other shock survivors, see [www.coalitionagainstpsychiatricassault.wordpress.com](http://www.coalitionagainstpsychiatricassault.wordpress.com) Click on: 'Articles', and 'Personal Testimonies'.

# Extracts from Peter Breggin's Blog in *The Huffington Post*

## **ELECTROSHOCK FOR CHILDREN & INVOLUNTARY ADULTS**

30 January 2009

In America involuntary adults are being shocked despite the best efforts of psychiatric reformers (Oaks, 2009, references, at the end of article and on website: [www.breggin.com](http://www.breggin.com)). And in Victoria, Australia, psychiatrists have taken shock treatment to a new level of barbarity by shocking 55 toddlers aged four and younger (Hale, 2009).

The controversy over shocking children has a long history. In 2000, Steve Baldwin (then a professor of psychology in Australia) and his co-author Melissa Oxlade wrote a book reviewing and condemning the practice throughout the world.

Shock advocates have proven impervious to science and to public criticism. Like men who beat their wives and abuse their children, shock doctors escalate their violence when criticized. Like other abusers, criticism by itself will not stop them. Shock treatment must be banned. We can begin by banning it on involuntary adults and on children.

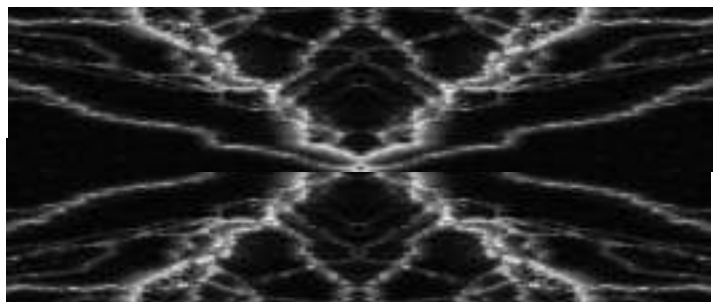
I began writing about this abusive practice thirty-odd years ago when I published the first and only medical book devoted to looking at the damaging effects of this treatment (Breggin, 1979). I have written scientific articles on the damaging effects of ECT (Breggin, 1998) and updated the scientific facts in my medical book, *Brain-Disabling Treatments in Psychiatry: Drugs, electroshock and the psychopharmaceutical complex* (2008).

I have not been alone in criticizing the 'treatment' as "wholly ineffective" (Ross, 2006) and as dangerous. One heroic shock survivor, Leonard Frank, spent decades re-educating himself and learning to live with long-term harmful effects. He devoted himself to reform in psychiatry, and even to writing one of the best scientific critiques of ECT (Frank, 1990).

Lately, doctors who recommend or carry out ECT have been taking heat in US courts. In South Carolina, in June 2005, I was the medical expert in the first ever malpractice trial in which a jury found a doctor negligent for referring a patient for ECT (see [breggin.com](http://breggin.com)). Not long ago, I was the medical expert in a malpractice case that was settled for a very large sum. It involved a man whose life was ruined by considerably more than 100 treatments (a huge number!) over a two-year period.

Meanwhile, the shock advocates themselves have published a long-term follow-up of patients treated with electroshock and found massive harm to the brain and mind, including persistent dementia (Sackeim et al, 2007). How have the shock doctors responded to the latest confirmation that their treatment destroys the brain and mind? Not a single one has expressed any caution following the publication of the study. As we now see, they have pressed harder to enforce it on children and involuntary adults.

Shock treatment has been going since 1938. It's about time to put a stop to it, once and for all.



## **NEW STUDY CONFIRMS ECT CAUSES BRAIN DAMAGE**

9 April 2012

A new study shows electroconvulsive therapy causes brain damage? That's not what you will find in the many promotional press releases published in the mainstream media. As usual, biopsychiatric press releases always come out before the research articles are easily available, making critical analysis impossible until the wave of false promotional euphoria has passed. *Fox News'* headline for the Reuters news story said: "Study shows how electrotherapy may treat depression."

Media coverage was unquestioning and wholly positive. ECT is touted as the best treatment for depression and we are told that science has finally, after more than seventy years, found out how it works. The method used was bilateral ECT – the most grossly damaging and most commonly used form of the treatment. Both electrodes are placed over the temples, overlapping the frontal lobes of the brain. The most intensive surge of electricity hits the memory centers in the tip of the temporal lobes and affects the highest human functions in the frontal lobes.

The title of the research paper actually tells the story:

“Electroconvulsive therapy reduces frontal cortical connectivity in severe depressive disorder.” The specific area is the ‘dorsolateral prefrontal cortical region’. This is the same area assaulted by surgical lobotomy. It contains nerve trunks connecting the rest of the brain with the frontal lobes – the seat of our capacity to be thoughtful, insightful, loving, and creative. Think of what it takes to be a person: all of that requires the unimpaired functioning and connectivity of the frontal lobes of your brain.

Using a functional MRI in nine patients, the authors of the study conclude: “Our results show that ECT has lasting effects on the functional architecture of the brain.” The result of these lasting effects is “decrease in functional connectivity” with other parts of the brain. In other words, the frontal lobes are cut off from the rest of the brain. The authors call this “disconnectivity”. Does this sound familiar? It is a “lasting” frontal lobotomy.

This new study contradicts claims by shock advocates such as psychiatrist David Healy that ECT *does not* cause brain damage.

The report argues that this ECT effect supports the idea that depressive patients have too much activity in their frontal lobes and are returned to normal by damaging the offending area of the brain. Psychiatry frequently takes this position. For example, antipsychotic drugs (which four of the nine patients were taking) also reduce the function of the frontal lobes, in this case by suppressing the main trunk nerves from deeper in the brain to the frontal lobes (dopamine neurotransmission). Proponents of the drugs then claim that the patients have an excess of activity in these nerve trunks, so that the patient is helped by damaging the region.

The word ‘damage’ is never used in this study. But what else are these “lasting effects on the functional architecture of the brain”, other than a manifestation of ECT-induced brain damage in the before and after shock treatment MRIs that were done?

The study is so poorly reported that we only know that the MRIs were conducted sometime ‘after’ – presumably very soon after the ECT. We can only hope that these victims of ECT will recover with time, but the most extensive long-term follow-up study indicates that most ECT patients will never recover from the damage, in the form of persistent severe mental deficits.

Since the patients had all been heavily medicated in the past, and were continued on medications and given anaesthesia during the ECT, a combination of traumatic effects probably complicate and add to the brain damage to the frontal lobes.

For a long time now, I have been scientifically demonstrating that ECT is a closed-head injury in the form of an electrical lobotomy. Now we find that the ECT damage is sufficiently gross to show up on an MRI – but we are told it’s good for the patients. This is what I call ‘the brain-

disabling principle of psychiatric treatment’. Lobotomy, ECT and psychiatric drugs all share the common factor that they ‘work’ by damaging the brain and suppressing brain function.

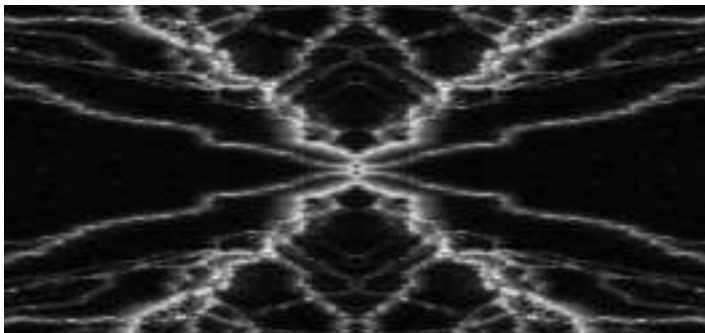
The authors of the study note that antidepressants probably work by doing the same thing – producing “disconnectivity” between emotion-regulating centers in the brain.

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From its inception, psychiatry has promoted brain damage as treatment. Nothing has changed in this regard except the arguments are more subtle, and lobotomy is now being called “disconnectivity”.

The authors here argue that the patients are helped because they do better on a checklist of depressive symptoms. In this study, the checklist was administered after the last ECT, when the patient’s brain is most acutely disturbed and the individual is frequently disoriented and even delirious. It would be similar to giving a psychological test to someone right after a very severe series of concussions.

After brain injury – especially to the highest centers, which express emotional awareness, self-insight, and judgment – individuals stop reporting their upset or distressing feelings. They have either lost awareness or they are too apathetic to care anymore. That, again, is the lobotomy effect. Apathy and indifference is the final result of all of the most potent psychiatric treatments.



## **UK STEALTH ECT PSYCHIATRIST IN THE MOVEMENT FOR PSYCHIATRIC REFORM**

16 February 2012

When I was a college freshman I got to see shock treatment. Patients were brought into the shock room led by burly aids and strapped down on the shock table.

Before the shock, the patients were sometimes depressed, sometimes extremely anxious, frequently terrified, and on occasion physically resistant. They were individual people with feelings and willpower. After being held down and driven into a seizure by a jolt of electricity, they always came out the same – confused, disoriented, and helpless, like

victims of head injury – and always they became docile and manageable. The ‘most difficult patient’ was always easily led away to languish on the ward. Concussive-like head injury, especially involving electrical trauma to our frontal lobes, makes us all alike in our vulnerability.

As described in my book, *Toxic Psychiatry*, I asked one of the psychiatrists how shocking the patients could possibly be helping them and he replied: “Shock kills bad brain cells.”

At the age of 18, witnessing this barbarity helped transform me into a psychiatric reformer.

Soon after I became a psychiatrist I discovered that lobotomy was making a comeback. It was the early 1970s, and I took four years out of my life to carry on a successful international campaign to stop lobotomy. It was my baptism into the maelstrom of psychiatric reform. I knew that lobotomy and shock (now called electroconvulsive therapy or ECT) were nearly one in the same – both assaults on the highest centers of the brain, one with scalpels and hot electrodes, the other with searing jolts of electricity.

Eventually, I took on ECT. My first published medical book became the first and still the only medical book critical of ECT: *Electroshock: Its brain disabling effects* (1979). The basic science in that book would be updated over the years.

In the early stages of my reform work in the 1970s, I discovered how and why these treatments had always gone unchallenged within the profession. There is a secret psychiatric code: You do your thing, and I’ll do mine, and we’ll never criticize each other ...

Probably the leading proponent of shock in the world today is the psychiatrist, David Healy. With Edward Shorter, a Canadian, in 2007 he published one of the few recent books to unabashedly promote ECT: *Shock Therapy: A history of convulsive treatment in mental illness*. They state: “the charge of brain damage from ECT is an urban myth” (p. 3) and “Therapeutic convulsions induced by electricity, by contrast [to epilepsy], do not harm the brain and can save lives” (p. 9). The statement, “ECT really does work in illnesses where drugs fail” (p. 7) connects to Healy’s work criticizing drugs.

Later, Healy (2008) wrote “ECT rarely, if ever, causes clear clinical evidence of brain damage and has not been shown to do so in animal studies.” He said, “critics have found it difficult to demonstrate memory or other cognitive problems that endure beyond three months.” And Dr Healy declared “ECT is the most effective treatment for severe depressive disorder.”

Healy is selling ECT as a replacement for antidepressants. There was no mention of human service, caring approaches, such as psychotherapy or family therapy, or even of exercise (which has also proven as effective as or more effective than antidepressants). He also failed to mention that placebo has proven as effective as or more effective than both

antidepressants and ECT – obviously without producing any brain damage.

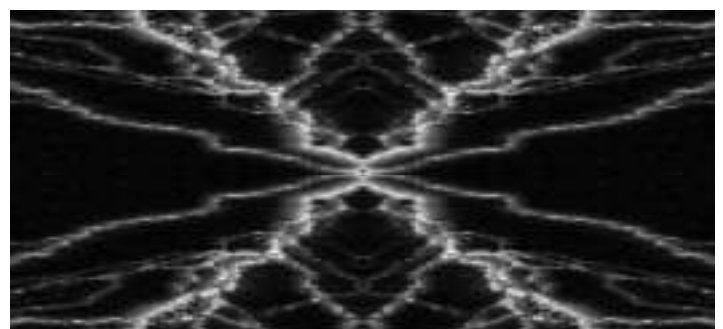
However, the damaging effects of ECT have been well documented for decades. Healy sees himself as a psychiatric reformer. I’ve never thought in terms of litmus tests, but if we were to have one litmus test for inclusion in psychiatric reform, it might be this:

“Thou shalt not shock and lobotomize people.”

Remember the haunting moral question we must always ask ourselves about atrocities? In this case: “Where was I when they came for the shock patients?”

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# CARRIE BURNS

KB

I am a psychiatric survivor.

In 1999 I was given Paxil for panic attacks, and it turned me into a suicidal, very physically ill person. I had been curled up in my parents' bed, sucking my thumb, praying to God to kill me during my ordeal, from August 1999 to the beginning of 2000. In January of 2000 I woke up and everything was just completely destroyed in me. After multiple drug cocktails to fix what Paxil had broken, I resorted to ECT and had eight treatments.

My life has been a nightmare ever since, with severe mood swings, memory problems, attention deficits, constant therapy, doctors, naturopathic physicians, etc. I have made 41 attempts to get back to work. I was never able to last very long at most of these jobs, and when I actually stayed somewhere I was frequently absent, suffered severe headaches that made me throw up, and had so many mood problems. I have experienced severe anxiety and drastic personality changes, and what my therapist says is PTSD.

Since then I have felt like someone switched off my life when it was going normal and then turned it back on and everything was different, like a parallel universe. I have never felt the same, and everything around me has felt different, less rich, less real.

Despite once being known as 'gifted', I have never been able to advance because I simply cannot retain the amounts of new information to be truly successful at any job. I tried to do grad school but had to drop out.

No one ever told me I should have been on disability benefits. I tried to sue, but I was told the statute of limitations had passed, three years after the treatments. I have been unsuccessful at getting anywhere with class action lawsuits.

I didn't find out about disability benefits until 2008. I tried to hold out, and tried again and again to work, until the end of 2009 when I finally filed for benefits. I finally had the hearing in August 2012. I had to represent myself because my lawyer dropped my case after not bothering to find the medical records and not even trying to go to my hearing – which he had done to me in February and then again in May. I could not find any legal representation because the hearing was too close by then, so I also had to deal with that.

I hate those people for ruining my fucking life and taking away the career I would have had, and the life I would have had if I hadn't been like this. Because I was never depressed until after Paxil and ECT. All I had were some panic attacks. Since then I have periods of severe depression and a constant anxiety that I feel will never go away. And I want to go home and home doesn't exist. I want to be Her again – who I was before. But she's dead. And I want her back and I can't. I am a mess. I feel damaged. I feel sick and sad and utterly exhausted from trying to meet expectations I can't meet.

That is my story. I had to reach out. I hope they stop this someday. And stop wrecking people's lives. God help us all.

## MAYDAY – Doctors Who Can't Wait<sup>1</sup>

(For Elizabeth Ellis and all other courageous women shock survivors – my sisters)

Wake up everybody  
it's shock day every monday-wednesday-friday  
in psychoprison Anoka  
where 67-year-old Elizabeth Ellis  
waits in silence, refuses to talk to  
doctors who can't wait  
to label her 'catatonic'  
doctors who can't wait  
to fire 200 volts  
into her fragile aging brain  
doctors who can't wait  
to perform electrical lobotomies on her sisters  
doctors who can't wait  
to commit elder abuse  
doctors who can't wait  
to commit psychiatric rape  
doctors who can't wait  
to conspire with sons and husbands  
to lock up and shock  
daughters, mothers, grandmothers, wives  
doctors who can't wait  
to traumatize, re-traumatize, stigmatize  
women labeled  
depressed  
bipolar  
manic  
histrionic  
schizophrenic  
post-partum  
premenstrual dysphoric disorder  
doctors who can't wait  
to erase memories – 'side effects', collateral damage  
doctors who can't wait  
to damage brains,  
doctors who can't wait  
to destroy careers and lives  
your daughter  
your sister  
your girlfriend  
your mother  
your grandmother could be next  
doctors who can't wait  
to silence voices of 'noncompliant patients', freedom fighters  
doctors who can't wait  
to con health ministers to fund shock mills  
like Anoka, CAMH, Riverview, Bellevue, McLean, Langley-  
Porter, Rockland State,  
doctors who can't wait  
to lie to patients, prisoners, families, lawyers, reporters  
about 'safe, effective and lifesaving ECT'  
to a disinterested disconnected world  
ignorant, betrayed, brainwashed by  
nazis in white coats who torture  
in the name of *DSM* and ECT  
who torture/lie/cover up in the name of mental health  
time to rise up, fight back  
against psychiatric fascism  
MAYDAY! MAYDAY!

1. Mayday – M'aidez – Help! Distress call sent by captains of ships or planes about to sink or crash. Poem revised and expanded. First read at the May-works Poetry Marathon, May 1, 2011, and at another anti-shock protest, Stop Shocking Our Mothers and Grandmothers, May 7, 2011, Toronto.



# ECT: 'THERAPY' BY HARM

Phil Virden

## BRAIN DAMAGE IS THE INTENTION, NOT A 'SIDE EFFECT'

Perhaps the successes of psychiatry have always been no more than the product of humane care and placebo, and *in spite of* whatever damage is wreaked by the purportedly medical techniques. In the case of shock treatment the damage is not trivial. However, this harm is conceived as *directly therapeutic*. Psychiatrists and their textbooks do not clearly announce that idea – it is too shocking – but it can only be assumed that their theory is: the greater the organic damage to the preferred site within the brain, the more effective the remedy.

In 1998, 65% of a sample of UK consultants said that it was their treatment of choice when dealing with a depressive illness with a high risk of suicide, and 89% chose it for a depressive illness with a refusal to eat or drink.<sup>1</sup> It is also often the treatment of choice with puerperal depression (following childbirth) when the life of both the mother and the baby are at stake. This 'pragmatic' resort to ECT is endorsed even by some liberal psychiatrists. Prof Alec Jenner co-founded *Asylum* magazine, and practised psychiatry for fifty years. In 1999 he said:

I came to the conclusion that in a limited way ECT does work, but only in very special circumstances. Of course there have been campaigns against its use and it is given far less often now. I didn't use it once in the last five years of my clinical practice, because I didn't feel it was needed. I avoided it like the plague because I thought it was a very crude solution to a human problem.

I do not think ECT should be rushed into. When I began in psychiatry ECT would be given routinely, and if it didn't work – *then* we would speak to the patient! Its use has been moderated, but I do think it's still far too much over-used. But I was opposed to a total ban. During the last five years when I didn't use it at all, one woman was in a dreadful state and all the staff wanted her to be given ECT. They said I was just letting my ideology stand in the way of treating the lady. So, democratically, it was agreed that she should be given ECT. But she couldn't sign the forms and her relations wouldn't sign them, so we had to wait to get a second

opinion from outside Sheffield. That was going to take a week or so. The day before the other psychiatrist was due to arrive she suddenly got better!

This also illustrates the great difficulty in making confident decisions. I strongly advise humility in the face of psychiatric disorder.<sup>2</sup>

\*\*\*

The only beneficial effect of shock treatment which has been reported with any reliability, for some patients, is the remission of their symptoms for a month or so. This is for some patients in a condition of deep and almost psychotic depression, who are perhaps insomniac and have lost the will to eat and live. However, electroshock is actually employed

more generally than that. It is cheap and easy to carry out. And it is used disproportionately on women and the elderly. That indicates the possibility of an unacknowledged and systematic social abuse – a pseudo-medical 'quick fix' rather than a level-headed and equitable use.

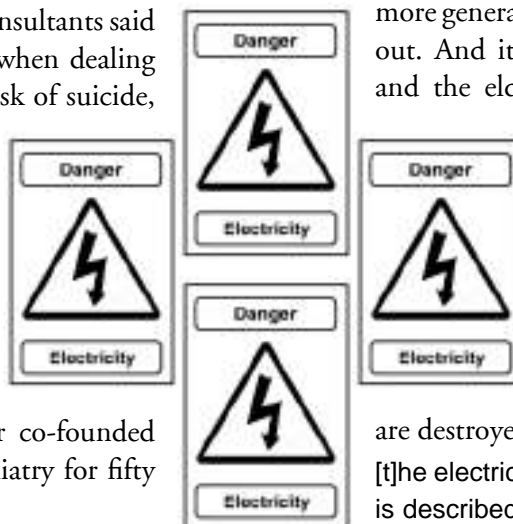
The only thing certainly known about how it works, as discovered by autopsy, is that there is often haemorrhaging and that brain cells are destroyed. This is not surprising since:

[t]he electrical activity of human brain nerve cells is described in millivolts, or one-thousandth of a volt (0.001 volt). Nerve firings are on the order

of 50–100 millivolts (0.050-0.1 volt). It is now clear that other means of brain cell communication (sometimes called 'electrotonic communication') operate on fractions of a millivolt or one-tenth of a millivolt (0.0001 volt). ECT consists of 'shooting' approximately 120 volts through a person's skull and brain. Other factors bearing on the electrical reaction are amperage, skull resistance, and duration and type of current used ... All this supposes the ECT machine is working properly.

Comparing ECT's 120 [or more] volts to the brain's natural .0001–.001 volts, and given the extraordinarily sensitive electro-chemical nature of the human brain, it is not difficult to realise the gross overkill of ECT ... [which] is a form of electrical brain-burn and short-circuiting, and that electrical destruction and damage in some degree cannot be avoided ...

Thus ECT damages, and most likely destroys,



1. Benbow, SM et al (1998) Electroconvulsive therapy practice in North-West England. *Psychiatric Bulletin*, 22, 226–9.

2. Jenner, FA (2008) Working as a psychiatrist. Ch 8 in Virden, P et al *Psychiatry – The alternative textbook*. Asylum Books.

brain cells with every shock. These cells, unlike those in the skin, bone or liver, have a limited ability to repair and reconstruct themselves. Every electric shock treatment damages the blood-brain barrier, as the brain's blood vessels take the brunt of the electrical assault. This causes haemorrhaging in the brain and a massive release of natural brain neurotransmitter chemicals. These effects manifest themselves in the totally confused, disoriented, and 'wiped out' condition of the person being shocked.

The personal testimony of many who have undergone shock treatment attests to the fact that it can and does cause permanent memory loss. Languages, special skills, recollections of personal experiences can be blotted out of the mind as if an eraser had swept across a blackboard.

Despite the psychiatric party-line – that ECT causes only temporary memory loss and no permanent memory or intellectual loss – there is no hard evidence to back up these claims.<sup>3</sup>

Even one or two ECT treatments risk limbic damage in the brain leading to retarded speed, co-ordination, handwriting, concentration, attention span, memory, response flexibility, retention, and re-education. On the psychological side, fear of ECT has produced stress ulcers, renal disease, confusion, amnesic withdrawal, and resistance to re-educative or psychological therapy. The research thus indicated that ECT was a slower-acting lobotomy with the added complications of shock-induced terror. As with lobotomy, it facilitated custody, but it damaged therapy. For the sake of the patient's present (or the staff's), his future was sacrificed.<sup>4</sup>

There are various first-hand accounts of undergoing ECT, but what is frightening, and indicative of the general attitude of conventional psychiatry towards its patients, is that very little research has ever solicited patients' subjective responses to shock treatment, or treated them seriously when it has done so.<sup>5</sup> But of course: according to the medical model, someone who 'has a mental illness' is the last person to be trusted to evaluate therapy.

3. Richman, DL (1978) Brain burns. In Frank, LR (Ed) *The History of Shock Treatment*. San Francisco: LR Frank, p. 136.

4. Morgan, RF (1966/78) The isolation, description and treatment of the pathological behaviour of ECT-damaged patients. Unpublished thesis, quoted in Frank, LR, op. cit., p. 77.

5. For example: Weeks, D, Freeman, CPL & Kendell, RE (1980) ECT: III: Enduring cognitive deficits? *British Journal of Psychiatry*, 137, 8–37. This study reports hitherto hidden evidence of deaths by ECT, solicited patients' experiences and feelings about treatment, found enduring cognitive impairment and fear – and then proceeds to discount the patients' responses as irrelevant.

## WHO GETS ECT?

These days ECT is used mainly to treat severe depression, and mostly the elderly: those over the age of 40 are much more likely to be given the treatment, and mostly those between the ages of 61 and 80. Women are more than twice as likely as men to be given ECT. Research shows that it is often given to those who actually have good cause to be depressed due to serious physical problems. It also seems that electroshock is too often employed without taking into full account the individual's medical history, such as, for example, giving proper consideration to the physical and social changes a woman undergoes from middle-age, and the effect they might have on her mental condition. Although only a small proportion of patients are not already medicated, and even though doctors assume that medication increases the dangers, the combination of drugs and ECT is poorly researched.

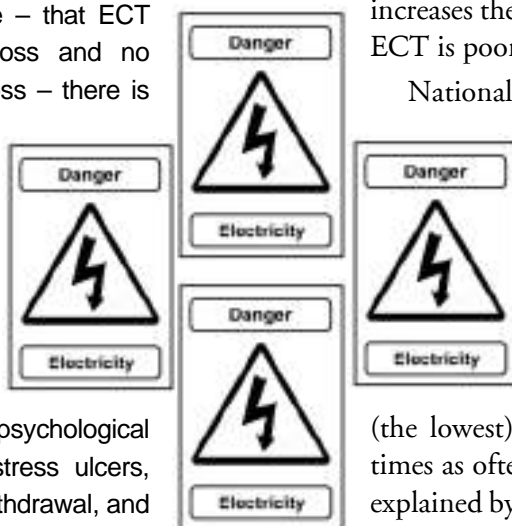
National statistics are not regularly collected but in 1979 a Royal College of Psychiatrists study found 200,000 individual ECTs were administered in the UK. There were great differences between regions and different facilities. Psychiatric patients in Yorkshire (the highest use) were three times as likely to get ECT as those of Oxfordshire (the lowest). Some hospitals gave ECT seventeen times as often as others. These differences were not explained by any obvious links to socio-economic or demographic factors: they seemed to depend on the whim of whichever doctor held psychiatric power in each locality.<sup>6</sup>

By 1986, 139,000 uses of ECT were recorded for England alone: it was given to one in four inpatients. In the UK in the mid-1990s 20,000 psychiatric patients per year – still one in four of those hospitalised – were given at least five ECT shocks during the year. And whilst most were nominally voluntary treatments, some 3,000 patients were treated with electroshock against their will. By 2003 numbers receiving shock had fallen to about 9,000, of which 1,500 patients were compulsorily treated.

Nowadays the Care Quality Commission (CQC) monitors the operation of the Mental Health Act and its amendments. Its *Annual Report* contains brief statistics and comments on the use of ECT – but only on patients considered incapable of making a decision about ECT (most likely they resisted it?) and therefore treated without their formal consent.

The CQC has a panel of psychiatrists (second opinion appointed doctors: SOADs) who approve treatment.

6. Pippard, P & Ellam, L (1981) *Electroconvulsive Treatment in Great Britain, 1980: A report to the Royal College of Psychiatrists*. London: Gaskell, p. 108.



SOADs very seldom withhold approval for ECT, so the number of SOAD visits is nowadays the best approximation we can get to the number of people actually getting ECT without their consent. According to the 2013 *Report* for England, during 2011–12 about one quarter of the patients had already been given at least one ECT treatment before the SOAD visit, and there were 1,006 completed SOAD visits. This was a slight increase (about 3%) on the previous year. But the latest CQC Report (for 2012–13) shows 1,464 completed visits from SOADs. This is an increase of about 20% over the previous year.

The *Report* for 2011–12 shows that more than 85% of those treated with ECT without their consent were women. The latest report gives no details about the people who receive ECT without their consent – nothing about age, sex, whether or not they objected to the treatment, nor whether the ECT course had been started before the visit from the CQC (something that had happened for about a quarter of the patients according to a previous CQC annual report).

Over the past thirty years the use of ECT on consenting patients in England has apparently decreased by about 80%. But its use on people deemed unable to give consent has not shown such a significant decrease. And this sudden increase is not explained in the CQC Report.

In 2012 The Board of Community Health Councils published a report on the use of ECT in Wales. It said ECT was “a treatment utilised for a small number of severe mental illnesses ... Approximately 360 patients underwent ECT during the years 2010 and 2011, 70% of were female.” The report did not specify how many had the treatment without consenting.<sup>7</sup>

MIND recently found a depressingly high use of the emergency powers permitting shock treatment without a second opinion. In its study, electroshock was also used in a surprising 20% of the cases of sectioning (compulsory hospitalisation and treatment). Neither are children exempted.

Although apologists say that ECT is used only as a last resort – as was advised in 2003 by NICE Guidelines – a survey at the end of the 20th century found that almost 18% of those receiving ECT had not been offered *any* other treatment, and that only just over 15% of the sample had ever received any kind of counselling or psychotherapy; 76% had already been medicated, and 78% said they would not want to have ECT again. The same survey found that while 35% reported their experience of ECT as ‘damaging’,

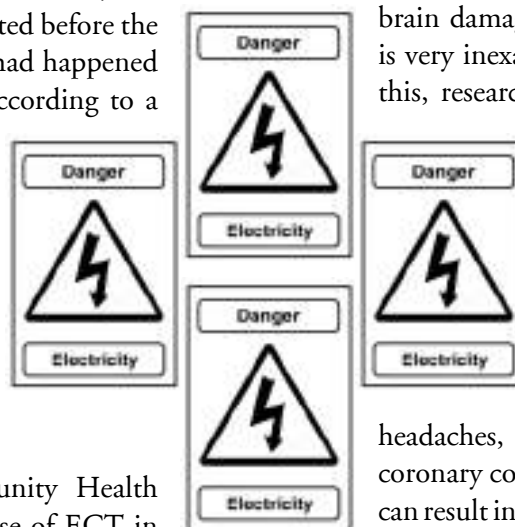
13.6% did find it ‘very helpful’. Another survey found that 47% of the sample considered ECT ‘unhelpful’, whilst 30% found it ‘helpful’.<sup>8</sup> On balance recent research indicates that many more patients feel that ECT is unhelpful or is positively harmful than report benefits.

## DOSAGE AND THE EFFECTS OF ELECTROSHOCK

Seizure thresholds vary by a factor of 40, so in theory the exact dose should be corrected for each individual. The threshold is higher for men than for women, and it rises with age. Psychotropic drugs can raise it, as can some of the anaesthetics used during the process. This leads some physicians to give much bigger doses than the estimated threshold, ‘just in case’ or for ‘quicker results’. However, this expedient obviously runs a greater risk of irreversible

brain damage. In fact, the administration of shock is very inexact and its routine use is casual. Besides this, research shows that training and supervision of ECT is inconsistent, poor and sometimes non-existent, at least in the UK.

Research shows that loss of memory is the major long-term effect,<sup>9</sup> along with apathy, learning difficulties and losses of creativity, drive and energy. Other effects are headaches, sometimes dangerous respiratory and coronary complications, and strokes and falls which can result in fractures (often leading to complications and hence to an earlier death in elderly patients subjected to the treatment).



## PLACEBO ECT IS JUST AS EFFECTIVE

For more than thirty years it has been known that the use of ECT is not based on any evidence of its efficacy since there have been trials which clearly indicated that anaesthetic *on its own* is adequate for clinical benefit. These were follow-up studies to a famous experiment carried out accidentally at a mental hospital in the early 1970s: For two years the staff and the patients believed their shiny new ECT machine was working just like the old one it replaced. However, *nobody*

8. *ECT Survey* (1995) Sheffield: United Kingdom Advocacy Network; also: Faulkner, A (1997) *Knowing Our Own Minds: A survey of how people in emotional distress take control of their lives*. Newport, Gwent: The Mental Health Foundation; Bird, L (1999) *The Fundamental Facts: All the latest facts and figures on mental illness*. Newport, Gwent: The Mental Health Foundation, p. 31.

9. In a meta-analysis of twenty-seven studies, it was found untrue that memory loss is only temporary: at least one-third of patients reported persistent and long-term memory loss; also, contrary to what psychiatrists seem to believe, 80% of patients with severe depression reported no recovery after a course of ECT. Rose, D et al (2003) Patients’ perspectives on electroconvulsive therapy: A systematic review. *British Medical Journal*, 326, 1363.

7. Care Quality Commission Reports for 2013 and 2014; *Electroconvulsive Therapy Report* (2012) The Board of Community Health Councils (Wales); ectstatistics.wordpress.com

had ever properly switched on the new machine. This was not noticed until a new doctor arrived and realised what was happening. And although the machine had not delivered an electric shock to a single patient, for those two years the staff had continued to register the same levels of patients' improvements.<sup>10</sup>

The most recent review of the available literature on the efficacy of electroconvulsive therapy was published in 2010. In order to promote evidence-based practice, the authors trawled for data worldwide in an attempt to identify every single study which compared ECT with simulated ECT. This review comprehensively debunks the belief that ECT 'works'. It finds that placebo-controlled studies show minimal support for the effectiveness of shock treatment for either depression or schizophrenia. That is to say, only in some studies and for some patients, on some measures, and sometimes perceived only by psychiatrists but not by other 'raters' (perhaps less partisan assessors of patients' mental health). Beyond the treatment period, for either diagnosis, there is no evidence of any benefits. There are no placebo-controlled studies which evaluate the hypothesis that ECT prevents suicide, and no sound evidence from other kinds of studies to support that idea.



Besides this, the review summarises strong evidence of persistent and permanent brain dysfunction for some patients, mainly in the form of retrograde and anterograde amnesia which is related to ECT. There is also evidence of a slight but significant increased risk of death. Given all this, the authors conclude that the cost-benefit analysis for electroconvulsive therapy is so poor that its use cannot be scientifically justified.<sup>11</sup>

These facts indicate that, apart from short-term memory loss and whatever organic damage is done, the chances are that the elaborate and awesome or reassuringly 'medical' rituals of administering ECT have no more beneficial psychiatric effects than placebo ECT. In which case, why

10. Coffey, RR (1974) Hospital shocked by finding no shock in shock machine. *Chicago Daily News*, 20 Sept; this reported an article in the journal *World Medicine*, and is quoted in Frank, LR, op. cit., p.105. The discovery was made in 1974 at a psychiatric facility in the North of England. For controlled testing of real ECT vs. placebo ECT, see: Johnstone, EC et al (1980) The Northwick Park Electroconvulsive therapy trial. *The Lancet*, 20-27 Dec, 1317-20. Two equivalent groups of patients both improved at four weeks, and no differences between real ECT and placebo were found at six-month follow-up.

11. Read, J & Bentall, R (2010) The effectiveness of electroconvulsive therapy: A literature review. *Epidemiologia e Psichiatria Sociale* 19(4) 344-7.



not run through the routine but not actually switch on the machine? This would prevent the well-authenticated damage caused by electroshock.

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# ECT SURVIVOR

Dena Roland

I was hospitalized for nervous breakdowns in 2005 and 2006. I had learned about ECT in my psychology class, with claims of about an 80% success rate.

My ECT sessions started in 2006. I decided on it because I was desperate to get help for my bi-polar disorder. The hospital where I was admitted carried out the treatment.

My first round was thirteen treatments, every other day. The doctors made it sound as if there would be hardly any side effects, and then I wouldn't need meds. But that wasn't the case. I did the shock treatments and continued on medication.

After a year I had another breakdown, so again I had ECT: another thirteen treatments, every other day. But at this point, no maintenance treatments.

The process of the ECT is horrific. From the pain of the headache to the jaw, joint and muscle pain (from tensing while they shocked me), to the anaesthesia which would make me so sick. I got through those sessions. I started to see some after-effects at the first treatment, but after the second sessions my memory really went. I could hardly remember any of my past, and when someone would say "Dena can you go get a gallon of milk?" I couldn't remember they had asked me. I mean no recollection at all. My memories were gone, like they had never happened in my life. And even if someone had told me about an incident, I had absolutely no recollection of it.

By 2008 I was really sick with anorexia nervosa which, in turn, kick-started my depression again. I was admitted for treatment into the Anorexia Ward at Shephard Pratt hospital in Baltimore, MD. During that time I had another round of ECT sessions, but this time it lead afterwards to monthly 'maintenance treatments'. I stopped all treatment in 2009.

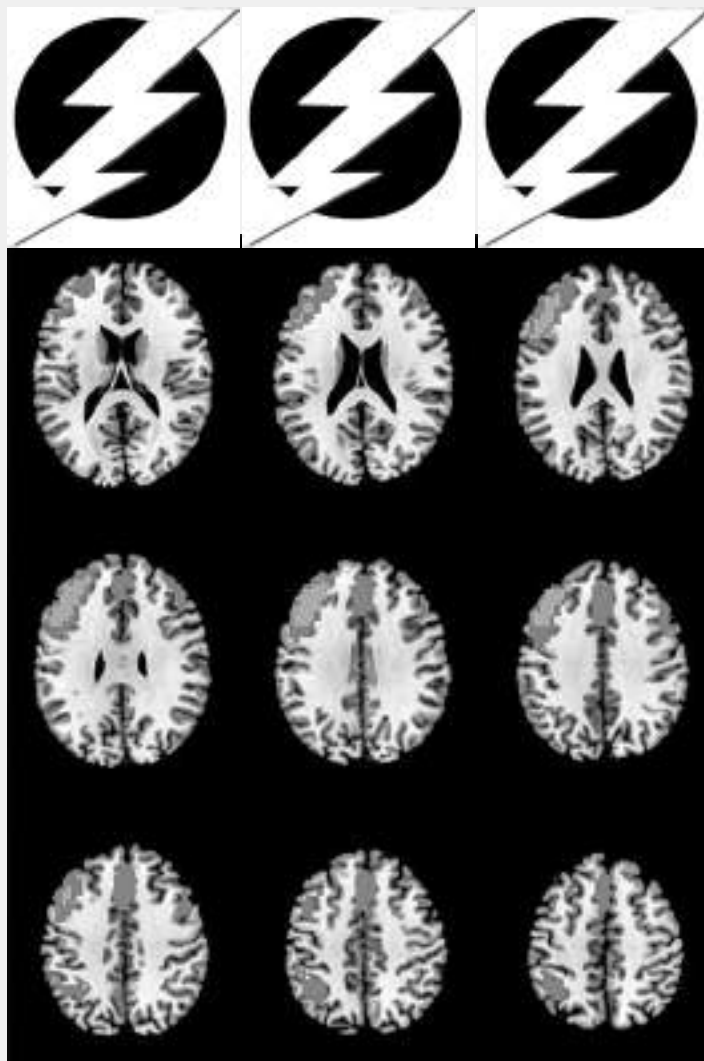
ECT has horrible side effects. I live my life with huge gaps in my memory. I hardly remember the birth of my daughter, my wedding, my university days. There are gaps of years in my memory, where I couldn't even tell you where I was living or what I was doing. My short-term memory has improved, and some of my long term, but a lot of it is gone permanently. Because of the treatments, I don't know what I did to myself long-term. I don't know if the severe headaches I have are caused by all the ECT – I can only speculate. The worst is when someone walks up to me because they know me, and I have absolutely no idea who they are. I don't want to be rude and ask who they are, so I play it like I know them, and forever will never know how they met me.

What is scary is that I CAN remember the treatment. They would bring me into a surgical room and start an

IV (intravenous drip), and while doing that they would start to put a cap on my head. They would tell me to count down, and the next thing I knew I would be waking up – usually screaming in pain because it was the most horrific headache that you could experience. My mom is totally against everyday medicine but she had the bottle of Hydrocodone waiting for me when I got up. I would hurry up and take that medicine. Then the puking from the anaesthesia would begin. The treatment would knock me out of daily functioning for three days. And then, four weeks later, I would have another maintenance treatment.

One day I finally wised-up. I realized what was the point if I was going to be on medicine forever? Obviously I wasn't one of the 80% that was successful.

Then I saw Dr Oz on tv, promoting the treatment, with a woman claiming she had experienced no side effects, and ECT was a miracle. It peeved me to see they were selling such a treatment to the masses. People need to know that ECT is no joke and that there are awful and permanent side effects.





## RISKS OF ECT IN PREGNANCY

Cheryl Prax

Electro-convulsive therapy passes up to 400 volts through the brain for up to 8 seconds - until the brain has a massive epileptic seizure. It is generally given two to three times a week for around six weeks, and then perhaps once a month. ECT causes brain bleed and cell death. This results in memory loss and cognitive deficits. Other possible effects include stroke, heart attack, broken teeth, headache, epilepsy, and death.

For expectant mothers, the risks include pre-eclampsia, miscarriage, premature labour, disrupted bonding; for the foetus: detached placenta, irregular heartbeat, unknown pain, and death; for the baby: brain damage, breathing problems, stillbirth.

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### **THINGS HAVE GOT TO CHANGE!**

- Stop drugging and electroshocking pregnant women and new mums.
- Ban electro-convulsive therapy & psychosurgery – they are barbaric!
- Stop the influence of the pharmaceutical companies on psychiatry.
- End compulsory treatment - all treatment should be consensual.
- End the psychiatric drugging of children.

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[info@shock.org.uk](mailto:info@shock.org.uk)

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[www.endofshock.com/truth\\_about\\_electroshock.htm?](http://www.endofshock.com/truth_about_electroshock.htm?)

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