

Voices

Newsletter of the Psychiatric Survivor Archives of Toronto



ABOVE: The Friendly Spike Theatre Band performs a musical number from *The Walls Are Alive With The Sounds Of Mad People* at the 2012 Take Back the Night Rally in Toronto, Ontario. Photograph courtesy and copyright of Gelay Amdo.

Getting into Gear...

PSAT has been working with volunteers Christina F. and David A. to clean up, box, file, and index our materials. The archive is still in its storage location at the Gerstein Crisis Centre. We will eventually move our collection to the Parkdale Activity and Recreation Centre (PARC), pending the Centre's winter or spring renovation, which will provide our materials with an environmentally secure space. We are hoping to have the archive open to the public by autumn 2013!

December 2012
Vol. 3, No. 3

Chair
Erick Fabris

Archivist
Mel Starkman

Treasurer
Geoffrey Reaume

Board Members
Erick Fabris
Kevin Jackson
Gian Mura
Geoffrey Reaume
Ruth Ruth Stackhouse
Mel Starkman
Don Weitz

Copyediting and Layout
Eugenia Tsao

**Psychiatric Survivor
Archives of Toronto
(PSAT)**

**280 Parliament Street
Toronto, ON
M5A 3A4
(416) 661-9975**

**psychsurvivorarchives@gmail.com
psychiatric survivor archives.com**

Struggling Against Psychiatry's Human Rights Violations: An Antipsychiatry Perspective

BY DON WEITZ

"First, do no harm."
— The Hippocratic Oath

I was once tortured for six weeks over fifty years ago—it happened in December 1951 and January 1952 when I was twenty-one. While locked up for fifteen months, I was forcibly subjected to a series of 110 sub-coma insulin shocks which psychiatrist Douglass Sharpe prescribed as a treatment for "schizophrenia." Although Dr. Sharpe and other shrinks labelled me "schizophrenic," I never believed and still don't believe I was "schizophrenic" or "mentally ill" and told them I was not crazy or "mentally ill." Like many other antipsychiatry activists and other critics, I totally reject "schizophrenia" and all other psychiatric labels as valid medical terms because they don't exist, they don't refer to medical diseases, and they're fraudulent labels. As psychiatric critic Thomas Szasz has explained, psychiatric diagnostic labels are metaphors for dissident or non-conformist conduct, pseudo-medical terms which discredit and permanently stigmatize people.

In the early 1950s, I was just a very confused college student struggling to find himself, a common identity crisis. I was never violent and never charged with a criminal offence. Nevertheless, I lost my freedom, locked up as an involuntary patient, a psychiatric prisoner in McLean Hospital (a teaching-research facility affiliated with Harvard Medical School and Massachusetts General Hospital). It should be called McLean Psychoprison. As is frequently the case, my parents colluded with the psychiatrists—they committed me.

Within six to seven weeks of admission to McLean, psychiatrist Douglass Sharpe prescribed a series of insulin shock treatments because I was openly angry and defiant toward my parents and the world—that's the real reason but you won't find it written in my medical records, where I'm labelled "schizophrenic," with the discharge diagnosis, "schizophrenia—acute undifferentiated reaction, improved." That fraudulent diagnosis has never been changed or erased on my medical records in over fifty years. Here's a telling excerpt by Dr. Sharpe written in my medical records which also appears in the book *Shrink Resistant*:

The patient was finally placed on sub-coma insulin and after a month of sub-coma insulin three times a day he showed tremendous improvement. There was no longer the outbursts of anger... He spends most of his time trying to figure out what the effect of insulin has on him (Burstow and Weitz 1988).

WEITZ, CONTINUED ON PAGE 3

It took me almost twenty years to understand my forced psychiatric incarceration and forced treatment in political terms, twenty years to realize that I was not a “mental patient” but a political prisoner of psychiatry locked up against my will, with no right to appeal the commitment or treatment, tortured with subcoma insulin shocks. It took me twenty years to understand that the “mental health system” is an oppressive social control system. Insulin shock was obviously a form of social control and torture—not treatment. This is also true for electroshock, psychiatric drugs, and all forced psychiatric procedures today. If a medical or psychiatric procedure is forced or administered without consent, it’s assault or torture—not treatment (Weitz 2002).

Insulin shock was a serious violation of my human rights, it was also a radicalizing experience which permanently sensitized me to the many human rights violations which psychiatrists have committed and are still committing against hundreds of thousands of allegedly “mentally ill” people—under the guise of “safe and effective treatment,” “medication,” “ECT,” “research,” or “mental health reform.” In the 1950s, many of us psychiatric survivors had no rights, such as the right not to be treated against our will or without informed consent; the right not to be abused, mistreated, or tortured; the right not to be harmed. Nevertheless, these rights violations are happening today in virtually every psychiatric ward, in every “mental health centre”—or psychoprison—in Canada, the United States and Europe, despite “progressive” mental health legislation and despite the fact some of these rights are enshrined in the Universal Declaration of Human Rights adopted by the United Nations General Assembly sixty years ago on December 10th 1948 and signed by 47 nations including “free and democratic” Canada and America, and more recently enshrined in the U.N. Convention Against Torture. Everybody, including all physicians, should be familiar with these documents. Unfortunately, there is no guarantee that psychiatrists and other doctors will respect our human rights or their own ethical guidelines.

The Right Not to be Tortured

- “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” (United Nations Universal Declaration of Human Rights, Article 5)
- “Everyone has the right not to be subjected to any cruel and unusual treatment or punishment” (Canadian Charter of Rights and Freedoms, Section 12)

Psychiatric prisoners and survivors typically experience forced treatment or treatment without “informed consent” as cruel and inhumane punishment or torture. Psychiatrists rarely inform their prisoners about the many serious effects or risks of their treatments and alternatives, especially non-medical community alternatives such as self-help groups, advocacy groups, crisis centres, co-op housing, supportive housing and drop-ins run by psychiatric survivors. All this, despite the fact that “informed consent” is spelled out in both Ontario’s Health Care and Consent Act and the historic 1947 Nuremberg Code. For example, whenever doctors prescribe “antipsychotic medication”—powerful brain-disabling neuroleptics such as Haldol (haloperidol), Thorazine (chlorpromazine), Clozaril (clozapine), Modecate (fluphenazine), Risperdal (risperidone), and Zyprexa (olanzapine)—as well as antidepressants such as Paxil and Prozac, without your consent or against your will, they are assaulting you, punishing you, violating the Nuremberg Code, violating the U.N. Universal Declaration of Human Rights, violating the Canadian Charter of Rights and Freedoms, violating The Convention Against Torture, and violating your human rights. Forced drugging together with its many traumatic, health and life-threatening effects is a virtual global epidemic, an international disgrace, and a crime against humanity.

Psychiatric Drugs: Chemical Lobotomies

The labels “antipsychotics” and “antidepressants” are seriously misleading. “Antipsychotics” do not combat or cure “psychosis” or “mental illness,” and “antidepressants” do not combat or cure depression or the fraudulent diagnosis “bipolar mood disorder.” Psychiatric drugs (“medication”) chemically control and disable people—sometimes permanently. “Neuroleptics” is a more accurate term for “antipsychotics”—it means “nerve-seizing.” These psychiatric drugs are much more powerful, debilitating and brain-disabling than “tranquilizers” (benzodiazepines), which, by the way, are addictive. The neuroleptics and antidepressants frequently make people look and act apathetic, zombie-like as if they’ve been lobotomized—even at moderate or low doses. These allegedly “safe and effective medications” always produce painful and serious “side effects.” Some are health-threatening and brain-damaging; others are life-threatening. Consider these common effects: muscle cramps, dizziness, blurred vision, seizures, tardive dyskinesia (a permanent neurological disorder characterized by involuntary movements caused by the neuroleptics), tardive dementia, akathisia (constant restless pacing),

nightmares, psychosis, parkinsonism, Neuroleptic Malignant Syndrome (a neurological disorder with a prevalence rate of 2%-3% and mortality rate of 20%-25%), and sudden death. Tardive dyskinesia (TD), tardive dementia, NMS and parkinsonism are all signs of brain damage. Although TD was discovered and reported in medical journals in the mid-1960s, the psychiatrists covered up or failed to warn patients about this horrific neurological “side effect” for about twenty years until the 1980s. After a few weeks or months on such “medication,” most patients look and act like zombies: apathetic, indifferent to their surroundings. Dr. Peter Breggin (1997, 1991), Dr. Lars Martensson (1998), and other professional critics have documented these horrendous effects. Many psychiatric survivor-activists and other critics prefer the label “chemical lobotomy,” as it succinctly describes their zombie experience. In a psychoprison or psychiatric ward, virtually everyone gets drugged—“put on meds.” Or threatened—“take your meds, or else.” This is also true of children who are admitted to psychiatric wards (LeFrancois 2006).

Forced drugging compounds this abuse. Informed consent is a cruel sham, since psychiatrists rarely if ever warn incarcerated involuntary and voluntary patients about common health risks and non-medical alternatives to the drugs. More often than not, psychiatrists coerce, threaten, or intimidate patients into consenting to “medication” (Burstow et al. 2005, Breggin and Cohen 1999, Lehmann 1998, Martensson 1998, Whitaker 2002). Powerful personal testimonies against the antidepressants and neuroleptics, including frequent violations of the right to informed consent, were frequently voiced by approximately twenty-five Canadian survivors during public hearings sponsored by the Coalition Against Psychiatric Assault (CAPA) and held in Toronto City Hall in April 2005 (Burstow et al. 2005).

Electroshock: Electroconvulsive Brainwashing

Electroshock (officially, “electroconvulsive therapy” or “ECT”) is another high risk, degrading, and inhumane psychiatric treatment chiefly prescribed for severe “depression,” “bipolar mood disorder,” and sometimes “schizophrenia.” Since its main targets are women and the elderly, the procedure is sexist and ageist in its administration. According to government statistics, including those of Ontario’s Ministry of Health, two to three times more women than men (at least 70%) are prescribed ECT. Despite denials by the Canadian Psychiatric Association and shock promoters, the scientific fact is that electroshock always causes some brain damage including permanent memory loss and other intellectual

disabilities. A recent, comprehensive study confirmed that women suffer more brain damage by electroshock than men, and that elderly people suffer more damage than younger persons (Sackeim et al. 2007). The immediate effects of electroshock are also alarming and include epileptic or grand mal seizure, coma, physical weakness, confusion, disorientation, nausea, and a migraine-type headache which can last a day or longer. According to many critics and dissident professionals in the United States, such as psychiatrist Peter Breggin and neurologist John Friedberg, electroshock is an “electrically-induced closed head injury.” According to Breggin, Friedberg and other professional critics, the so-called “improvement” or “high” that some shock survivors experience after several shocks is actually euphoria, a common sign of head injury. One doesn’t have to be a doctor, scientist or engineer to understand that approximately 200 volts—the average amount of electrical energy delivered to the brain for a half-second or longer two to three times a week during a course of ECT—will damage the brain, permanently. It’s the electricity and seizure which do the damage and cause memory loss—not depression or any “mental disorder.” Nevertheless, the shock promoters and other psychiatrists continue claiming that the electroshock “seizure is therapeutic.” Try telling that to people with epilepsy and neurologists! More nonsense, more psychobabble.

Women shock survivors and feminist critics appropriately call electroshock “psychiatric rape”—an appropriate term since electroshock is frequently prescribed or administered over women’s refusal or without their informed consent. The violations of informed consent and trauma that women and men shock survivors experience is systemic—this alarming fact was exposed by virtually all survivors who courageously testified during two days of public hearings in April 2005 in Toronto City Hall. In a public lecture three years ago at the Ontario Institute for Studies in Education, Dr. Bonnie Burstow—a widely respected feminist, author, antipsychiatry activist, and chair of the Coalition Against Psychiatric Assault (CAPA)—called electroshock a feminist issue. I totally agree. I also agree with the term electroconvulsive brainwashing (ECB), an apt term coined by Leonard Roy Frank, a widely-respected shock survivor-activist, author and editor who permanently lost two years of university knowledge as a direct result of over thirty electroshocks and fifty insulin coma shocks in the early 1960s in California. Frank also calls shock a crime against humanity and wants it abolished—as do Drs. Burstow, Breggin and Friedberg, and many other critics including shock

survivors and human rights activists like myself (Burstow 2006; Frank 1978, 2006; Breggin 1997; Weitz 2004; Weitz et al. 2005; Breeding 2001).

According to the province of Ontario's own statistics for the years 2000-2002, the administration of ECT on women and old people, particularly elderly women, is on the increase in Canada. It's also on the rise in the United States. Shocking old people (some in their 80s and 90s), even with consent, is elder abuse: they are typically in fragile health and more vulnerable than younger people. ECT has caused over 400 deaths since 1942, as reported in English language medical journals (Frank 1978). Many more have undoubtedly been unreported or covered up.

The struggle to abolish this psychiatric atrocity began over thirty years ago in California under the leadership of the legendary Coalition to Stop Electroshock, which achieved a partial victory in 1982 when over 60% of the citizens of Berkeley voted to ban electroshock. The struggle continues in California, Texas, the U.K. and other European countries, and New Zealand. In Canada, I am particularly proud that several of us survivors and activists contributed to the struggle for several years (1984-1992), when the Toronto-based Ontario Coalition to Stop Electroshock and its successor Resistance Against Psychiatry (RAP) organized major demonstrations in front of "shock mills" such as the Clarke Institute of Psychiatry and Queen Street Mental Health Centre (since merged into the Centre for Addiction and Mental Health). Some of us also carried out non-violent civil disobedience in the health minister's office. A friend and I were once charged with trespass and arrested for trying to hand out copies of factual anti-shock information to patients on the ward during visiting hours—we launched a court appeal but lost. Although there are anti-shock campaigns in various cities, unfortunately there is no national or international movement to ban electroshock; I confidently predict there will be (cf. Frank, 2006). In fact, a total of five anti-shock protests were recently held in Toronto, Ottawa, Montreal and Cork, Ireland, on Mother's Day in 2007 and 2008. The theme and slogan in all of these protests was "Stop shocking our mothers and grandmothers." The May 2007 protest in Toronto organized by CAPA attracted 140 people; it featured women shock survivors and other women speakers.

Physical Restraints

The use of two-point and four-point restraints and solitary confinement ("seclusion") on psychiatric wards is particularly alarming and dangerous. Many psychiatric prisoners and survivors describe the

restraints as cruel punishment or torture. The restraints consist of thick leather cuffs or straps which are tied around the prisoner's ankles and wrists and anchored to the sides of the bed. As result, the prisoner can hardly move while being forced to lie flat on his/her back for hours at a time, sometimes days with, only brief restraint-free periods. Since physically restrained prisoners are also chemically restrained by powerful neuroleptics or antidepressants, they are doubly restrained. Commonly invoked reasons for restraining prisoners are "control" or "management" of allegedly disruptive prisoner behaviour, or "staff shortage." Frequently, tying up or caging psychiatric prisoners is for the convenience of the staff. Whatever the reason, the prisoner experiences such restraint as severe punishment or torture.

To the best of my knowledge, there have been no significant restrictions on the use of physical restraints in Ontario's psychiatric wards. In the early 1990s, lawyer and former Ontario systemic policy advisor Duff Waring published an article criticizing the overuse of restraints in Ontario's ten provincial psychiatric hospitals (Waring 1991). There was no media or public concern about his article and similar ones written by a few nurses, no public outrage. There should have been. I still have a vivid memory of witnessing in horror my close friend Mel trying to raise himself while being physically restrained by four-point restraints approximately ten years ago in the notorious Queen Street Mental Health Centre. The nurses and attendants tied his wrists and legs because he was allegedly "uncontrollable." About the same time, they also threw him into "seclusion" (solitary confinement) for "head banging behaviour"—agitation caused by one or more of the antidepressants. The ward staff kept Mel in restraints and/or seclusion for several weeks. He wasn't fully released until 1995, two years after several of us protested outside this notorious psychoprison.

Physical restraints have also caused several deaths in psychoprisons. A few years ago, investigative reporters exposed hundreds of such deaths in a series published in *The Hartford Courant* (Weiss 1998). In 2005, in Toronto's CAMH, Jeffrey James died from "pulmonary thromboembolism" after being physically restrained in a four-point restraint and confined in "seclusion" for 5½ consecutive days. In Ontario, there have never been media or government investigations into the use of physical restraints and solitary confinement. There was also no media criticism or public outrage over the brutal death of 26-year-old Zdravko Pukec on September 26th 1995 in Whitby Psychiatric Hospital. Pukec was a recently-arrived immigrant from Croatia,

At the time of his death, Pukec was already restrained with neuroleptics and cuffs when a head nurse, with the approval of administrator Ron Ballantyne, called the Durham branch of the Ontario Provincial Police (OPP) to help restrain him. The police stormed the ward, pepper sprayed Pukec, and forced him to lie on his stomach so he could barely breathe. He died thirty minutes later. The coroner's inquest was a sham. "Positional asphyxia"—not pepper spray or police assault—was listed as a major cause of death. No psychiatric staff and no OPP were seriously criticized, and no police or hospital staff has ever been charged. A good example of psychiatric justice in Ontario.

CTOs: Ontario's Leash Law

Under Ontario's conservative government (1995-2004), outpatient forced psychiatric drugging or "community treatment orders" (CTOs) became law in Ontario when "Brian's Law" (named for an Ottawa sportscaster killed by a person with a psychiatric history) was officially proclaimed as an amendment to the Mental Health Act on December 1st 2000. CTOs are also law in Saskatchewan and British Columbia, and will probably become law in Manitoba and Alberta. In the United States, these leash laws are called "involuntary outpatient committals" (IOCs). Over forty-one states have passed this draconian decree which targets many thousands of psychiatric prisoners and survivors for outpatient treatment—usually forced drugging in a clinic, doctor's office, even in one's own home. Under a CTO in Ontario, you can be forced to take psychiatric drugs or electroshock for up to six months, sometimes years, since CTOs can be renewed indefinitely. If you refuse an ordered "medication" or fail to keep a doctor's appointment in the community, an Assertive Community Treatment Team (ACTT)—typically consisting of a psychiatrist, psychologist, nurse and social worker—can forcibly drug you or force you back into a psychoprison, without a hearing or trial and for a longer period of incarceration.

Despite protests against CTOs organized by the survivor-led political action group People Against Psychiatric Treatment (PACT) for almost three years (1998-2000) and despite continuing criticism, CTOs have not yet been challenged in court as violations of the Canadian Charter of Rights and Freedoms. It's time CTO and IOC laws, as well as Ontario's Consent and Capacity Board, a quasi-appeal court which rubber-stamps virtually all psychiatrist-ordered treatments and involuntary committals, were challenged as serious human rights/civil rights violations. Appeals to this Board are useless, a waste of time since this government-appointed tribunal

rejects over 90% of patient appeals. It can be argued that CTOs violate several sections of the Canadian Charter of Rights and Freedoms—particularly section 7, which guarantees all citizens "the right to life, liberty and security of the person"; section 9, which guarantees "the right not to be arbitrarily detained or imprisoned"; section 12, which guarantees "the right not to be subjected to any cruel and unusual treatment or punishment"; and section 15(2), the equality clause which prohibits discrimination based on "mental or physical disability" and several other grounds including age, sex, colour, religion, and national or ethnic origin (Fabris 2006, Weitz, 2000).

In the next few years, we can expect more psychiatric imperialism—more invasions of our communities and our privacy, more CTOs and IOCs, more psychiatric abuses, more forced drugging, more electroshock, more use of physical restraints, more patient deaths and more cover-ups, more stigmatizing, more stereotyping, more biased reporting, more medical model myths and psychiatric lies promoted as "medical science" and parroted in corporate-controlled media. Violations of human rights of psychiatric prisoners and other extremely vulnerable populations will continue unless or until many more psychiatric survivors, antipsychiatry activists, other social justice activists, human rights activists, dissident health professionals, and other concerned citizens start speaking out, fighting back, demanding action and real "accountability and transparency" from provincial governments and the federal government—such as independent and public investigations of psychiatry's numerous human rights violations. In practical terms, this means much more grassroots organizing, lobbying, networking, direct action and public protests in our own communities, cities, provinces, states, and countries. ■

Don Weitz is a psychiatric survivor, antipsychiatry and social justice activist, author of the e-book, *Rise Up/Fight Back: Selected Writings of an Antipsychiatry Activist* (2012), and PSAT board member.

Editor's Note: This article was first published in *Radical Psychology* (summer 2008, vol. 7, no. 1). To access the original version, follow the below links: www.radicalpsychology.org/vol7-1/weitz2008.html or coalitionagainstoppsychiatricassault.wordpress.com/?attachment_id=514

References

- Breeding, J. (May 18, 2001). *Testimony to New York Assembly on Forced Electroshock*.
- Breggin, P.R. (1991). *Toxic Psychiatry*. NY: St. Martin's.

Breggin, P.R. (1997). *Brain-Disabling Treatments in Psychiatry*. New York: Springer.

Breggin, P.R. and Cohen, D. (1999). *Your Drug May Be Your Problem*. Reading, MA: Perseus Books.

Burstow, B. and Weitz, B. (1988). *Shrink Resistant: The Struggle Against Psychiatry in Canada*. Vancouver: New Star Books.

Burstow, B., Cohen, L., Diamond, B., Lichtman, E. (2005). *Report of the Psychiatric Drugs Panel. Inquiry Into Psychiatry*. Toronto: Coalition Against Psychiatric Assault.

Burstow, B. (2006). Understanding and ending electroshock: A feminist imperative. *Canadian Woman Studies*, 25, 2.

Fabris, E. (2006). *Identity, Inmates, Insight, Capacity, Consent: Chemical Incarceration in Psychiatric Survivor Experiences of Community Treatment Orders*. M.A. Thesis, Ontario Institute of Studies in Education, University of Toronto.

Frank, L.R. (1978). *The History of Shock Treatment: ECT Death Chronology*. San Francisco, CA: Self-published.

Frank, L.R. (2006). *The Electroshock Quotationary*
<http://www.endofelectroshock.com>

Funk, W. (1998). *What DifferEnCe Does iT Make? The Journey of a Soul Survivor*. Cranbrook, B.C.: Wildflower Publishing.

Lehmann, P. (Ed.) (2004). *Coming off Psychiatric Drugs: Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquilizers*. Berlin: Peter Lehmann Publishing.

LeFrancois, B.A. (2006). "They will find us and infect our bodies": The views of adolescent inpatients taking psychiatric medication. *Radical Psychology* 5.

Martensson, L. (1998). Deprived of our humanity: The case against neuroleptic drugs. *Geneva: The Voiceless Movement*.

Waring, D. (1991). Use of restraints in Ontario psychiatric hospitals. *Journal of Law and Social Policy* 7, 251-283.

Weiss, E. M. (1998). Deadly restraint: a *Hartford Courant* investigative report. *The Hartford Courant*, October 11-15.

Weitz, D. (2004). Insulin shock—A survivor's account of psychiatric torture. *Journal of Critical Psychology, Counselling and Psychotherapy* 4(3), 187-194.

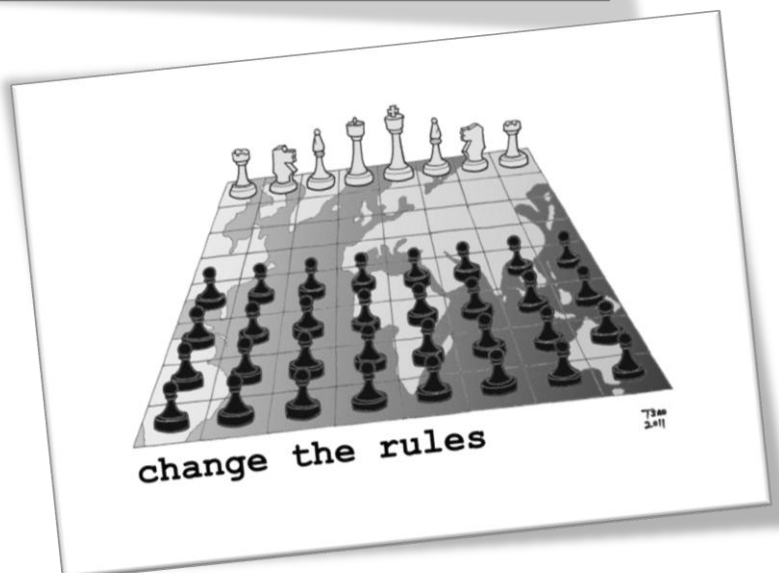
Weitz, D., Crowe C., Moodley, R., Rahim. C. (2005). *Electroshock Is Not A Healing Option: Report of the Panel on Electroshock, Inquiry Into Psychiatry*. Toronto: Coalition Against Psychiatric Assault.

Weitz, D. (2000). Fighting words—Community Treatment Orders and 'Brian's Law.' *Canadian Dimension*, September/October.

Weitz, D. (2002). Call me antipsychiatry activist—not 'consumer.' *Ethical Human Sciences and Services* 5 (1), 71-72.

Weitz, D. (1997). Electroshocking elderly people: Another psychiatric abuse. *Changes: An International Journal of Psychology and Psychotherapy* 15 (2), 118-123.

Whitaker, R. (2002). *Mad in America*. Cambridge, MA: Perseus Publishing



Artwork courtesy and copyright of Eugenia Tsao.

Getting Sucked into the System

BY MEL STARKMAN

Does suffering from ennui necessarily mean illness or madness? How do you define mental illness? I have now reached the stage where I strongly feel by intellect and emotion that there is no such entity. However, in 1966, I really thought that I had a mental illness and one that was beyond the capacity of any psychiatrist to alleviate. I thought that I had spent my life warding it off and that I would have to pay the consequences of trying to fool the world that I was sane. Dr. Johns fed into this conjecture, as did all the mental health workers I came across, as well as my family. I was, according to them, in the throes of an illness, albeit through no fault of my own, and the psychiatrist would have to search for the proper medication to alleviate what they saw as my suffering. I would be bound to take this medication and related therapies for the rest of my life. It was all arcane to me, as was general medicine, and because I was not trained in those fields I concluded that I would leave the science up to the doctor. It also gave my guilty feelings an escape hatch, though not much of one, and, when I found that the insurance companies covered depression as an illness, it confirmed my impression that I was being fed the medical etiology of mental health.

When I entered Branson, I discovered to my relief that the doctors and the nurses did not walk around in starched whites, I was able to smoke in the unit, and the ambience was not as decrepit as that of the old 999 Asylum, where my father had stayed. My wife accompanied me, and I was very nervous, but the thought of a justification for getting off work was uppermost in my mind. I was put in a room with three other men just a few steps from the nursing station and, in short order, I unpacked the few belongings that I had brought with me. I got the lay of the land on my own by walking around the Mental Health Unit, given that the nurses were tied up in their daily routines. There was not a lot of literature around; certainly nothing that explained the procedures I might now have to face. The head of the

unit, Dr. George Johns, was not on duty that day and I remember filling out some forms that seemed to be more geared to protecting the hospital than providing me with information. I had to fill out a menu for the next few days and was reluctant to do so as I suspected that they would file it away and later use my shaky handwriting as evidence of the inner turmoil I was undergoing.

The kitchen was small and crowded, with only decaffeinated coffee available, and I recall wondering who would boil the water for me. There were general guidelines as to visiting times and privileges. I passed by a room that was labelled a meeting room, and later found out that ECT was administered there. However, the significance of that procedure was not yet clear to me and there was no visible reference to it. Dr.

Johns had broached no procedure to me, not even medication, but simply indicated that I come to the unit for a change of scenery or environment and a rest. I saw him a day or so later and he told me that I was going to start a relatively new medication the name of which I could not remember. Nothing was discussed vis-à-vis dosage, how long I would be on the drug, or potential side effects. No literature was even available. I later found out that what I had been given that first day was Chlorpromazine, which incapacitated me, making me feel like a zombie with a dry mouth, immobilized my limbs and fogged my mind. I had not been warned about these side effects and, when I inquired, I was told they would soon clear up. However the side effects did not clear up—and soon I was on side effect medication that only exacerbated the problem.

Shortly after it became clear that the medications were not making me feel any better, Sheila and I met Dr. Johns in his office, where he began to talk about the possibility of my taking

This an edited excerpt from archivist Mel Starkman's unpublished autobiography.

STARKMAN, CONTINUED ON PAGE 9

electroshock (ECT) to try to alleviate the situation. This was an extremely tearful session for me; I had been afraid of this and, given my father's experience of shock, I was very reluctant to willingly take the treatments. The thought of electricity going through my brain had always frightened me immensely. Dr. Johns indicated that it was a harmless procedure but I remained reluctant. He tried unavailingly to alleviate my fears and hesitations, insisting that unlike the pills ECT had no side effects, and that the procedure was now improved. The most I would concede was that I would try one shock to see what it was like, and my only reason was that I felt guilty about my father's experience with ECT, and so I agreed to take one to duplicate his experience.

Even though I was amply aware that my father had had shock treatments at the Asylum on Queen Street, it was not clear to me that I would follow in his footsteps. I was sad and anxious for a number of reasons but did not see myself as acting out excessively in the way my father once did, which I thought had made him a candidate for shock. I did not know that shock and disabling drugs had become the treatments of choice in mental health wards. The dawn of the era of biologically invasive treatments had arrived, and I found myself caught in a system that even today's apologists for magic bullet psychiatry now admit had been a dark age for mental health treatment.

While I basically trusted Dr. Johns, I had my hesitations. He proffered no information about the side effects of the procedures I would undergo. Even though I was somewhat averse to it, I felt that the "talking cure" would be more useful to me. Basically, I wanted to talk out my problems and reclaim my youth from the feeling of dysfunction that was hammering me. Also, there was a disproportionate emphasis on invasive treatments in the Mental Health Unit that did not address my problems in a holistic way. If only they had offered courses in typing or filing, or linked up with other educational resources that were then developing in North York. That would have been invaluable to me as a history and English teacher, and addressed important gaps in my technical knowledge.

At first, Johns indicated that I was undergoing a mild "depression" that hung on many hooks: the teaching trauma, my unpreparedness for conjugal

living, the illnesses of my father and mother, their economic marginality, their dependence on me and my sister. According to him, my depression would soon be alleviated, and we did not speak of the lifelong implications of any "illness."

A few hours after ingesting Chlorpromazine with juice, my mouth and lips became very dry and I felt zombie-like throughout my body, legs, and arms. My brain began to feel like cotton batten—I was suddenly unable to read or write, due not to sadness but a sort of shrinking of my consciousness and body. My dry tongue was balled up in my mouth, my lips were dry and cracked, and I felt feverish. I mumbled and found it hard to conceptualize and articulate my feelings, which, according to the Rogerian approach to psychotherapy, was important to do.

After a few weeks in the hospital, I was given a weekend pass and had to adjust to being back at home with my wife and in what, to me, had suddenly become alien surroundings. Taking pills slowly took over my life: I had a number of small bottles of the regular pills and side effect pills to counter the debilitating effects of the Chlorpromazine and whatever other pill I had been induced to take without full information as to their short or long term effects. I was a mess and felt like I was in a losing cause. After a few more weeks in the hospital, I returned to my teaching post feeling overwhelmingly guilty, stigmatized, and inadequate for my students. With a dry mouth, my pockets rattling with pills, and a humiliated demeanour, I stood before them unable to articulate or conceptualize what I was presenting and vulnerable to their jibes—as well as pleas from those concerned about the progress of the course. I felt that my students and colleagues knew everything about me as I held a sign over my head: psychiatric patient, handle with care. I avoided personal contact with everyone and isolated myself to an extent that benefited no one. The next few weeks were disastrous. Soon, Sheila, Dr. Johns and I thought another visit to the hospital was in order.

It was during this visit that the mental health system's crimes against me became compounded beyond the bounds of reason. At this time—and quite by accident—I glimpsed into the medicine cabinet and discovered that my diagnosis was "schizo-affective," not "depressive" or "manic depressive" as Johns had previously indicated. It is patently clear

that he had moved me into a label we had not talked about, and when I, visibly upset, confronted him with this, he insisted that the label did not differ much from manic depression and that the two were interchangeable, which they were not. Although he claimed to have had specific reasons for designating me “schizo-affective,” he refused to share his reasoning with me, as he did not trust me sufficiently to grasp the whole picture in its present and future implications. Johns thought that ECT was in order and spoke to Sheila and I of the “great” benefits of that procedure. I steadfastly refused and Sheila, who was out of her element, was non-committal. Johns then admitted the side effects and inefficacy of medications, and described ECT in sparse detail, indicating again that it was painless, effective, and incurred no side effects. I cried copiously out of fear and frustration, knowing implicitly that I did not want shock. We went back and forth for fifteen to thirty minutes and Johns was quietly insistent that this was the best way to go. He spoke of the successes he had had with the procedure and, finally, I agreed to try *one*, hoping that this would help to assuage the guilt I felt over my father’s experience.

A day or so later, I went with a number of patients to the hospital theatre, where we were shown a movie about ECT wherein a young woman with what seemed like mild depression acceded to a series of shocks. The procedure was shown in its best light, and, while I do not remember the details of the flick, I did realize that it was a propaganda piece. I sat on the highest tier of seats and again cried copiously at the depiction of the procedure. It seemed to mean going through a lot of hell for no particular positive outcome. I simply did not believe that shock would work and felt eerie about electricity being passed through my brain. No one debriefed us after the movie. We were left to draw our own conclusions, which I definitely did.

I was not asked to sign any permission papers until the very moment I was carted into the ECT room. A clipboard was handed to me as I lay on the gurney, and I was asked for my signature. I signed the permission papers on which I saw nothing except the hospital releasing itself from any responsibility for the upcoming procedure. By this time I was calm and had resigned myself frankly to my demise. I was neither in a position to inspect them closely nor could I ask any

questions amid the tumult of a bunch of people—at least six—who were lined up, awaiting treatment and drawing straws to determine the order we would go in. I don’t remember what position I picked.

In the treatment room, there were a number of nurses and doctors and two beds and a lot of wires and medical supplies. They transferred me onto a bed and then they spoke to each other about the absence of Dr. A. Green, who was supposed to check my heart before the procedure. In his absence, Dr. Johns reverted to his erstwhile general practitioner status and checked out my heart giving me more time to stew for which I was appreciative. I dearly wanted the procedure to be suspended in what I hoped would be a reprieve but had no such luck.

Things get blurry from then on. I lay back on the bed. Electrodes of some type were applied to my temples which had just been smeared with something. Perhaps wires were attached to my chest. Perhaps not. An anaesthesiologist loomed over me and injected something that relaxed me and made me limp, and an object of some sort was put in my mouth. Then a mask, and in the next few moments another needle and I was asked to count back from a hundred. I reached about ninety-seven and suddenly lunged into blackness which I saw but was not conscious of.

I awoke somewhere near the nursing station. I was stunned, bewildered, but knew I was in the hospital on the Mental Health Unit. My first question was, “When do I get the shock treatment?” They told me it was over and I was going to breakfast. I staggered over and wondered what had caused that horrible lunging in my head, that convulsion that had betokened death to me and had been the scariest conscious moment of my life. I was glad it was all over. The orange juice, toast and coffee were delicious. I knew I wanted to talk with Johns about the experience but discovered that he had gone back to his office and it would be a few days before I would see him for my next treatment. “What next treatment?” I asked. I had agreed to *one*. The nurses left any discussion up to the doctor. Then I went into a haze and do not recall what happened later.

The next time I saw Johns I hypothesized that it was the anaesthetic that had lunged me into darkness and a convulsion. He agreed, declining to reveal that this effect was inherent to ECT itself.

In truth, most people spoke little about their shock treatments, except to say they got massive headaches or to make gallows jokes about living better electrically. No information was provided about the short or long term effects of the procedure, and I came to be seen as a maladjusted freethinker who was questioning the miracles of brain science. My queries not answered by Johns or any of the staff. I took a series of about six to twelve shocks, one each Monday, Wednesday, and Friday. I felt no real lift and, when I came home for Christmas, the only relief I had was being away from my teaching load. Sheila and her family were no help, as they assumed that I would return to the classroom. I saw no way out, but now shouldered the extra burden of having been so “sick” that I required virtually the ultimate in psychiatric intervention. How would I face the students, if my relationships with even my family, friends, and wife had become so tenuous? I was as depressed as I had ever been, and was not looking forward to a fresh start.

When I returned to school in January, I felt that my psychiatrization was written over my whole slouching body. The self-stigmatization was awful and my practice in the classroom left in my mind much to be desired. Planning lessons became nearly impossible, and I felt guilty about leaving the students in the lurch during the first term. Energy was lacking in my preparation and delivery of my lessons. I remember gaining weight and the desire for cigarettes was uppermost in my mind, such that I could not wait until the end of class to go off to the teachers’ lounge to indulge. The smell of smoke was all over me and this intensified the dry mouth I experienced. Behaviour problems became worse as I lost control over my classes. A couple of students started acting out and I could do nothing but send them to the Vice Principal’s office, which only made things worse. When it came time to be observed, I was rarely ready and I often just read aloud to the class, as when I read out *The Pit and the Pendulum* by Edgar Allen Poe. During the reading of that poem, the students sat back and enjoyed it while I myself had no idea of the story or where it was going. I was so badly prepared and in a state of stupefaction that I had never experienced before. Such were the effects of my psychiatrization. Many of those days are blanks in my mind, having been wiped out by the shock

treatments. New learning was well nigh impossible, which in retrospect was caused also by the effects of ECT. Of course, to Dr. Johns, this was evidence that I was going down again and getting more anxious and agitated. So, he advised me to re-enter the hospital for another series of ECT. This seemed to me to be compounding the problem, not alleviating it, but as a compliant patient I fell into line.

The ensuing shock treatments are a blank in my mind. I remember only that my fear of them did not diminish and the only adjustment that was made was that a big pillow was put under my head during the treatment to mitigate the horrible lunging feeling. I recall no details of the ECT, the subsequent group therapy sessions, doctor consultations, or other modalities of treatment that I received. All I remember is that whenever I talked to Johns, he referred to the “sickness” I had and how I would have to cope with it for the remainder of my life, and how new and newer pills were coming out that would help me live a quasi-normal life. Any literature that I got hold of was arcane to me. I did not know where to start reading and was given no guidance on these matters other than propaganda pieces that reaffirmed the spurious salad the doctor was dishing out. I was developing on my own anti-psychiatry perspectives without being led into any of the then-existing literature, with the exception of R. D. Laing whose writings I found very hard to read. All I knew was I had an inchoate dislike and disdain for the psychiatry that was being practiced on me, which neither alleviated my symptoms nor permitted real personal growth.

I did not return to the classroom and all the psychiatric intervention turned out to be a washout. My step-father-in-law wrote a letter on my behalf to the North York Board of Education to facilitate my resignation, and I now had the freedom of failure and newfound doldrums. My future lay ahead without much promise. What career should I choose? Like a fool, I stayed with Dr. Johns and did not then wean myself off of medication. Instead of blaming psychiatry, I blamed myself and felt guilty and inadequate. I took a vacation, during which I should have read more about mental health, but had no one to guide me. I was hooked as a psychiatric junkie and had my medicine increased. ■

Mel Starkman is a psychiatric survivor poet, co-founding board member of PSAT, and PSAT archivist.