



NEWSLETTER Summer 1999

The Ballot:

Last year ECT Anonymous asked the membership what they wanted us to campaign for, of the following:

1. A suspension of ECT
2. An independent inquiry
3. A ban on forced shock
4. A ban on children and elderly
5. More honest information
6. A total ban on ECT.

Here are the results of the ballot. 400 forms were distributed and approx. 200 of these were returned. Some respondents voted for more than one category, with members able to vote on all six choices. This is what you said:

1. 32% want a suspension
2. 55% want an independent inquiry
3. 39% a ban on forced shock
4. 39% a ban on children and elderly
5. 51% want more honest information
6. A full 60% came out in favour of a total ban.

The results speak for themselves.

Stop Press:

Proposals to change the Mental Health Act 1983 is the special subject for this issue. We print the ECT Anonymous submission in full, along with lots of additional details. On 22nd June we had a response by 'phone. Helene O'Neil from the MHAR Scoping Team rang Una Parker, who rang Pat, who made sure she spoke personally with Ms. O'Neil. What the Scoping Team wanted was permission for our response on ECT to be sent to a psychiatrist in Scotland - the lady declined to give his name - for his opinion on our arguments. The reason for this is that these include points with which the committee feels unable to deal!

Pat asked several searching questions. She wanted to know why the committee didn't also seek the opinion of a psychologist who is an expert in the after effects of ECT (namely Professor Steve Baldwin), in order to obtain the wider picture, especially seeing that psychiatrists do not acknowledge many of the effects with which Professor Baldwin is conversant. She asked if we could have a copy of the comments by the psychiatrist in Scotland - and also asked why we hadn't been invited to one of the Regional meetings, held so that those whose comments on the proposals were being sought could enter into face-to-face discussion with the Team. Helene O'Neil was clearly embarrassed by this and tried to fob Pat off with the excuse that everything had had to be done in such a hurry. Pat was scathing in reply, pointing out that such unseemly haste is hardly appropriate. Ms. O'Neil promised to pass on Pat's comments to the Team - so we shall see.

Please address all communications re. newsletters to: Mrs. J. Campbell, 88 Gaunt Road, Sheffield. S14 1GG

When ordering the newsletter, please specify which newsletter.

The Autumn / Winter '99 issue is due out in November.

ECT Anon working in partnership with Alex Doherty's 'Need for Change' Campaign (Scotland)

Affiliated to UKAN (United Kingdom Advocates Network)

Member of the UK Federation of Smaller Mental Health Agencies

Member of Women and Mental Health Network U.K.

Member of Support Coalition International

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A FACTPACK is available from Head Office for a minimum donation of £2. (ECT Anonymous is unfunded.)

For General Interest, Students / Journalists, we now have the following publications:

Research References (What psychiatrists say about the long term effects of ECT - see p.17) - £2:

Bibliography - £1: Statistics - 50p. All include P & P. Cheque / P.O. payable to 'ECT Anonymous'

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STOP PRESS!

Simon Holborn of Harrowell Shaftoe is preparing a 'Group Action Update,' which is almost ready for distribution. Those who are part of the Group Action will receive their copy automatically. If you are not part of the Action but would like a copy, please send an A4 s.a.e. to Head Office, marked 'Group Action Newsletter.'

Editorial

'Et tu, Brute' (- so you're mixed up in this too). 1999 has been the year when all kinds of skulduggery has come to light. It has become increasingly clear with each scandal that is covered and uncovered, suppressed or expressed the extent of the corruption in all areas of medicine, government, the media and the law.

Be aware folks the 'establishment' is working against us, "us" being those considered mentally unfit, weak or incompetent. Their words not mine!

What is the establishment afraid of? They are afraid of the truth - it's as simple as that. However I am convinced that someone will have to pay and pay dearly in the near future, for the ruination of people's lives in the name of psychiatry.

Issues surrounding BSE and GM foods are just another part of what is happening to the people of this country - we are being sold out, we are being given half-truths and untruths. And never was it more sure than now that people in the mental health system come bottom of the list. All the talk of including 'users' (I personally hate that word - psychiatrists are the users) in decision-making is largely just lip service. It's clear that the nation's long-term health is in danger (see our survey results!) but who cares? Not those with vested interests or those who seek to conceal the reality. Their only worry is that the truth will out! Well, let's get it out.

Dr Kendell, retiring president of the RCP, blithely stated in a newspaper article this year that there had been no scandals associated with psychiatry so far. Psychiatry itself is a scandal. At present the training of junior doctors (psychiatrists) is so appallingly lacking in humanity, understanding and truthfulness that those responsible for setting the agenda could be accused of acting criminally. It is only by chance that a few good men and women get through the system unscathed by this corruption. Good psychiatrists are as rare as feathers on a fish. Luckily I know a few of them, but they too suffer alongside the rest of us.

It suits the Government to keep psychiatrists in power. Psychiatry has always been used as a measure of control and as a cover for unscientific and unethical experimentation. Psychiatrists and Governments condone legitimised abuse under the auspices of scientific investigation and for the good of the majority. Genetic engineering has always been practised on human beings. Sweden admitted recently to the mass sterilisation of unmarried mothers and the mentally ill in the 70's! All were victims of state approved abuse. Finally the victims were awarded a paltry sum by way of compensation. What an insult! It is so easy for this to happen; it's a chilling reminder not to place your trust in those who have ultimate power.

The so-called mentally ill have always been perceived as fair game. A person classed as mentally ill is all too often unprotected and vulnerable. Even the law does not recognise that they are competent to make their own decisions or capable of deciding what is best for themselves. Until an advanced directive is made irrefutable in law, psychiatrists will continue to override the patient's wishes. This doesn't happen in general medicine!

Ignorance can no longer be the plea. There is evidence in abundance to support the daily abuses by psychiatry. ECT is one of them. Sadly few in the media care enough to root it out. It seems that because it has been a 'treatment' for many years this somehow means it is okay. Well it's not okay. The application of ECT against someone's express wishes is criminal. It is also criminal if information is withheld, and it is also criminal to use ECT in order to force someone to eat. The media are pretty quick to destroy the reputations of politicians, so why don't they investigate psychiatric abuse? Who stops them? Guess who?

It is vital that we keep telling the truth and shouting it loud and clear. There are daring investigative reporters out there, and we have reached some of them but we need more. Let's have the scandal of ECT splashed across the newspapers and television. Let's make sure that the world knows that the UK condones the use of torture whilst parading around Europe pretending that they are squeaky clean by condemning violence and the violation of human rights by other countries. Until the UK cleans up its act with regard to shocking brains we have no right to accuse another country of abuses. Keep writing to your MP, your EMP, Churchman / woman - everyone you can think of. I'll end where I began with a Latin quote, 'nil desperandum' (- never say die / nothing is to be despaired of). So keep telling your stories; one day soon we **will win** this particular war.

Re. stories, by the way, I have just been privileged to read several chapters of Alex Doherty's proposed book, *Two Brothers*. It tells how Alex's brother Joe becomes involved with and dies in the mental health system. It makes incredibly powerful reading. I can't wait for the next chapters. We all wish you every success Alex. This book will let the world know the real truth about what goes on inside a mental hospital and the crass attempts to cover up vital information by the authorities

Pat

* * *

The Big Alternative Conference (17-18 March)

Note: 'Strategies for Living' is a 3-year programme of work undertaken by the Mental Health Foundation, which aims to:

- **Document and disseminate people's strategies of living with mental distress, through qualitative research, publications, newsletters and networks.**
- **Promote an holistic approach towards mental health, taking account of people's mental, physical, spiritual and emotional needs.**
- **Raise user, carer, professional and public awareness about alternative ways of living and coping with mental distress, including complementary therapies and religious and spiritual beliefs.**
- **Encourage and promote user-led research in mental health, enabling service users to set the research and to carry out their own research.**

Report by Una Parker:

Two days of presentations and workshops at the Mental Health Foundation's *Big Alternative Conference*, held at The Commonwealth Institute in London, meant that there were a lot of choices to be made, even though I did not take the opportunity to try out some alternative therapies during the lunch hour each day. I had to choose one of seven workshops at each of the three times for workshop options, and wasn't able to get my first choice the first two times. I found it exhilarating and very full, and a bit bewildering at first. There were about 250 people on the list of participants and I recognised quite a few I had met before. It was good to see Jan Ross there also, speaking up about ECT Anonymous, and to sit with her some of the time.

The subtitle for the first day was '*Strategies for Living and User-led Research*.' In the plenary session Vivien Lindow, of Bristol Survivors Network, answered the question: Why survivor-led research? She suggested we can aim for a survivor-friendly model - taking racism, sexism, poverty, poor or no housing, etc., into account, and not seeing it as "something wrong with us." (She had lost a friend in an accident, but was not allowed to shed a tear; the drug dose was increased.) She gave as an example the disability movement where the research had been emancipatory in objecting to people being treated as "subjects" of research - so bringing about more appropriate methods. She had been welcomed as a researcher as, "you'll know the right questions to ask." We need to learn the mystique of research, but not use it to exclude people. Money has been wasted on drug studies which have looked at a narrowly defined group of people, for a very short duration. We can look for survivor-stated outcomes, giving power to survivors, influencing policy - letting the need to influence policy direct us towards looking for statistics, and using all possible methods - and here she mentioned the value of UKAN and ECT Anonymous researching into people's experience of ECT. Viv spoke also about partnerships in research, ethical issues (should she, researching into risk management, tell people in psychiatric services when someone is suicidal; ?with their agreement - or what if there is no agreement?) We can, she concluded, harness user-research to free ourselves from the effects of distress caused by the system.

Jan Wallcraft of the Mental Health Foundation described how their 'Strategies for Living' research had been done: consultation about questions, the decision that it should be user-led and qualitative, that the sample should be representative and purposive, include men and women, ethnicity, all regions, and that interviewers should be recruited from survivors of distress / psychiatry. They had found that people's strategies for coping included:-

Physical - exercise, sleep, diet, complementary therapies.

Emotional - positive thinking, expressing feelings, distraction from problems, counselling, psychology. (Expression of feelings: laughter improves mood, lifts depression. When people spend time with you the opportunity to talk helps you find your own solutions, takes your mind off your problems and other people's interest in you gives you the motivation to try again.)

Social - mutual support, relationships, helping others, voluntary organisations, work.

Medical - access to appropriate medication, help in reducing or withdrawing from medication.

Relationships - partner, family, friends of similar background, people in a housing project, drop-in centres, places of worship, professionals, CPNs, a GP 'not a pill pusher.' (These personal relationships bring:

not being alone, someone to listen, being trusted / believed / understood, sharing experiences, practical help, doing things together, love, caring, acceptance, "enough nutty people in this village for me not to be noticed.")

Mina Sassoon spoke briefly about '*Issues for Asian Women*,' saying that circumstances surrounding the woman are important for her in making choices, and that pain can and does lead to transformation. She then read a moving poem she had written on the theme. The discussion afterwards emphasised the importance of training professionals in the different issues for ethnic minority people. Viv Lindow spoke about an Asian woman on a ward where no-one spoke her language - and professionals wanted to send her to a white day centre. Black people are over-researched, by researchers using a Western psychiatric point of view.

I went to a workshop about '*Collaborative Evaluation of a rehabilitation service*,' where there had been experience of partnership with professionals, developed over a period of eight years - which seeks to ask, *Are service-users satisfied with the services offered? What worked for them? What would service-users change if they could?* The timetable and details of the work were fully explained.

After lunch, in the afternoon plenary session we heard about the Mental Health Foundation's '**Strategies for Living**' research projects, and the Sainsbury Centre's '**User-focussed Monitoring**.' The Mental Health Foundation publishes '*Research Support News*,' intended for potential user-researchers in mental health. Soon MHF will be publishing '*A Survivor's Guide to DIY Research*,' and will develop a library of materials, including on their website. MHF aims to show that user-led research can be sound research, and to raise the profile of user-led research with other people. Currently MHF supports six small research projects led by users. '**User-focussed Monitoring**' has a model of a cycle, which continues on from informing and involving users, staff, and managers > recruiting local user-interviewers > developing a set of questions > training in interview skills > carrying out interviews > analysing information gathered > writing up findings and making recommendations > acting on recommendations - and continuing round the cycle.

On the second day of the conference '*Creative Dialogue between Service Users and Professionals*' began earlier than I'd expected and I missed the beginning of Rabbi Julia Neuberger's opening speech. She spoke of the cycle of dialogue, the need for professionals to listen to service-users, for service providers to have ongoing dialogue with service-users - who have the expertise because they have lived with the condition and the treatments for a long time.

Dr Phil Thomas of the Bradford Home Treatment Service gave a professional perspective on working with service-users. There are impediments to dialogue and we need to be aware of them. He reminded us that when the NHS started 50 years ago there would not have been a meeting like this, and in that time we have developed technology and systems of knowledge, including medical knowledge. He told us about a doctor he knows in Wales who became depressed as he lived through the changes in medicine. Trained in the 50s, he had been giving morphine to a cancer patient, waiting quietly with the patient - and he realised it was not the drug that was helping. The difference came immediately, and morphine takes effect after half an hour - so he realised it was his presence alongside the family. In 1990, many years after this incident, he saw a 'syringe driver' advertised, "to save time in palliative care."

Evidence Based Medicine (EBM) is being accorded much importance, but is dominated by technology and human values can be lost. Phil Thomas quoted from a Mind survey: "I felt I was treated as an object, not a person" and "They have a set diagnosis, which they treat with drugs and ECT and do not seek causes." EBM is an attempt to provide a standard against which treatments are assessed. Data from different studies is pooled to make meta-analyses of evidence about drugs. A gulf can open up between patients and doctors focussing on diagnoses or categories, between the medical model and the validity of treatments. Definitions set a victimised group apart, targeted for special treatment - and something of that seeps into the attitude to the individual. Those categorised as having 'severe mental illness' do not have the same civil or human rights as those who do not have that label applied to them. The medical model puts the problem within the person and disregards the context of people's lives. Caring is lost.

In a sentence that seems particularly apt for us in ECT Anonymous, Phil Thomas said "that psychiatrists see themselves as experts in pharmacology rather than in human behaviour, and retreat into technology rather than dealing in encountering the grief and emotion of patients." (I think he said this was a quote from Dr Kathleen Jones.) Answering a question from Jan, in which she remarked, "the brain is a finely tuned instrument," he said of the psychiatrist using ECT, "He has no insight."

Alison Faulkner of MHF gave answers in '*Why Listen to Service-users?*' She pointed out that we are all experts in our own mental health. We have some good ideas. We know that services need to prove and improve quality. We have evidence for Evidence Based Medicine. She listed different levels of listening - to the individual in a therapeutic relationship, to the representative in developing advocacy and local services through surveys of users, in evaluating services, complaints, and clinical governance, and in influencing national policy development through research and campaigning. Service users are asking for someone to listen (especially in acute care), for alternatives to medication, self-help alternatives, for information and practical help (housing, money, work) / help in a crisis. She outlined work the MHF is following, through the Strategies for Living project as outlined above in what Jan Wallcraft said.

I attended a workshop on '*Doctor / Patient Dialogue*,' led by Dr Richard Byng, a GP from South London who trains GPs. He said that doctors can be more effective if there is dialogue with the patient, but they may not offer the opportunity. He is particularly involved in training GPs in this, and he commented that psychiatrists do not have any training in these skills! He has a wide range of interests in holistic medicine, particularly in shiatsu, which he would like to research in his own practice. He also commented on the problems with Evidence Based Medicine - pointing out there are no clinical trials for surgical procedures. **When I asked about ECT, he seemed to agree that a positive result of EBM might be to push out ECT.**

There followed a plenary session: '*Black Services* -

What is different about them? was done by way of a conversation between Yvonne Christie and another black woman. What was said included the following: People *think* they know us.

There's too much research, not enough reflection. Black people are seen as "too loud, too much movement, too...."

Separate 'Black Space' makes white people uncomfortable, but for us it is sanctuary - a safe place to be, in harmony. In

Black Space we can celebrate the many good things about black families, we can celebrate our identity, have a space to be angry, to loosen the bonds we have absorbed, and to acknowledge the importance of elders. There is need for the recognition of racism and the way it operates. As a black person I am not going to talk

about it if you are likely to be uncomfortable. People don't talk about our history. Black professionals may meet other black people with cold eyes - which they've had to do in order to get to their position. As for decisions about funding; black groups should not be left to flounder, nor should outcome measures be 'white.' We expect that projects will take time to develop. Providers and purchasers need to be pro-active.

In the afternoon Karen Campbell of the Manic Depression Fellowship spoke about '*Self-management Training*.' She briefly mentioned her own experience of no admissions in 7 years - after 20 years, 21 admissions and 13 sections. MDF has a network of self-help groups and has a Self-management Training Project following on from a Conference in 1998, where ideas based on a workbook by Mary Ellen Copeland were trialed and 20 people were trained as trainers. There are now programmes in Leicester, Birmingham, Cambridge and Brighton. MDF sells a booklet, '*Inside Out*,' that helps people get started on their own. The programme makes use of past experiences - understanding the different elements involved and trying to keep them in balance - and is given to small groups of 8-10 people. It takes 6 sessions - 2 on Recognition / Acceptance, 2 on Awareness (what are my triggers?) and 2 on Action (coping strategies, support system, mood diaries, maintenance). MDF has set up user-evaluation and there is also clinical evaluation. It is not easy! It is a challenging process. The programme demands commitment: taking responsibility for your own mental health.

Angela Linton-Abulu spoke about the '*Black Women's Project*.' Black women speaking for themselves - 'Active today for a better tomorrow,' recognising that we need "one of us" to listen, not just "someone." The project has no permanent base. It was started by themselves and interest shown only when someone wanted to take them over. There were issues around the use of the term "*Survivors*," with it being asked, "Why? We want to call you "service-users"." Women are visited at home and in hospital. 'Black space' is black users and survivors sharing with each other, and bringing information to other groups. As white users and survivors we can only gain and have nothing to lose.

I went to a workshop that was being led by Jim Read and Veronica Dewan (people I know) called '*Healing hurts through emotional release*.' As we arrived we were asked to work in threes, each talking about when we last had a good laugh. There were about 30 of us finally, and Jim said he had come across the phrase 'emotionally illiterate' - and that many of us had been taught to suppress our emotions and be emotionally illiterate. Veronica spoke about some forms of emotional release - animated talking, laughing, crying, and angry raging. We

anti-depressants. (When I was in hospital ECT was prescribed because I was found crying.) Jim asked us to share in the big group safe ways of letting off anger, and there were some very varied suggestions, amongst which were sport, tearing up papers and writing poetry. We each then said what we had liked about the time we had been together. And all this was accomplished in just an hour!

I am grateful for the financial assistance for my fare from ECT Anonymous, for which this report is intended as thanks.

Complementary Therapies in Mental Health:

Some of the focus of the Big Alternative Conference was on alternative and complementary therapies. Homoeopaths, acupuncturists, reflexologists and a whole range of practitioners of other therapies were present at the conference, talking about and demonstrating their treatments. (Una barely touches upon this aspect; as she says, she didn't attend any of the therapy sessions.) Alternative therapies offer (sometimes suspect) alternatives to orthodox Western medicine and the term 'complementary therapy' generally indicates that the therapy complements orthodox medicine.

In mental health, user dissatisfaction with psychiatric treatments has resulted in an upsurge of alternatives and complements. Sometimes therapists have focused on finding ways to manage the side effects of psychotropic medication and even ECT. In this connection, Maria Clarke, a registered osteopath (and Senior Osteopathic Registrar at the Osteopathic Centre for Children in Harley Street), who attended the conference in her capacity as a therapist, afterwards contacted Pat to explain the potential benefits of Cranial Osteopathic Techniques for post ECT patients. She writes, "**These are non invasive and gentle techniques that have the capacity to treat problems emanating from the central nervous system.**" Also, "I have a personal interest in mental health issues (I am in my last year of a Masters degree in the Ethics of Healthcare) and other gross abuses of Ethics that occur through the medium of modern medicine."

Whereas osteopaths have treated isolated cases of the side effects of ECT there has been no pilot study. Maria Clarke proposes conducting a study with 20 ECT survivors to evaluate if osteopathic treatment would make a difference. There would be no counselling, or drugs, used – simply the application of Osteopathic Cranial techniques, with evaluation prior to each session. Treatment would be fortnightly for 3 months - with the option to extend to 6, but patients would be asked to commit to 3 months initially. Many ECT survivors suffer headaches, neuralgia, neck and back stiffness and pain, eye problems, compromised hearing and epilepsy. These symptoms as well as others should benefit greatly from what, quite marvellously, is being offered.

Cranial Osteopathy Pilot Study – Can You Self-Fund?

Political opposition to complementary therapies from mainstream healthcare professionals flourishes and this, combined with lack of resources, means availability of complementary treatment on the NHS is limited. Although Maria Clarke is offering an initial session free of charge, after that there will be a charge of £25 per treatment (lasting approximately 20 minutes). Fares must also be found, as treatment is to take place at the Hale Clinic, 7 Park Crescent - in central London. Sir Charles Jessel, who is personally interested in treatments for mental conditions, has generously donated £1,000 to the project, for which we are most grateful. Thank you, Sir Charles, from the whole of ECT Anonymous! Approaches have been made to other sources of funding, but Ms. Clarke hopes to commence the treatment series in less than two months. So, if any person who feels Osteopathic Cranial techniques would be ideal for them is able and willing to fund themselves, wholly or partly, please get in touch with Pat a.s.a.p.

It's All In The Diet:

Book: 'Guide to Mental Health.' A few lone medical pioneers have discovered incredible scientific evidence showing that much of what we consider mental illness – the so-called "sick" brain – is not 'mental' at all. Allergies or even simple vitamin or mineral deficiencies can make us act funny, even crazy. These trailblazing pioneers have also made astounding advances in successfully treating an array of so-called psychiatric diseases, just with vitamins or diet. In a special handbook, the 'Guide to Mental Health,' the editors of *What Doctors Don't Tell You* (WDDTY) have assembled a colossal body of evidence demonstrating that it is mainly an unhealthy body – through allergies or nutritional deficiencies – that creates a sick mind, and that great strides can be made through dietary regulation. In this invaluable handbook you will learn that:

- **A low-fat or low-cholesterol diet often brings on depression**
- **A homoeopathic remedy has been found to be more effective than drugs for insomnia**
- **A gluten allergy or a folic acid deficiency has been linked with many cases of schizophrenia**
- **Many hyperactive children are deficient in vitamin B6**
- **More than half of all autistic children improve once they are taken off wheat, milk and sugar.**

Evidence of the side effects and problems of electroshock treatment and drug therapy is also offered as are genuine alternatives for treating depression, anxiety, insomnia, schizophrenia, hyperactivity and autism. There is a large section devoted to maintaining mental health, which describes in detail the dietary and supplement programme that will keep you in the peak of mental health. To order, send a cheque - or credit card details - for £5.99 (which includes p & p), to:

WDDTY, 77 Grosvenor Avenue, London. N5 2NN

Booklet: 'Mental Illness – Not all in the mind' is available from Head Office, price £1, including postage. It is the work of the Mental Health Project, a voluntary action group open to all, set up and supported by the Institute of Nutrition and existing to disseminate information about the role of nutrition in mental health. (This is becoming increasingly understood. The Mental Health Foundation 'MHF Briefing 23' states, "Research into nutritional dietary medicine has demonstrated that food sensitivities may cause psychiatric symptoms....")

It is estimated that 2 in every 10 people suffer from allergies and, given that a great number of psychiatric drugs are similar to antihistamines, a theory being propounded is that this suggests some mental problems could be allergenic in origin. One of the findings is that approaches to mental illness which give specific nutrients to supply the raw materials the brain needs to rebalance neurotransmitters are much safer and less toxic than giving drugs that block or enhance neurotransmitters. The definition of mental illness the booklet provides is controversial, and in view of the booklet's contents generally it seems a pity that the compilers have seen fit to play safe and not question that what they have defined really is mental illness, rather than psychiatric symptoms caused by the imbalances described.

Depression, the new world epidemic:

'Mental Illness – Not all in the mind' suggests the main reason people become mentally unwell is they fall prey to "a chemical imbalance that affects how they think and feel, brought on by years of inadequate nutrition and exposure to pollutants and environmental toxins." These factors may indeed play a key role in the way people feel. The *Daily Mail* (12//5/'99), relating the gist of a recent World Health Report, warns, "Depression is becoming the scourge of the young and middle-aged worldwide. ... Throughout Europe, depression and

The Great Big ECT Anonymous Newsletter

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In April the World Health Organisation published four Fact Sheets (217-220) and a Press Release (WHO/26) dealing with mental health issues. The *Disability Awareness in Action* Newsletter No. 73 (June '99) contains the following, revealing, extracted highlights:

- 50% of the leading causes of disability world-wide relate to mental illness.
- People experiencing mental illness are at a higher risk of having their human rights and freedoms violated.
- Legislation to protect the rights of people experiencing mental illness are 'a necessary requirement.'
- WHO emphasises that social conditions, including unemployment, inadequate education, discrimination, human rights violations and poverty have been identified as causing mental illness.
- Legislation should aim to ensure that treatment can be imposed only in strictly limited and clearly defined circumstances.
- WHO calls on governments to review priorities and commitments, whilst also recognising that substantial benefits flow from investment in mental health.
- WHO and the European Commission will collaborate to promote mental health.

(WHO press releases and fact sheets can be accessed on the Internet at <http://www.who.ch>) Clearly, what the World Health Organisation has to say on the subject of mental health is poles apart from the way understanding and the law in relation to mental health care in Britain are heading.

Adaptation Behaviour Therapy – A Technique:

"Thoughts held in mind produce after their kind. What I focus on expands."

ABT is a (controversial) practical method of training your mind to fight depression, pioneered by Oxford psychiatrist Clive Sherlock and described in *The Times* (16/2/99). Instead of trying to change your thoughts, as advocated by cognitive behaviour therapists, accept them. Don't suppress them or avoid them but don't dwell on them. Just decline to give them the time of day or do anything with them. Let them flow in on one side of your head and out the other. Rather than lingering on past events or worrying about the future, which locks you in anxiety or depression or anger because of the emotions that accompany the thoughts - take a deep breath, label what's going on in your head "thoughts" and get on with what you are meant to be doing. According to Sherlock, we spend over 50 per cent of our lives thinking about something other than what we are doing. In our heads we are living elsewhere than the place in time and space we occupy and this can give rise to all sorts of mental problems, including panic attacks and even obsessive compulsive disorder.

Responding with zero questioning or reflection will change the way you react and ease you out of habitual patterns of responding. Once you get used to using the technique it will clear away a lot of clutter. Thus, instead of thinking of yourself as hopeless, you will start to realise it is a complete waste of time even to think about such thoughts. How we feel controls what we do, and if we can be self-disciplined enough not to let our thoughts take over - if we practice not being preoccupied with our thoughts - the feelings that go with them and stress us out won't take hold and drag us down. As for feelings, accept them in the same way. All that is necessary is simply to say "Yes" to a feeling in your head and feel it for a few seconds. Don't suppress it, express it, tense up against it or distract from it.

Note: Some would disagree and suggest that ideally you should establish a system of *positive* self-programming, as:

Life itself cannot give you joy unless you really will it.

Life just gives you time and space - it's up to you to fill it.
(Chinese proverb)

'The Shocking Truth' – a shocking mockery:

ECT needs to become a subject of public debate - like GM foods. In Britain recently, despite survivor's letters to national dailies and t.v. programme producers, the little interest generated tends to favour psychiatric truth. Where survivors are granted space, they're humoured. Annabel Ferriman (*The Independent*, 4/5/99) exemplifies the attitude. She writes, "Ever since its introduction into Europe in the late Thirties, the use of ECT has been fraught with controversy. To many lay people, its use is barbaric. They associate it with the electric chair or torture, and base their ideas of how it is carried out in the terrifying scene in *One Flew Over the Cuckoo's Nest*...." What this means is that, having been taken in (along with other journalists), she is happy to parrot psychiatry's propaganda, including parroting objections to 'vintage footage' allegedly conveying the wrong impressions. In fact, the scene in the film of *One Flew Over the Cuckoo's Nest* where ECT is shown is pretty low key compared with other scenes. In any case, why did a work of fiction affect public consciousness to the extent that, decades later, somebody like Annabel Ferriman feels impelled to refer to it for colour? Let us not forget that Ken Kesey's account of treatment as meted out to psychiatric patients was the brainchild of a 10-month stint of work he put in within a mental institution.

If the showing of unmodified ECT from times past is unrepresentative of what ECT-in-progress looks like nowadays it must be remembered that the showing of modified ECT - as was done on prime time television (*Look North*, April 1998) is a gross misrepresentation of what is really happening to the person involved. As indication that Ms. Ferriman has not even begun to comprehend what's at stake here - for no matter which version of ECT is shown the viewer cannot see its effects on the brain and health of the recipient - she gaily quotes Dr Chris Freeman, consultant psychotherapist at the Royal Edinburgh Hospital and chairman of the Royal College of Psychiatrists special committee on ECT. "If every time they showed an appendix operation on television, they showed a barber surgeon carrying out the operation without an anaesthetic, with staff holding the patient down and blood spurting everywhere, the public would be terrified of having their appendix out. And people would complain that it was inaccurate. Yet every media clip on ECT is seriously out of date, and shows patients having treatment without anaesthesia, without a muscle relaxant, and with staff in white coats holding the patients down. It is a travesty of the truth," he said."

Presumably, Annabel Ferriman hasn't acquired responsibility for her own health column without having intelligence and common sense in good measure. Did she not see fit to query this tasteless account? In the first place, ECT isn't comparable to an appendectomy as described - with blood spurting everywhere. The essential point is that no clip (no matter how "seriously out of date" the footage on ECT) ever shows brain cells being demyelinated or starved of oxygen and nutrients, blood vessels in the brain bursting, the limbic system being ablated, the heart stopping temporarily, etc. - as, with ECT, all of these outcomes happen unseen. Rather than "the truth," Freeman must have been after the emotional reaction mentioned of blood and cuts usually cited, travesty being the forte of psychiatrists. It is to be noted in this

equipment most widely used in British hospitals has not been designed for use with the electroencephalogram and “EEG monitoring has rarely been used in the UK, unless for research,” according to John Pippard (‘Audit of Electroconvulsive Treatment in two National Health Service Regions,’ *Brit. J. Psychiat.* (1992), 160), would make doing this difficult. Secondly, although modified ECT does not require medical personnel to hold the patient down, images of modified ECT are even more a travesty of the truth than those obtained when the ECT was unmodified, as the fact that a seizure is occurring is disguised. Freeman neglected to mention finer points of the sort, and the inconvenient actuality that muscle relaxants carry their own risks.

Through Annabel Ferriman, we are treated to a below-the-belt criticism of the government from none other than Dr. Robert Kendell. Seemingly, “Dr Kendell feels that the Government is not interested in the administration of ECT. The Royal College of Psychiatrists wrote to the chief executives of all the NHS trusts two years ago, drawing their attention to the guidelines on ECT. But when the college recently asked the Department of Health to write to the same chief executives to ask them what action they had taken following the letter, the department did not respond.” (The relationship between government and psychiatry would appear to be somewhat stormy at the moment! Other hints to the effect have been picked up on and are mentioned in this newsletter.)

Ferriman concedes (or gets in a sly dig), “Given the controversy that ECT attracts, it comes as a surprise to discover that the Government does not know how often the treatment is used, and whether its use is waxing or waning. The Department of Health has not collected statistics since 1991 when the then Health Secretary, Kenneth Clarke, decided that such monitoring was unnecessary. ... Now the Government has decided to update its figures. **Every psychiatric unit has recorded its use of ECT during the first three months of this year and the Department of Health intends to publish the results in the summer.**” She then remarks, “Whatever the figures show, certain groups are bound to protest that it is still being used too often.” What this health correspondent has failed to take on board is that the objections being put forward by these “certain groups” centre on the argument that ECT is not a valid medical treatment. If a reliable guide to medical treatment are the findings from the medical profession itself, then Annabel Ferriman *was in receipt of material from within psychiatry* to indicate that ECT is a harmful perversion of legitimate therapy. ECT Anonymous sent it to her. It’s doubtful lay people do associate ECT with electrocution and torture; however groups opposed to ECT are not the ones encouraging that imagery. Our position is far subtler and is in line with what the lawyer, Mrs. L. O. Smith (see MHA Review) proposed when stating, “The words “treatment” and “therapy” used in conjunction with “electric shock” are typical of the redefinition of words and concepts which seemingly justify its use.”

Here is Annabel Ferriman’s summary of the ECT Anonymous survey. “ECT Anonymous has just published the results of its own survey, a questionnaire which it sent out to 500 people who had previously complained about the serious harm they had suffered from ECT. Mrs Pat Butterfield, the organisation’s co-founder, said the results were “so horrifying that it is difficult to comprehend the scale of the harm that is occurring. About half our respondents were able to report that ECT initially had some effect... [but] when it came to the long-term result, almost three-quarters reported that it had been completely ineffective. All our respondents found the after-effects widespread and devastating”. Only 7 per cent had been able to return to their original occupation. Eighty-seven per cent felt they had been pressured into having ECT, and 98 per cent felt that the risks had not been fully explained to them. “At the moment, people cannot give informed consent because they are not being given the full information. Anybody who was fully informed would not agree to it,” said Mrs Butterworth.” (!)

Needless to say, the Ferriman article is peppered with psychiatry’s myths, especially:

- “For certain people, ECT is a life-saving treatment,” said Dr. Susan Benbow, consultant psychiatrist for the elderly at Manchester Royal Infirmary and a member of the Royal College of Psychiatry’s special committee on ECT. “In the vast majority of cases, it is given for severe depression,” she added. “Usually the patient is so acutely ill that you cannot wait long enough for anti-depressant drugs to work. Often the patient is reluctant to eat or drink, or is acutely suicidal. You may feel that if you wait, he or she will die.”
- Dr Kendell admits that many patients suffer temporary memory loss after ECT, but says that research shows that after three months, memory impairment is almost undetectable, and permanent impairment extremely rare. “The problem is that when people are depressed, they cannot concentrate, so they don’t take things in. They interpret that as being memory loss.”
- Another myth paraded is “it is the seizure which is the therapeutic agent, not the electricity itself.”

In relation to the last one, the truth of the matter as finally admitted by psychiatry is that electricity is both the therapeutic (*sic*) agent and the source of cognitive damage. Here it is in black and white:

“After Ottosson’s (1960) work, cognitive impairment was generally regarded as an effect of the electricity mainly, and the therapeutic benefit of ECT was attributed to the seizure. ... [However] **many long-held assumptions were false** and there is increasing evidence that... **the degree to which electrical dose exceeds seizure threshold, and not the absolute dose administered, determines dosing effects on clinical outcome and the magnitude of cognitive deficits.**”

(John Pippard, ‘Audit of Electroconvulsive Treatment in two National Health Service Regions,’ *Brit. J. Psychiat.* (1992), 160)

Annabel Ferriman hasn’t done her homework. She has carelessly squandered an opportunity for journalistic denunciation, which, had she been interested, she could have recognised the necessity for from the clues available to her. Not can she claim impartiality, given her parting shot: “Even the Royal College’s campaign to improve training and supervision annoys those who would like to see the practice banned. So when the Department of Health publishes its statistics on how many patients are having the treatment, we can expect to see more sparks fly.” Well actually the RCP campaign doesn’t so much annoy us as leave us fearful about the lengths to which psychiatry will go to make ECT appear sound and to detract attention from a core issue – that ECT is never safe and effective even though personnel were superbly trained. How delightful of Ms. Ferriman to close with so terrible a pun. Those at risk certainly don’t need the Annabels of this world to mock their plight – the representatives of a free press, whose public duty it supposedly is to peer into the dark corners of abomination and deceit and to stand up for the oppressed. Is the press never going to cotton on! Sadly, it isn’t a matter of what is true, or just and ethical. Rather public opinion / public interest – i.e. what will sell papers - are the yardsticks by which what gets into print are measured (and who controls what).

In reply to Annabel Ferriman:

studies – of the effect of ECT on animals, of autopsies, on brainwaves (EEG), and psychological and clinical research – provide overwhelming evidence that ECT kills substantial numbers of nerve cells with resulting permanent memory loss. There is no such thing as safe ECT.

“When ECT was first used as a treatment, the brain damage and permanent memory loss caused by it were seen as therapeutic by psychiatrists. In America, Max Fink, a leading advocate of ECT, still states that the basis of improvement is “similar to that of craniocerebral trauma” (head injury). British psychiatrists know that to openly admit to such views would cause a public outcry, but I do not accept that they really believe that ECT does not cause substantial brain damage. There is too much evidence to the contrary, in books like *Electroshock: Its Brain Disabling Effects* and, more recently, *Brain Disabling Treatments in Psychiatry*, by the American psychiatrist, Peter Breggin.

“There are many statements made by psychiatrists in the article that sound authoritative, but which could easily have been challenged by people who are well informed about ECT. Pat Butterfield of ECT Anonymous could have done so, or made the points made in this letter. It is a pity that she was not given the chance to respond directly to what was said.” (Donnard White)

Official Statistics and ECT:

June 1998 saw the end of a consultation period for a Green Paper on the future of official statistics. Ian Maclean, Chairman of the Statistics Users’ Council, in a letter to *The Times* (9/6/98) following the Panoramia report “on the unnecessary deaths of so many babies from heart surgery at Bristol Royal Infirmary,” stressed “**the need for a national statistics service to ensure the compilation of statistical evidence of this nature and its public availability.** The Green Paper is principally concerned with creating confidence in official statistics and with their role as “a window on the performance of Government... used by the people to judge whether the Government is delivering on its promises”. The improved availability of statistical evidence at both the national and...the personal level, will be a major step forward in allowing the public to make rational, informed decisions.”

Survivor Sue Kemsley has made available correspondence highlighting just how far we would need to go to get made obligatory accessible and correctly used statistics permitting the making of rational, informed decisions about ECT and giving us a window on the performance of the government in relation to mental health. A letter dated 9/4/99 from Justine Windsor, the Health Services Directorate (Mental Health) of the NHS Executive in London stated:

Dear Ms Kemlsey (!),

“Thank you for your letter dated 28 January to Mr Hutton regarding statistics on ECT. ...

“You ask why Mental Health Act Commission statistics were not used in reply to Mr Amess’ recent Parliamentary Question about numbers of people receiving ECT with and without patient consent. As you point out, the MHAC do not collect statistics on ECT carried out under section 58 and 61 of the Mental Health Act, so it would not have been appropriate to use these statistics in any reply as the figures would have been misleading.”

Here is Sue Kemsley’s response, dated 14th April:

Dear Justine Windsor,

“... The MHAC does collect statistics on the use of ECT under Section 58, as I pointed out in my letter to Mr. Hutton.

“Sometimes when a question that requires a statistical answer is asked in Parliament the answer given does not tally exactly with the question. ... This is not misleading as long as it is made clear exactly what the statistics refer to.

“For example, it would be misleading to say, “4,607 people were treated with ECT without their consent in England and Wales in 1993-1995.” It would not, however, be misleading to say, “The MHAC received 4,607 requests to use ECT under Section 58 in 1993-1995. ECT can also be given to non-consenting patients under Section 62. Information on the use of ECT under Section 62 is not collected by the MHAC.”

“Mr. Hutton could also have referred Mr Amess to the recent Royal College of Psychiatrists’ audit of ECT in East Anglia and Wales, in which 17 (13%) of 130 patients observed undergoing ECT were “being given ECT against their will under the provisions of Section 62 or 58.”

“Perhaps the government is reluctant to draw attention to the extent of the use of ECT without consent in this country, especially in view of the concern expressed by the Parliamentary Assembly of the Council of Europe and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment over the use of ECT without a person’s consent.

“Indeed, it is strange that information on the use of ECT in general (that is, with or without consent) is no longer “available centrally,” while MPs who asked questions about ECT use in the 1980s were given detailed statistical answers.”

Interest in Canada:

A determined survivor of what he feels was ECT used inappropriately – for addiction to alcohol - Wayne Lax of Kenora is now a well-known anti-psychiatry figure in Canada, whose story has also become known in North America and Europe. In 1966, at the age of 25, Wayne turned to drink to ease depression following a sudden, deeply upsetting, death. His brother, taking a nap in his car with the engine running, was asphyxiated by carbon monoxide fumes as the car became buried in snow. Sucked into the psychiatric system, Wayne was prescribed numerous mind-altering psychotropic agents (“everything on the market,” to use his own words) and ECT, on which he came to depend and which went on for years. He had 108 psychiatric admissions and was living in a nursing home by the age of 44 after being told he would never live on his own. In the end, however, jolted by a charge of impaired driving after a motor vehicle accident in 1992, he made the decision to go cold turkey. It took him a year to wean himself off medication and ECT and start feeling better without them. “Then the alcohol left,” he says, “and I never heard any voices and I’ve never been in the hospital since.”

According to a recent newspaper account (*Kenora Enterprise*, 21/3/99), “The journey to recovery continues for Lax. What galls and pains him is that the electroshock treatment he received on 80 occasions robbed him of much of his memory. ... Lax’s long and emotionally charged story has made him something of an international celebrity. His story of alleged psychiatric abuses was included in a riveting series in the *Toronto Star* last fall. Award-winning broadcast journalist Scott Simmie penned the multi-part series. Simmie won the tenth annual Atkinson Fellowship, which gave him a year to study the dark underside of mental health in Ontario and across the country.” Wayne has corresponded with Pat Butterfield, and in response to their article about him, she wrote the following letter to the *Kenora Enterprise*, published on 25/4/99):

“It takes courage for survivors to speak out against their oppressors and Wayne is to be congratulated for doing this.

“There is evidence in abundance that ECT causes brain damage. And a recent study by Lucy Johnstone of Bristol University, confirms that ECT causes long-term psychological damage. Our own recent survey of 200 survivors shows that ECT has a devastating effect upon the physical and psychological body.

“ECT should not be regarded as a ‘treatment.’ For too many it is simply torture and should, under no circumstances, be forced upon anyone. Thank you for continuing to debate this issue in your newspaper.”

We should not forget that ECT abuses are perpetrated in ‘civilised’ countries world-wide. Links with fellow sufferers like Wayne remind us not only of our common humanity and vulnerability but also that we do not resist in isolation. Everywhere, men and women, long euphemised as ‘sick’ but actually thought of as beneath contempt, are finding dignity and a purpose in standing up to be counted as the ECT-damaged.

Recommended Book:

“What DiffErenCe Does IT Make?” (The Journey of a Soul Survivor) by Wendy Funk

“Wendy Funk has written a brutally honest, moving and courageous account about what it’s like to survive electroshock and the psychiatric system. She seeks help for a sore throat and ends up getting forcibly drugged, electroshocked and terrorized in a Canadian psychoprison.” (Don Weitz, anti-psychiatry activist; co-editor of *Shrink Resistant: The Struggle Against Psychiatry in Canada*, and CKLN radio producer and host of *Shrinkrap*)

“Wendy reveals as only a survivor can the travesty, the dehumanization, the affront to self, and the theft of self perpetrated by the psychiatric system. A gripping and terrifying account that serves as a warning to anyone who thinks that they are beyond reach.”

(Bonnie Burstow, psychotherapist and anti-psychiatry activist; co-editor of *Shrink Resistant: The Struggle Against Psychiatry in Canada*)

Wendy Funk tells the story of how a male psychiatrist decided to take over from the husband he believed was failing to restrict her role to that suited to a woman. She lost her freedom and the rights we take for granted, was maltreated by all-powerful psychiatric staff, drugged into zombiehood and given around 40 doses of ECT. Her husband, knowing no better, accepted that incarceration and treatment by psychiatrists were necessary, even good - and it took a long time and much damage for realisation of what was really going on to dawn. Wendy Funk is in process of suing the doctors responsible. This is a well-written book, easy to follow even for someone with ECT-induced reading problems, and comes highly recommended. It is a book that should be required reading for older schoolchildren, for its consciousness-raising properties! Published by Wild Flower Publishing, the ISBN is 0-9683913-0-3. Your local bookseller should be able to order it for you.

Interest in New Zealand:

Members of the Patients Rights Advocacy in Waikato, Hamilton have written to compliment us, saying, “We are particularly impressed with *The Great Big ECT Anonymous Newsletter*. Keep on going.” They included a cutting from *Waikato Times* (30/3/99), headed ‘Shock treatment: new allegations against Lake Alice.’ A huge case involving 110 claimants is well advanced and is being watched carefully by Waikato advocates Anna de Jonge and Margaret Jongeneel. Basically, the allegation is that in the Seventies when they were boys aged between 9 and 16, the claimants were routinely subjected to ECT as punishment for smoking and other misdemeanours at Lake Alice Hospital, Wanganui. Interestingly, the services of Professor Steve Baldwin of Teesside University have been procured by the lawyers prosecuting the ‘Children of Lake Alice’ case. Professor Baldwin is fast gaining world-wide renown as an expert witness in cases involving the use of ECT on children and adolescents. Extracts from one of his published papers appear below.

Also included, a letter by Anna de Jonge (that had featured in *Metro*, an Auckland periodical) describing the work she does, says, “In my present vocation, as a patient advocate, I am still kept in touch with patients who have been damaged. I also know members of our society who have been harmed by ECT despite the fact that the psychiatrist responsible maintains he did them a good service. Despite the defence of modified ECT, it is interesting that two current complaints laid with me concern patients who have had this type of treatment. One refers to a man who has been, as reported in writing, “reduced to a wreck, permanently brain-damaged, unable to do anything but walk around mumbling incoherently.” The other concerns a brain-damaged baby boy in the care of the complainant (his grandmother) who alleges the damage occurred before the boy’s birth when his mother was subjected to ECT during her pregnancy. As the mother has three other perfectly normal children, her Hamilton doctor believes that the ECT treatment must be held accountable for the child’s brain damage.”

What Effect ECT In Utero?

“...while carrying Rose, her mother..., Daisy, had received electroconvulsive therapy.” The ‘Daisy’ in question was Daisy Letts and the daughter electroshocked in her mother’s womb is none other than the infamous Rose West. As a child, apparently, Rosemary Letts “was so passive that her siblings used to call her ‘Dozy Rosie.’ But whereas the atmosphere of violence and mental torture deeply affected the rest of the family, Rose appeared unperturbed....” She is described as being, in childhood, pliable but cunning. “Rose appeared to accept her father’s sexual attentions as normal. She may have been pliable because sexual intimacy with him was preferable to the alternative – mental and physical torture.” (*Murder in mind*, Marshall Cavendish)

ECT-induced brainwave abnormalities will show up on an EEG, sometimes a long time afterwards. Slow delta rhythms are a typical type of abnormality - and the delta rhythms of degeneration, death and disease are rarely recorded in normal, awake adults. Their appearance is indicative of various pathological states, including failure of homeostasis, and they are interpreted as evidence of pathology. It has long been known that “The [delta] rhythm can be induced in young patients by many electric fits....” (Denis Hill, ‘The Relationship of Electroencephalography to Psychiatry,’ *J. Ment. Sci.* (91), 1945) Indeed, inducing the rhythm of pathological states was justified by such as Hill as necessary to therapeutic brain re-regulation. Revealingly, in respect of the above description of young Rose Letts,

“The only characteristic of behaviour which was significantly correlated with the presence of delta activity in these children was...a relatively promising reaction to their mothers, to leisure, and to their fellows, as estimated by the authorities responsible for classifying them.

Rather than finding her father's attentions "preferable to the alternative," Dozy Rosie may instead have been ductile / pliable because she had the brainwave abnormality ECT can induce. What kind of society accepts the risk, however remote, of creating monsters forever stuck in pathological ductility as a result of a 'treatment' used on the mother in pregnancy?

For that matter, what society allows its elderly to be tampered with?

So asks Sue Stevens (*The Big Issue Cymru*, May 31-June 6), stating, "I would like...to repeat the warning to elderly people that they need to put their wishes on file. This follows the quoted outrageous statement from the Mental Health Commission that ECT may be used more often on elderly people who are not eating and drinking [whereas the ones that do take nourishment risk being starved to death – see 'The Temptations for the Medical Mafia']. This reveals so much – what society would allow its elderly people to be 'treated' in this manner? It is about time the agencies devoted to older age groups started to speak out; so far they remain disquietingly silent."

Help the Aged:

The Big Issue Cymru (June 14-20) printed the following response to Sue Stevens' letter:

"... I personally know of cases in hospital where old people turned their backs on life and died peaceably although many attempts were made to get them to eat. Force feeding is forbidden to be used on prisoners in prison and any mechanism such as the violent use of electric shock therapy is illegal when used for the purpose of making patients eat. Doctors assume rights which they do not have. If as a result of not using this shock treatment the old die, they have done so of their own volition. There is nothing worse than seeing food forced down people's throats and seeing it dribble out, making the person so abused as to lose all dignity.

"The use of shock treatment against the will of the individual should be reported as a crime to the police and the media immediately it is known." (John Stanley Coburi)

(Sue Stevens comments: Thought you might like to publicise a rather novel idea, i.e. bypass complaints' systems, even solicitors, and GO STRAIGHT TO THE POLICE to report assault and battery!!)

Agencies for the Protection of Children Should Also Speak Out:

Ronald Allen of Hartlepool campaigns against ECT, having lost a brother as a result of psychiatric mistreatment. In April he felt impelled to write to the NSPCC to ask this organisation to support a ban on the giving of ECT to children. He did so in consequence of an article in his local press claiming that, as part of the NSPCC's 'Full Stop' campaign, "Peter Mandelson has challenged the people of Hartlepool to do all they can to stamp out cruelty to Britain's children." As far as Mr. Allen is concerned people should be challenging MPs like Mandelson about their hypocrisy. He points out that child cruelty has been covered up for years by each new government, in general across the country but also in NHS and private clinics where psychiatrists electroshock and drug children. He wants to know, Is not ECT given to a child cruelty to that child? David Truan, Legal Officer for the NSPCC, replied as follows:

Dear Mr. Allen,

"I thank you for the information that you sent to us, relating to Electro-Convulsive Shock Therapy.

"The NSPCC is of the opinion that any treatment given to children should meet their particular needs. This area of medicine is not one in which we can make any informal comment, as such decisions would have to rest with medical professionals that are able to comment on the issues involved.

"I was sorry to hear of the death of your brother in 1966, and I wish you well with your ongoing campaign."

In fact, Pat herself had also taken note of the new impetus to stamp out cruelty to children, and written to Jim Harding at the NSPCC:

"Having watched the promotional programmes and new adverts concerning child abuse last week, one cannot help but be appalled at the sheer scale of the problem.

"What you seem to fail to address however are the abuses to children at the hands of psychiatry. We have a growing number of survivor members who were given electric shock treatment as minors. It appears that many of these abused children were given ECT for very dubious reasons. Some because they were 'odd,' others for behaviour problems, one (which we have well documented) for a gender 'problem.' This young man has suffered immensely. Fortunately through our intervention he has now been referred to a gender clinic, where he should have been seen in the first place. He has had to suffer the consequences of memory loss and cognitive impairment and psychological damage on top of everything else. He was 14 at the time!

"There are psychiatrists who are truly distressed that anyone should be given ECT, and are adamant that giving shocks to a child whose brain is still developing is unethical and disgraceful. If there is such controversy within the medical profession then there has to be an enquiry, and those children who are being abused under the guise of 'treatment' properly protected within the law.

"It is well nigh impossible to obtain figures from hospitals about the number of children treated in the UK. All we rely on are those reported to us. We know it goes on and we know that the statistics are disguised, as minors are being treated in adult units and therefore included in adult statistics. (Incidentally, it is difficult obtaining statistics per se as they have not been collected in any sensible way since 1991.)

"We feel that as the NSPCC is committed to eradicate 'all' child abuse then it should take our concerns very seriously indeed. John Gunnell, MP for Leeds, takes us seriously and is extremely worried about the whole issue. There are growing numbers of MPs who are also concerned; one especially, in Wales, Julie Morgan, who is planning to hold a meeting with concerned MPs in the near future.

"I enclose our recent survey results on the long-term harm of ECT, our factsheet and a statement by one psychiatrist who is prepared to speak out against ECT. Thankfully he is not a lone voice. We ask that you investigate this matter vigorously."

Eventually, a reply from Carol Sexty, Policy Adviser (family support and health issues) reached Pat, saying:

"... The NSPCC believes that any treatment given to children should meet their particular needs. The area of medicine is not one on which we have a particular expertise. However, my post is a new post within the NSPCC and I am currently looking at a range of 'health' related issues on which it might be appropriate for the NSPCC to comment on, including mental health issues.

"As I am sure that you will appreciate, there are many issues that we should pursue as part of our campaign to end child cruelty. I will keep the issue of children and the effects of ECT in mind as I develop and prioritise the policy and campaign proposals for the NSPCC. Thank you again for your information."

What follows is the sort of argument the NSPCC ought to be taking on board:

"Some children hospitalized in psychiatric units may never fully recover after the multiple traumata of: psychiatric diagnoses, the consequences of this labelling and subsequent physical treatments such as ECT delivery. Often these minors are stigmatized and scapegoated by peer group members, with resultant psychological trauma (Gaoni et al., 1996). After a child has been admitted to psychiatric services, feelings of shame, guilt, and poor self-worth may ensue. These negative self-concepts are highly likely if rights to free choice and

contribution. An abused child may be subject to the additional abuse of the side-effects of psychiatric diagnosis and ECT administration or aggressive pharmacotherapy; the original abuse can thus remain masked and untreated, attributed to "side effects" that are viewed as necessary for treatment."

Also,

"Moral objections to the use of ECT with children and adolescents have been based on challenges about the appropriateness of allowing parents, guardians or professionals to give consent "on behalf of" juveniles and teenagers. The moral imperative in this complex environment should be first to guarantee the minor safety from harm. (Paradoxically, medical practice was founded along a similar axis "primum non nocere"). Arguably, physicians' clinical freedoms to choose between rival treatments should be a secondary consideration in this specific clinical situation."

(*'Controversial Issues - ECT, Infants, Children and Adolescents: Shocking Abuse of Power, or Valuable Treatment Medium?'* *Behavioural and Cognitive Psychotherapy*, 1996, 24)

NOTE: Our understanding is that Professor Baldwin has apprised the NSPCC of the situation with respect to abuses to children from ECT. Of course, despite retaining its name, the NSPCC is no longer an independent organisation, but was incorporated into the Social Services Department. Ultimately, therefore, their policy reflects that of the parent government agency.

Only In America:

"The neuropsychiatric evaluation also affords an opportunity to determine the patient's handedness, an issue of relevance to nondominant (for language) unilateral electrode placement. Patients should be questioned about which hand they use to write, throw a ball and use scissors, as well as which leg is used to kick a ball and which eye is used to sight a gun."

(*'The Pre-ECT Evaluation,'* C. Edward Coffey, MD, *Psychiatric Annals* 28:9, September 1998)

I thought the typical ECT patient in the U.S.A. is supposed to be an elderly, white, middle-class (?football-playing, ?gun-toting) woman! (Sue Kemsley)

Psychiatrist to ECT patient: Which eye do you use to sight a gun?

Patient: Give me a gun and I'll show you. (Sue Kemsley)

Text of a Presentation to the AGM of Amnesty International (U.K.), Swansea, 11/4/'99, on Electro-Convulsive Therapy:

Motion: This AGM expresses its concern at the potential for human rights violations in medical procedures imposed without informed consent, and in particular instructs the Board to ask Amnesty International to investigate the use of electro-convulsive therapy as a violation of Articles 1 and 5 of the United Nations Universal Declaration of Human Rights.

Proposed by Daisy Price (Bristol), presented by Terry Simpson (Leeds)

"This treatment involves the passage of a large enough current through the human brain to produce an effect similar to a grand mal epileptic seizure. In the past the resulting convulsions led often to broken bones and teeth. Nowadays, anaesthetic and muscle relaxants are given, although there are serious problems attached to these, and in some parts of the world – for instance, Rumania – ECT is still given without them.

"Today we are seeing for the first time the emergence of patients' rights groups who can speak with first-hand authority about the effects of this treatment. A newly published survey of over 200 people by the UK group ECT Anonymous shows over 80% of respondents claim loss of past memories, impaired present memory and impaired concentration directly attributed to use of ECT. ECT leaves permanent disability, loss of confidence, of skills, caring, loving and memory. It is truly barbaric, has no place in humane treatment, and has led to death through brain haemorrhaging and heart failure. ECT has been linked to subsequent suicides in many cases. It is used on children and pregnant women – and in the U.K. the biggest single group to receive it is elderly women.

"In my work as an advocate for people in the mental health system I was called upon to plead the case of people who were detained under the Mental Health Act and forced to have shock treatment, and it is this particular use that we feel should be of grave interest to Amnesty members concerned about human rights. In particular, I supported a 70 year old man who died after 32 forced shocks. I also supported a woman who locked herself in a bathroom, the door of which had to be broken down so that nurses could literally drag her out to give her ECT. I've seen a normally talkative young woman pacing a ward room in silence from end to end continuously, in utter terror before being given this treatment to which she had clearly and articulately objected. I've also witnessed a young distressed pregnant woman under considerable pressure to accept it.

"It is simply turning a blind eye to say that this is just another medical treatment, or to say that Amnesty must not get involved in challenging clinical judgements. If we only listen to what doctors and the Royal College of Psychiatrists - i.e. the status quo – tell us, this is tantamount to being content to find out about the political situation in a country by only asking government spokespeople. We would like an investigation of the role of ECT, to take evidence from survivor organisations like ECT Anonymous, Survivors Speak Out, the All Wales User Network, the Scottish Users Network, the UK Advocacy Network and the European Users Network – all of whom have taken a strong stand on this issue – as well as sister organisations like Support Coalition in the US, and organisations like Mind who have called for a ban on compulsory ECT. Some US states have banned ECT, and some countries use it less than others, particularly Germany – where its use is linked to atrocities committed under the Nazis. In others, sadly, its use is increasing as a cheap option that will inevitably be used proportionately more on working-class people and ethnic minorities, who are over-represented in the mental health system – not to mention refugees, who suffer a high incidence of mental health problems.

"It's not enough to quote people who say this treatment has helped them. **Independent research shows that traditional 'success rates' have been exaggerated, that they tend to apply to people who have not been forced, that beneficial effects tend not to last, and that at least some of those who claim to have been helped are in denial of damage obvious to people close to them.**

"The Universal Declaration of Human Rights is very clear in Article 5 that no-one should suffer treatment that is cruel or makes them feel less than human. This is echoed in Amnesty's mandate, which says that we carry out research and take action on cruel, inhuman and

Terry reported “We weren’t successful – although we did change a few minds. About a third of the conference did vote in favour, so it was worth it!”

An Anonymous Personal Account:

On comparing notes with a friend about ECT, we felt that doctors had been cavalier about both drugs and ECT. Since I had my ECT I have read many articles about it. It seemed interesting that the technique was developed from stunning pigs (in abattoirs) and inducing epileptic-type fits. I have never felt convinced to believe claims for its efficacy. In my view, if there is cause for sadness it is that it is simply more economic to wipe out brain cells than to employ more sensitive methods of therapy. To kill the person would be even more economical, but illegal!

I had not realised until today that ECT is still utilised. Speaking for myself I have to say that I never met a psychiatrist or psychologist who was probing or sympathetic or able to use some common-sense or kindness. They are never going to use such labour intensive methods where high-tech reinforces the criteria of expertise, whereby they collect good salaries. I suppose my experiences have taught me wisdom the hard way to see through the hypocrisies of professionals, to learn, far too late, that even families are often treacherous, jealous, murderous, ambivalent.

At 65 I for one won’t be much use to you because the joint problems, memory loss and depression now could simply be those of old age, or lead or aluminium. At the time I realised that I must not moan any more or it could all happen again. My situation might have been stressful to anyone. Maybe I just needed therapy – I was exhausted and lonely. As a single mother of 34 I had twins (brought on prematurely, given X-rays, and denied breast-feeding). I had absolutely no help and no social circle. I had not developed any business acumen let alone common sense, so I also had awful and unnecessary strategies to save money at a time when I needed to spend in a crisis. I needed a washing machine. I needed a bit of sleep, but I had a gift for choosing the wrong people. None of these things deserved their stunning my brain cells, but I had not got my own life together, freed myself from opinions and prejudices and the company of my parents, so I was not grown-up enough at 34 to have a family. I needed a mentor or a friend.

I regret very much that I was pressured to subject myself to questionable methods. I suppose some of the doctors really believed it was a miraculous cure, discovered by accident - and there was a neat explanation for any social ailment requiring a real fault or advice. Use the word “endogenous” and you can safely recommend ECT. A bungee-jump would probably have been much more therapeutic.

Quote: “...an expatriate doctor...wrote, “The people of Serbia have not been told they are being led into war by a man-made psychopath. They do not know the full horror of their betrayal. Slobodan Milosevic was given psychiatric treatment by the world’s most wanted criminal, Dr Radovan Karadzic.” (*The Times*, 27/3/99)

ECT Cases: Do you need to find a solicitor?

An approach by Sue Stevens to a solicitor in Wales resulted in Rhys Thomas indicating he would like to help survivors interested in bringing an ECT case who have been unable to access legal advice. Anyone wishing to consult him can ring in confidence, on **(01222) 222333**, or write to him at **9 – 11 St Andrews Crescent, Cardiff**. Thomas also made plain his interest in an article in *The Big Issue* (Wales) in March, here reproduced. Apart from anything else, this item will serve to illustrate legal thinking on ECT medical negligence:

“A Cardiff solicitor is interested in helping people who feel they were wrongly treated with a controversial therapy to gain legal redress. However, many of the treatments took place over 20 years ago – the statutory cutting-off point for such claims is three years. Rhys Thomas of Rees, Wood and Terry told *The Big Issue Cymru* he would be interested in hearing from people who feel they had been given Electro-Convulsive Therapy, or ECT, inappropriately.

“At the moment there’s a test case going ahead and I’m waiting for the outcome,” he said. “But if people are concerned about the way they have been treated – there are issues of consent and damage – it’s a matter of whether they believe the medical treatment was inappropriate. If so, they can contact me.”

“Thomas said he believed in strong cases for medical negligence Legal Aid would be made available, and he would hold legal surgeries where the first half hour was free to determine cases. Upon receiving Legal Aid, Thomas said he would consult experts as to whether the treatment was appropriate, i.e. whether alternative methods existed at the time that would have been more beneficial. There were also considerations of permanent mental and physical harm and people being treated without their consent, he added.

“Problems surrounding ECT have only come to light in the last couple of years, Thomas said, but cases date back to the Sixties and Seventies, bypassing the three-year deadline for bringing claims. But it is up to the courts’ discretion. “That’s the starting point in many of these cases – can we avoid it being statute barred?” he added.

“The controversial treatment involves having an electric current fired through the brain under general anaesthetic to treat severe depression, mania and schizophrenia. A recent study [the Lucy Johnstone report – see below] found common reactions to ECT were feelings of terror, failure, humiliation and rejection. One woman quoted in the report was Pam Baker, 39, of Aberystwyth, a survivor of sexual abuse. “Having a male psychiatrist stand over me then backing out and coming round not knowing where I was mirrored my sexual abuse and reinforced my mistrust of men,” she said. “It’s another trauma for me to deal with.”

“Cardiff North MP Julie Morgan has also taken up the issue. She has said any of her constituents are welcome to contact her, in confidence, regarding ECT.”

News of a Group Action for PTSD sufferers:

Primeau et al. found that “A variety of syndromes, including post-traumatic stress disorder (PTSD), ... major depression and adjustment disorder are suggested by the constellation of patients’ complaints.... The question whether these are “organic” or “reactive” is a difficult one; for instance, it has been pointed out that the experience of electrical shock is the prototype of one-trial aversive conditioning and a potent inducer of PTSD symptoms.” (see Kelley, Pliskin, Meyer & Lee, ‘Neuropsychiatric aspects of electrical injury: The nature of psychiatric disturbance,’ *Ann NY Acad Sci*, 1994; 720) However, PTSD shares with the possible presentation of late EI and LI the features of the acute frightening trauma, gradual emergence of psychologic symptoms, the experience of flashbacks, and a tendency to avoid associated stimuli. If you have post-traumatic stress disorder, *either* as a condition ECT was used to treat *or* as a result of use of ECT, you may be

Psychological Trauma From ECT:

In January psychologist and lecturer Lucy Johnstone published a paper on 'Adverse psychological effects of ECT' (*J. Mental Health* 8, 1). Anyone wishing to read it can obtain a copy from the author at University of the West of England (Psychology Dept.), St. Matthias Campus, Oldbury Court Road, Fishponds, Bristol. BS16 2JP

An abridged version appeared in *Open Mind* (May/June '99).

Also in *The Survivor*, Issue 16 (June '99), available from:

Room 3, 1st Floor, North Wing, St. Edmunds House, Lower Baxter St.,

Bury St. Edmunds, Suffolk. IP33 1ET (Tel: 01284-724456)

Forceful points are made – for instance, “that a minority of people in all the [attitude] studies did express very strong negative feelings about ECT, although this has been obscured by focusing on the majority view.” The odd point appears to be present to appease, e.g. “Few participants doubted the good intentions of the professionals. ...the fact that professionals genuinely believe that they are acting in the patient’s best interests.... [etc.]” A criticism must be that grey areas detract from the message. To pinpoint one such, take the argument - “...it is the central fact of having electricity passed through your head that was so unacceptable to these participants. Not only did this carry powerful symbolic meanings, it was also seen as irrelevant and damaging.” We seem expected to leap from the physical to the spiritual and back again – apart from which, are claims about symbolic meanings for survivors of electricity to the head representative or are they researcher projections that distract from the real complaints? After all, as a result of ECT language dysfunction survivor thinking tends to become more literal and prosaic. Although the phrase “a rape of the soul” is often used, this is a graphic metaphorical expression for abuse and damage, surely. Aren’t we in shadowy territory, descending into the realm of symbolic meanings to expose ECT’s psychological effects? The general reaction from within ECT Anonymous was disappointment.

In correspondence with Sue Stevens Lucy Johnstone says she had “a deliberate strategy to write an article that was acceptable and publishable in a mainstream journal.” To our way of thinking, for reasons of strategy – or unstated reasons - she hasn’t begun to scratch the surface in respect of ECT’s psychological sequelae. The major bone of contention is that in seeking to isolate the psychological effects, Lucy Johnstone has neglected a factor highly relevant to how people are when they have been damaged by ECT, which is that the impact of ECT on the *physical* body gives rise to significant *psychological* trauma. Maybe the survivors she interviewed had escaped brain or health damage, in which case the onus was on her to distinguish appropriately - assuming the feasibility of such an exercise, given she does note that ECT is an *organic* therapy. Well, Lucy Johnstone tells us “that organic therapies do carry meanings, and...these meanings, filtered through the individual’s own background context and interpretations, influence how such therapies are experienced.” Was evaluation of absolutes anathema to Lucy, that she prefers to pussyfoot? The reason for asking will be appreciated when consideration is given to her warning, “...we must be careful not to discount the possibility that some of their concerns also have a factual basis; for example that ECT does cause definite cognitive impairment and anxiety about brain damage is not just a psychological phenomenon but an understandable response to a real danger.” Naturally some of us have wondered why no survivors from ECT Anonymous were interviewed. Crucially, survivors can do without studies that hedge, given reporting bias is actively practised and encouraged by psychiatry, as Jones and Baldwin indicate:

“The apparent vogue popularity of ECT in the 1990s is partly explained by the repackaging that has occurred within psychiatry. ...

“There has been unequivocal evidence of reporting bias and selectivity in the ECT literature. ... Accounts of permanent memory loss after ECT treatments have been progressively filtered out of the psychiatric literature. For example, in 1958 Fink (arguably the “ECT product champion” in the USA) wrote that the biochemical basis for electroconvulsive therapy was similar to that of cranial-cerebral trauma. In contrast, in the 1990s “maintenance ECT” (sic) has been recommended for people who have relapsed quickly. ...

“...the debate has remained unresolved about the degree, severity and prevalence of resulting brain damage from ECT administration.

Exclusion of data in the psychiatric literature about the negative short and long-term effects from brain damage and memory loss, has created a climate to promote the “safety” (sic) of ECT administration. Such over-selective reporting, however, suggests that ECT has been marketed to avoid negative feedback / censure from public opinion.”

**(‘Controversial Issues - ECT, Infants, Children and Adolescents: Shocking Abuse of Power, or Valuable Treatment Medium?’
Behavioural and Cognitive Psychotherapy, 1996, 24)**

Where do details like those provided by the ECT Anonymous survey respondents fit in? Our self-report data suggests that the variety and severity of complaints survivors report indicate diffuse dysfunction and varying degrees of debilitation. We do not know that everybody is permanently affected - and it would be as inappropriate of us to call those who say ECT did them no harm “deluded” as it is for Lucy to suggest that, fundamentally, ECT’s psychological properties are due to ‘meanings’ filtered through interpretations. Whilst accepting that the question whether manifestations are “organic” or “reactive” is a difficult one, what really seems to be of greatest significance is that survivors of lightning and electrical injuries “show either normalization of mental status or sequelae ranging from headaches and distractibility to persistent psychiatric disorder and dementia. The fact of this variety has been recognized for a long time.” (Primeau, Engelstatter and Bares, ‘Behavioural Consequences of Lightning and Electrical Injury,’ *Seminars in Neurology*, vol. 15: 3, September 1995)

The burden was on the author to portray her respondents as accurately as possible - yet her criterion for inclusion was imprecise, the focus being on explanations from 20 recipients of ECT who had found it distressing. This could mean anything, as well as which the complication that many survivors just do not have total insight into their post-ECT condition was not addressed! A complex mixture of reactions were described by participants, including feelings of betrayal, worthlessness, punishment, helplessness, degradation and assault. However, although Lucy Johnstone does refer to fear and compliance as adverse effects, because her emphasis is purely on meanings for individuals, alongside fear as consequence of an acute frightening trauma there is no attempt to discern pathological fear, i.e. fear as the outcome of autonomic disequilibrium. Likewise for pathological ductility (a well-known outcome, sought by psychiatrists and linked to induction of brainwave changes), or malignant impact upon the personality giving rise to personality disorder. (A study of the psychological concomitants of ECT-induced personality disorder would have been especially significant, in the light of the focus of revisions to the MHA!) Clearly, that biologically-based determinants may have been present – let alone interwoven into respondents’ complaints - was not taken into consideration. Lucy defends herself against criticism re. non-incorporation of the neurological injury axis and appraisal of the relationship

qualitative (as opposed to quantitative) design, which is the one I used, is specifically designed to document and analyse people's subjective, personal experiences and reactions – the aspect that usually gets omitted from more traditional quantitative research, and tends to be dismissed as “anecdotal.” ... My main aim was to get emotional / psychological reactions documented in the “official” literature as a legitimate area of concern and enquiry.” (Letter, 8/3/99)

Hopefully Lucy's explanation (taken with ours) will help to shed light on the ECT Anonymous disappointment, based on disagreement with her about what ECT psychological damage actually is in its full complexity. Clearly, subjective experience does not exclude experience stemming from damage effects; it's a matter of phrasing the questions to get at what is there to be discerned. Our dismay is especially acute seeing that Lucy Johnstone quotes Lindow (1992) **“What is never discussed in the literature is the profoundly damaging effects ECT can have.”** Dissatisfaction has arisen because we consider that if Lucy Johnstone truly appreciated the profoundly damaging effects of ECT, she wouldn't have been content to reveal not so much the tip of the iceberg as simply that one exists – which hardly advances understanding. Jones and Baldwin felt able baldly to state,

“Evidence for physical and psychological damage after ECT administration has accumulated since the 1940s. A prominent psychiatrist, Salzman (1947) reported about: “malignant effects of shock therapy on the personality (sic) of the individual”. He concluded that: “the most persistent impression obtained is that shock patients show a picture resembling the post-lobotomy syndrome”. (*Controversial Issues - ECT, Infants, Children and Adolescents: Shocking Abuse of Power, or Valuable Treatment Medium?* *Behavioural and Cognitive Psychotherapy*, 1996, 24)

Below is a survivor account that doesn't mince words but gives some indication of just what psychological traumatism due to ECT involves. It was written in response to the item in the Special Spring newsletter about Dr. Michael Haslam and his use of psychiatric treatments (especially extensive ECT) to allow him to rape women patients:

“ECT has been likened to a rape of the soul. My perception of ECT is of another sort of violation to rape, whether actual or figurative (for rape is a profound image of violation). However, ECT resulted in me being raped on more than one occasion. ECT bears absolute liability because of the way it left me. I was no longer able to judge people or situations and nor could I stick up for myself any more.

“The images that fit what happened to me are, firstly, of being rubbed out by a giant eraser. Each of the up to 100 doses of ECT I received was like one vigorous swipe of that rubber. Afterwards there were faint traces on the paper of where I had been but little remained in terms of black markings laid down by the great pencil of life. I was well on the way to becoming a mindless vegetable, and I think that was the intention – which is why the notion of being rubbed out is apt. I believe ECT given to me was used in accordance with what the psychiatrist Abraham Myerson said ECT does to those who, in his view, “have more intelligence than they can handle” - it reduced me “almost to amnesia.” [Spring newsletter] I further believe that the ECT I had was impeccably given to the highest standards. The voiding of me was not the result of poor performance by junior doctors or faulty equipment – it was a feature of ECT itself.

“A second image of ECT applicable to my situation is of a butterfly with its wings torn off, combined with removal of the hope expressed by Princess Diana in connection with her children, that they would be allowed to “sing openly.” ECT left me incapable of flying and as though I hadn't a tongue in my head to sing at all. Thus, when I was raped, I was mute. I did not find it in me even to voice the word, “No!” If I had been one of the victims of the psychiatrist described in the Special Spring newsletter who raped his patients [c.f. the Survivors in West Suffolk input into the proposed revisions to the MHA in this newsletter], I like to think I would somehow have managed to castrate the b***ard – but I know in my heart he would have had his way. ECT having reduced me “the right amount,” I couldn't have done anything except submit – not scream, not run away, not fight.

“I liken that contemptible beast Haslam to the snake that immobilises the poor mouse. ECT creates victims for human snakes to fixate with a word or two, such as “Open your legs.” Actually, likening him to a snake is pretty apt. He will have been working from the primitive, reptilian part of his brain - which would have been intensely pleasurable in itself, aside from the addition of sexual gratification heightened by audacity. As for his victims, ECT having adjusted the same part of the brain the right amount, what we have are manufactured mice to be fixated by any unscrupulous snake who picks up on the presence of mouse. (They were snakes other than psychiatrists who honed in on myself, including ‘family’ snakes. When I think about it, I had become a near-perfect target – and it seems to me unconscious signals must unerringly have told a succession of snakes, Get in there – strike!) The primeval part of the brain knows neither logic nor compassion, it does not respond to reason, and it is essential to successful functioning. I suggest this Michael Haslam knew just what he was about, using ECT and carbon dioxide therapy to make patients acquiescent and diffident. Make no mistake, he wasn't himself fixed into a behaviour pattern demanded by the reptilian cortex. Instead, he deliberately and with cool calculation used his ‘human’ or ‘thinking’ brain at the behest of the ‘snake’ brain. If (by choice, or through scenting mouse) rational thought is out for the violator - who is whole - ECT damage renders it impossible in the victim. Thus conscious fantasies regarding forcible removal of the snake's trouser snake are futile, because these fantasies are generated in the higher brain. When it comes to the crunch, the higher faculties are powerless against the primitive brain where that primitive brain has been fixed the right amount into perpetual docility.

“Haslam was a learned medical specialist who put to predatory use his knowledge about the human brain and how ECT affects primitive functioning to get himself a steady supply of women who couldn't speak out but dumbly did his bidding. Psychiatrists can hardly protest their innocence about what ECT does when some among them are calmly using what are obviously known and understood effects to get away with years of rape, having pillaged from the victim first that which would have meant the chance for a ‘normal’ response – such as resistance.

“It has to be said that being permanently ‘fixed’ by ECT into complying with repeated sex attacks comes at tremendous psychological cost. You can't live with yourself – because you didn't scream, or hit back, etc. I couldn't give any explanation for why I put up no resistance. Who could understand it, especially nearly 30 years ago when I succeeded in bringing the first of my rapists to court? I didn't even understand it myself, because I'm not a psychiatrist and wasn't covertly in the know about ECT's capacity to produce patients and ex-patients ripe for rape. I, who had been a tough little bitch in childhood, blamed myself. To me, I reacted like an utter and contemptible yellow-belly and I have had to bear my base cowardice ever since. The man was found ‘Not Guilty’ and I was found in the News of the World for all and sundry to see my shame. I also ended up with an infection from the rapist – which meant more humiliation at a ‘Special Clinic.’

had suffered adverse psychological effects. Fantastic! Enough to buy my parent the knitting machine she craved, like the yielding daughter I'd become. Believe me, I want £millions out of my medical negligence claim." (A halfway survivor)

Interestingly, in Lucy's introduction, which describes findings by earlier researchers, she goes into detail about compliance, stating, "...there is the unusual degree of compliance noted by several investigators, who were puzzled by patients' willingness to agree to ECT despite being anxious and ill-informed: 'We were left with the clear impression that patients would agree to almost anything a doctor suggested' (Freeman & Kendell, 1980.) Referring to the same phenomenon, Riordan *et al* (1993) suggested, 'This may reflect a high level of trust, or a resigned lethargy, in part reflecting mental state, but also a feeling of lack of involvement in their own management'. Freeman & Kendell (1980) quote a particularly striking example: 'Two patients who misunderstood the initial appointment letter ... came fully prepared to have a course of ECT. Neither had been near the hospital for nine months and both were quite symptom-free.' Little attempt was made to explore the meaning of this kind of behaviour...."

Well, Lucy Johnstone has added nothing, contenting herself with, "The apparent willingness to consent to ECT remarked upon by other researchers may merely be a case of desperation and compliance temporarily overcoming terror and reluctance." The level we are at here is betrayed by her next comment – "Similarly, what seems like a successful outcome may simply be conformity and a fear of confiding one's true feelings to professionals."

Sue Stevens on Lucy Johnstone's article:

(With great respect for ECT Anonymous who contributes so much to the struggle against institutionalised psychiatric abuse.)

Sue Stevens entered into correspondence with Lucy Johnstone concerning the study, and received the following reply:

"You are right that my article used some objectifying language; this was part of a deliberate strategy to write an article that was acceptable and publishable in a mainstream journal. It does not (I hope) reflect my basic attitude to service users. But perhaps I am not the best judge of that ... The participants were involved in commenting on the article at all points and have certainly received their own copies.

"Yes, you can use my response as an example if you want."

SUE: "Lucy Johnstone's new study draws heavily on User / Survivor work, but seems to undermine their conclusions by being based on self-selected respondents.

However, many bio-researchers have backgrounds / training in psychological methods and practice and they were no more likely to publish biased results than any other group – including Lucy's rather small study of 20 self-selected respondents to adverts placed in mental health settings. All studies have variables which affect the study and are inherent in any research. Lucy has in the past carried out work from a 'User' perspective, but this study seems to reflect a rather dated "them" (Users) and "us" (Researchers) approach. Her expressed 'puzzlement' about reasons for (over) "compliance" / "submissiveness" is surprising, considering her knowledge of the User / Survivor movement and that the many accounts of ECT written by those who have experienced it have been widely circulated for the past decade. Surely, very few in the mental health field are unaware of these and of the call for a ban on ECT by User / Survivor organisations – as well as psychiatrists 'brave' enough to speak out. I would think we can take it as read that there will be adverse psychological effects to passing electricity through the brain, often against the person's wishes, when it has proven biological / physical "adverse effects" – which is one way of describing irreversible damage to a human being. Although the people who 'participated' in her study were crying out against ECT – Lucy's conclusion is to call for more research. Who by? Excuse my cynicism, but is she meaning psychologists? Are they (she) volunteering to become the research fodder? We think not. Let's ban ECT NOW and any further research - before more human beings are prevented from thinking properly at all after abuse by ECT and its advocates.

N.B. "Lucy Johnstone has not acknowledged who, if anybody, commissioned or funded her research project, as is customary these days – and it is important to know to what extent published research is independent, or not. It may be useful to note that the *Journal of Mental Health* is edited by Ray Hodgson, a professor with the Centre for Applied Health Medicine, Lansdowne Hospital, Cardiff. Cardiff, as some will already know, is notorious for its over usage of ECT. Practitioners have been obliged by the Health Authority to respond to concerns by monitoring and bringing down its use."

P.S. "I guess I am being tough on Lucy Johnstone, but where is / was she heading when she supposedly represents 'User' interests? I find the whole thing very worrying. There is still no explanation of who asked for the work or funded it. If she is not the best judge of whether or not the study reflects her basic attitude to service users [see Lucy's letter, above], then how are survivors who consider they were abused by ECT to know where she stands?"

Mobile Phones' Warning:

Reader Jeff Jordan wants us all to be as fully aware as possible of the true delicacy and vulnerability of the brain, and points to evidence from recent research linking mobile phones to memory loss to emphasise the true situation. It was reported in the *Daily Mail* (1/3/99) that "one leading British scientist...has now curbed his own use of mobiles. Colin Blakemore, an adviser to the National Radiological Protection Board, which regulates the £5billion mobile phone industry in Britain, now uses his phone for only two minutes at a time and for just ten minutes a day. The professor of physiology at Oxford University says using the phone over longer periods may have a more permanent and damaging effect. By limiting his use, Dr Blakemore said he had stopped experiencing the 'lack of awareness' he felt when making longer calls. There is evidence, he said, of an adverse effect on 'cognitive function, memory and attention. ... I have had the feeling that there has been a gap in experience while I have been on the phone and have not been aware of other things going on.'

He believes the radiation affects the way certain message-carrying chemicals move within the brain and inside individual nerve cells. Because many of these chemicals have electric charges, their behaviour can be influenced by radiation, preventing nerve cells from functioning normally.

Preamble:

A supposed failure of care in the community and efforts by mental health reformers to bring about change are part of the reasons for proposed revisions to mental health legislation which are due to be presented to ministers in July. As explained by *The Times* (18/4/98),

"Launched in the belief it would simultaneously provide kinder treatment for the mentally ill and more money for the Treasury, the system has become discredited by a string of violent crimes committed by patients released into the community without adequate supervision. One mental patient commits murder every fortnight. three commit suicide every week and thousands need acute hospital treatment after

closures. By then 100,000 beds had been shut. Centralised control was meant to be introduced by the NHS and Community Care Act in 1990, but this concentrated heavily on providing social services for the elderly, and the mentally ill were once more sidelined.”

A key issue to which reformers have, by their consciousness-raising (*sic*), succeeded in drawing attention is that of murders committed by the mentally ill. It is the issue on which new Labour has chosen to focus in order to justify plans to enforce ‘care’ (in institutions or in the community) – and the move to tighten up really is about plugging a gap in one particular area. However, it may actually have been prompted more by governmental frustration with psychiatry than for any other reason. As we know, psychiatric practices stem from psychiatric say-so, which conveniently leaves unanswered questions about the nature of illness that is mental and its treatment. That vast unknowns guide what is done to the mentally ill raises few eyebrows in high circles. After all, what matters is that undesirable elements are being controlled - or are they? Aside from recent criticisms in respect of the RCP’s inability to enforce high standards in psychiatry, it seems that psychiatrists are in trouble for failing to predict violent behaviour and for refusing to accept responsibility for preventing violent acts by those with a personality disorder - which psychiatric ideology deems untreatable. So, although the Institute of Psychiatry is saying their research indicates that the number of killings by people with a mental disorder has fallen in the last 30 years, and Mind (and others) point out that violence is more related to alcohol and drug abuse than to mental illness, the government has elected to get tough on those judged to have a mental disorder.

The Times, (Leading Article, 16.2.’99) reports:

“Yesterday, Jack Straw...outlined proposals to protect the public from people with dangerous personality disorders. In future, Mr. Straw would like the courts to have the power to order the indefinite, but reviewable, detention of such individuals. Crucially, this power would apply to people whether or not they had committed an offence. ...

“At present, individuals with non-treatable personality disorders slip through the net between hospital – where they can only be detained if they are diagnosed as “treatable” – and prison, where they can only remain for the duration of their sentence. High profile cases have added urgency to Mr Straw’s call to close this loophole. ... “So long as there are “regular quasi-judicial reviews covering both legal and clinical issues”, as Mr. Straw proposes, even some libertarians might grudgingly support the indefinite detention of individuals who have been found guilty of a crime and diagnosed as suffering from a personality disorder. Had the Home Secretary limited his plans to this, he would have had few critics. Yet his wish to allow a court to detain any individual with a “recognised severe personality disorder” who poses “a grave risk to the public” is, as the Home Secretary understates, “a very serious step” which can only be taken once a string of questions have been answered.

“... Top of these concerns is one raised by civil libertarians. They argue that individuals will be detained not for what they have done, but what they might do, and on the basis that they are suffering from a “personality disorder”, the definition of which is a contestable matter. According to the mental health charity MIND, it is a condition which afflicts over one in ten of the population. ...”

It should be noted that Jack Straw’s proposals, if carried, will mean that the personality disordered are unique in British society. They will become the only group subject to legislative control based on the dangers they are perceived to pose. In an ideal world, in an effort to limit personality disorder the tougher government attitude would be directed where it belongs – towards social conditions and towards psychiatry and examination of psychiatric practices. But psychiatrists are a powerful group who cannot readily be brought to book without widespread repercussions, so Jack Straw has taken the easier option, and approached the problem via personality disordered jack-straws who he can hold nominally responsible. After all, ‘psycho’ murderers draw attention to the system’s failings.

Potentially violent, the sick man of straw,
Has a mind in a mess from of yore....
With shrinks in cahoots,
The wily jackboots,
Seek to shore up the score through the law.
Of note is one studiedly unacknowledged factor.

Lack of interest in the reasons for personality disorders being as prevalent as Mind has indicated they are is going to lead to serious injustice. Of course, to explore causation and look too closely at what triggers such disorders could prove embarrassing, given that psychiatric drugs (and ECT) would be implicated. If vested (drug company) interests were taken into account that embarrassment would increase exponentially. As an indication of the complexity of the situation, “One [doctor] who sits on the committee that advises the government on drugs to be used in specific treatments, has shares worth £130,000 in two of Britain’s biggest drug companies. ... Professor Robert Kendell, president of the Royal College of Psychiatrists and a member of SMAC [Standing Medical Advisory Committee], did not believe potential profits from drug sales to the National Health Service would influence the value of his £130,000 holding in SmithKline Beecham and Glaxo Wellcome. ...” (*The Sunday Times*, 4/4/’99)

That drugs will have been tried and found not to have the desired effect is what lies behind the claims that certain categories of person are untreatable. Research and adverse reaction reports, including Mind’s yellow card scheme, suggest that adverse drug reactions are a significant feature of taking psychiatric drugs. There are indications that these same drugs have a mind and personality altering effect. Dr. Peter Breggin offers an explanation:

“...the basal ganglia are most clearly damaged during the production of tardive dyskinesia by the neuroleptics. ... But the basal ganglia...are intimately connected to the higher mental centres and diseases affecting the region ultimately impair the mind. ... The initial studies of tardive dyskinesia showed that many and sometimes all patients...were suffering from serious mental dysfunction....” (*Toxic Psychiatry*, Fontana, 1991)

Well, toxic drug effects have been known about for some time, as well as that these can be worsened by use of ECT:

“...prolonged administration of psychotropic drugs that cause neurological side effects carries the risk of structural damage to the nervous system, characterized by irreversible mouth-face dyskinesias. This risk is increased by the presence of brain damage or disease whether due to ECT, leucotomy or senile degenerative changes with or without cerebrovascular disease. ... ECT induced brain dysfunction, with cerebrovascular permeability changes as the underlying pathogenic substrate, appears to lower the threshold of resistance to

(Elmar G. Lutz, 'Shortlasting Akathisia During Combined Electro-convulsive and Phenothiazine Therapy,' *Diseases of the Nervous System*, April 1968)

Fascinatingly, it was none other than the president of the RCP, Dr. Robert Kendell (and his associates) who confirmed the cerebrovascular permeability changes identified by Lutz as the underlying pathogenic substrate of ECT-induced brain dysfunction:

"It is known that ECT produces a temporary breakdown of the blood-brain barrier (BBB) and this is probably due to the concomitant increase in blood pressure and cerebral blood flow. It is also known that repeated convulsions at short intervals produce cerebral oedema. It has been shown that macromolecules leak into cerebral tissue during the temporary breakdown of the BBB induced by ECT. This would cause an increase in the relative osmotic pressure of the brain."

(A. J. Mander, A. Whitfield, D. M. Kean, M. A. Smith, R. H. B. Douglas, and R. E. Kendell, 'Cerebral and Brain Stem Changes After ECT Revealed by Nuclear Magnetic Resonance Imaging,' *Brit. J. Psychiat.* (1987), 151)

On top of this, marvellously, it is also known that cerebrovascular damage is a trigger for paranoid psychosis – and many of the personality disordered *are* labelled 'psychotic':

"A high prevalence of impairment of the BBB was found. The condition was detected in a quarter of the total patients, but in the younger ones, the prevalence was still higher. No reference material is available, since impairment of the BBB has not previously been studied in psychiatric patients. The high prevalence of impairment of the BBB found in this material rules out any suspicion of a chance coincidence

between such impairment and paranoid psychosis. ... we cannot exclude the possibility of a common aetiological agent, with psychosis and impairment of the BBB as parallel effects. Several circumstances contradict the assumption that impairment of the BBB is an effect of psychosis. ... Impairment of the BBB is more probably a cause than an effect of the psychotic disorder. ...; it might generate, precipitate, or trigger the psychotic disorder. The impaired BBB might, for example, allow entry of substances with effects toxic to the brain which, at least in predisposed individuals, would cause psychosis. ... The highly significant difference in age at onset of psychosis was the one variable investigated that clearly separated the patients with impairment of the BBB from those without."

(Axelsson, Martensson and Alling, 'Impairment of the Blood-Brain Barrier as an Aetiological Factor in Paranoid Psychosis,' *Brit. J. Psychiat.*, 1982)

Small wonder that no formal investigations into the strange phenomenon of the personality disordered 10%, or what it is that corrodes mental health (? as done by battery acid) are on the cards! Nonetheless, the precise nature of disorders that involve the mind and personality are more and more being questioned. This means the draft proposals are anything but watertight, even if the committee making them has proceeded as though everyone's conception of what is meant by the terms 'mental disorder' and 'personality disorder is clear and undisputed.' In order to forge ahead, however, they have had to leave much unstated and unresolved. A low level of awareness among members has led them seriously to underestimate the central role physical disorder plays.

Michael Stone, convicted of two shocking murders, "was said to have had a history of mental illness and to have frequently threatened to kill people. Health sources said he suffered from a severe psychopathic or antisocial personality disorder, widely regarded as untreatable." Stone had been treated by "a long line of mental health professionals...since the age of 18 when he was diagnosed as having mental health problems." Revealingly, his "string of convictions for dishonesty dates back to 1972 [from the age of 12] but Stone's propensity for more violent crime did not emerge until 1981. Then he was jailed...after he attacked a homosexual with a hammer." (*The Times*, 24/10/98). Working it out, by 1981 Stone, born in 1960, was 21 – and had had the diagnosis of "mental health problems" for three years, during which time he will presumably have been subjected to 'treatment' with drugs or even ECT.

We all know what Stone did to the Russell family, but references to what happened to Stone at the hands of psychiatrists are studiously avoided. However, Rita Carter (*The Independent*, 30/10/98) does examine Stone's behaviour from the point of view of what she terms "a brain condition." In her opinion, his "...behaviour almost certainly resulted from a physical disorder that would show up on a state-of-the-art brain scan. ... Functional brain imaging allows us to look inside the living, working brain and see how it constructs our perceptions, emotions and thoughts. In most people the patterns of electrical activity that give rise to each mental state are similar; the brains of psychopaths and people with severe personality disorders, such as Stone, show distinct abnormalities." Carter goes into detail about those brain areas found to be dysfunctional in antisocial people - the amygdala (which co-ordinates autonomic and endocrine responses with emotional states, linking to the hypothalamus) and the frontal lobe that gives us control over our impulses. She remarks, "...frontal lobe dysfunction is known to produce a type of compulsiveness, known as "environmental dependency syndrome," in which people seem compelled to carry out whatever act they are "cued" to do. This often translates into antisocial behaviour." She mentions the impulsiveness of young children, where "the nervous tissue in their frontal lobes is not yet sheathed with myelin, the protein insulation needed to bring it on line," and adds, "Brain scans of violent criminals suggest that, in some ways, their brains are like those of infants." This echoes "the suggestion of something infantile" found when slow delta rhythms predominate (see 'What Effect ECT In Utero?'). In terms of myelin on nerve cells or the lack of it - researchers have noted that

"A history of electroshock therapy (EST) is associated with larger ventricles. The 16 patients who had received EST had larger ventricles than the 57 patients who had not."

(Weinberger et al., 'Lateral Cerebral Ventricular Enlargement in Chronic Schizophrenia,' *Arch. Gen. Psychiat.*, Vol. 36, July 1979)

Crucially, in ventricular enlargement, myelin loss is implicated.

Carter goes further than many and calls a spade a spade, at least in the sense of acknowledging that supposedly 'mental' disorders are 'physical' (with psychiatric symptoms) but she points out that studies looking at "abnormal activity in the frontal lobes [of murderers]...are

suffering from Binswanger's dementia, a condition in which blood clots cause an area of the brain to die. Pearce's barrister argued that in prison "his condition would deteriorate to dementia and early death. He needed special medical and psychiatric therapy to help him come to terms with his environment." However, "the judge warned that Pearce should not raise his hopes of being sent to a hospital under the Mental Health Act, rather than to prison. Judge Ryan added that there were "very scanty grounds" for thinking that a section under the Act would be appropriate...."

Indications are, the law operates on the principle that psychiatrists are experts, who act in accordance with theories and practices which are accepted by a competent body of men skilled in that particular art - and judges would not revise their opinions merely because there is a body of opinion which takes the opposite view. If it were otherwise Jack Straw wouldn't be going out on a limb with the expectation that basic freedoms can be eroded. Sadly, it appears that ingrained beliefs operate when it comes to criminal behaviours where an underlying 'mental' condition exists. A key concept - insanity - requires the sufferer to be out of touch with reality. Brain abnormalities featuring loss of myelin or pathological brainwave rhythms or dementia, although they would result in some changes with respect to contact with reality, do not correspond to traditional notions of insanity. Clearly, there is a crying need for re-evaluation - but perhaps those reviewing the Mental Health Act are not tackling established ideas that inform belief and the disposal of problematic human beings because it seems safe not to, given what does carry weight in law.

Instead of addressing causation - which might have led her to entirely different conclusions - Carter allows herself to be carried away by her enthusiasm for treatment "by drugs, or even by direct brain manipulation." She urges, "If the will (and money) were there to research the physical causes of antisocial behaviour..., the evidence suggests that these, too, could be treated. Just as Prozac alters the neurotransmitter that turns brain activity on and off in the areas affected by depression, so drugs could be developed to stimulate the frontal lobes or turn down activity in the amygdala. Existing drugs might even work: people with antisocial personality disorders sometimes have chemical abnormalities similar to those seen in addiction and depression, so treatments for those disorders would be worth trying. It may even be possible to change potentially dangerous brains by manipulating them directly. Neuronal tissue is exquisitely sensitive, and can be turned "on" or "off" by the lightest touch of an electrode. Electronic or magnetic pacemakers - similar to those already fitted in the brains of people with Parkinson's disease - could be fitted to regulate activity in particular areas." In what is almost a throw-away line, Carter sums up the crass and wilful blindness against which survivors struggle. She writes, "The idea of tinkering with brains of people we deem "antisocial" is rejected because of its associations with brain-washing, eugenics and totalitarianism. Given this, it is hardly surprising that psychiatrists turn a blind eye to the Stones of this world."

Nonetheless, nobody should be underestimating the power of medical interests. Make no mistake, if the green light was given, there would be no shortage of practitioners willing to explore the possibilities inherent in pioneering 'cheap' treatments for personality disorders. In fact, there already exist not only drug treatments for addiction and depression and neurosurgery to relieve the symptoms in severe depressives and obsessives but there is also a surgical 'cure' for heroin addiction - one "less painful than removing wisdom teeth and only slightly more expensive" according to Dr. Sviatoslav Medvedev, director of St. Petersburg's Institute of the Human Brain, where more than 100 such operations have been carried out in the last couple of years. As yet the West is supposedly sceptical, according to Dr. Medvedev. "I think the West is too cautious about neurosurgery because of the obsession with human rights and its association with the use of electric shock treatment. It is a pity because it cuts off a lot of possibilities." He explained, "Addiction is a kind of obsession. There's a kind of circle in the brain which has to be cut. That's our task." (*The Observer*, 7/2/99)

Psych Jokes:

- Girl to dentist: Why do I need teeth? You can pull 'em all out.
Dentist: What if funding will let you get neurosurgery, ECT or an extraction one day? Don't you want a sporting chance?
- Dentist: All your teeth will have to come out, I'm afraid.
Patient: How much will that set me back?
Dentist: Fifty quid.
Patient: Here's a tenner. Just give me a quick jolt.

One can appreciate how 'personality disorder' might readily be seen as a kind of circle which it is the task of men of wisdom to cut, thus miraculously relieving the sufferer - to applause from a grateful public and a government that wants to be seen to have acted on an intractable problem - cheaply, painlessly, safely and effectively. That psychosurgery for mental disorder might appear on the list of treatments which the law, revised as intended, could eventually compel should not be ruled out, and neither should ECT, similarly used, be ruled out. Emphasis on 'standards' in ECT in the past months must warn us that the government intends to defend use of this treatment through pointing to measures taken to ensure proper application and improved safety. A 'Written Answer' of 18/5/99 confirms the position:

Mr. Soley: To ask the Secretary of State for Health

- (1) what steps he has taken to monitor adherence to the guidelines issued by his Department on the use of ECT;
- (2) what audit he had carried out of the safety of ECT treatment in clinics; and if he will make a statement.

Mr. Hutton: Guidance on the use and safety of electro-convulsive therapy is issued by the Royal College of Psychiatrists and it is for the profession to monitor how well their guidance is being applied. ECT is an effective treatment particularly for patients with severe depression. The proper application of ECT and its procedures is an important issue for patients, for psychiatrists and for mental health services of the National Health Service. To emphasise this point, a joint letter* signed by the Chief Medical Officer and the President of the Royal College of Psychiatrist has been sent to all Consultant Psychiatrists in the NHS, all health authorities and NHS trusts. The letter states that, as part of the new clinical governance arrangements, both the Chief Medical officer and the President of the College expect the guidance to be applied so as to improve standards in the area.

(*The letter in question was reproduced in the Special Spring Newsletter.) Clearly, the intention is not to diminish the use of ECT, but to foster it.

Whatever the reasoning or mixture of motives - from self-interest to concern for public safety - ironically, the proposals to

“Stopping medication can often be a rational decision and lead to an improved quality of life” and, indeed, not so long ago organisations like ‘Turning Point’ were encouraged to invest time and effort in helping medication addicts come off their psychiatric drugs. However, so great is the attitudinal change that the government is now making plain that “non-compliance with agreed treatment programmes is not an option.” In other words, this is the basis on which a review of the Mental Health Act 1983 *must* proceed “to ensure that mental health legislation supports the safe and effective delivery of modern patterns of clinical and social care for people with a mental disorder, and to ensure that we achieve a proper balance between individual rights and the requirements of the safety of both the individual and the community.” The intention is to introduce “extra powers to treat patients in a range of clinical settings including, where necessary, in the community.”

Clearly the Committee has had to work with its hands tied over some issues. However, we should not waste sympathy on a committee which might want to do things differently but is constrained, as that that isn’t the way the cookie crumbles generally. The slant placed upon the whole business by the press indicates that the Committee is not the only body being told how to proceed. Indeed, what we must recognise is that everything that is happening is being done to ensure the smooth passage into law of extremist mental health legislation, with the minimum of hindrance. Just look at the following piece of biased reportage:

“Plans to allow the compulsory treatment of psychiatric patients against their will received official backing yesterday from a panel of experts formed by the Government. A survey by a mental health group also found a majority in favour of forced treatment.

“The Mental Health Act Review Expert Committee said it was in favour of compulsory treatment, provided it was overseen and approved by an independent body. Consideration must be given to each patient’s capacity to consent to treatment and, where possible, ways should be found to enforce compulsory treatment outside hospital, the panel said. ...

“Professor Genevra Richardson, chair of the committee, said that the members had been conscious of the need to improve public confidence in the system. The committee’s final recommendations will be sent to ministers in July.

“Publication of the document coincided with a survey of 2,300 mental health patients, carers and health professionals by the National Schizophrenia Fellowship. A third said that the threat of compulsory treatment would stop people seeking help, but 58 per cent thought it was a good idea.” (*The Times*, 16/4/99)

The draft proposals from this panel of experts (so-called) formed by the government are what ECT Anonymous was asked to respond to, of course. It is especially noteworthy that, to coincide with the publication of the draft document, a survey was conducted by a group representative of the forces of reaction. One must wonder who set that up so fortuitously! One must wonder how respondents were obtained, and what proportion of them were users. Clearly, this was nothing more than a clumsy propaganda exercise – but the problem is, one group is being permitted to speak for all mental health users and the results of a questionable survey are allowed to suggest a user response broadly in favour of the proposals. All in all, the considerable opposition they have generated receives little attention; the idea appears to be that the government *will* impose reforms.

It is in this light that the consultation process should actually be viewed. Generally, our annoyance at the way ‘consultation’ was addressed is apparent at the start of our response. Indeed, the way in which the committee chaired by Professor Richardson has directed its ‘consultation’ with us is nothing short of disgraceful. There was even a ‘user day’ in Leeds, a seminar at which concerned service users could air their views about the recommendations – but ECT Anonymous only learnt of it by chance afterwards. A failure to send invitations to others besides ourselves resulted in the meeting being attended by a mere 18 (ex) service users. Feedback from a member of ECT Anonymous who attended as a representative of Mind (Mind having obtained invites), who drew attention to the vulnerability of children in the context of ECT, suggests that Professor Richardson “appeared to be surprised that ECT is used on children at times.” Lack of awareness within the Committee is a serious failing! With respect to young people, Professor Steve Baldwin, who declares that his “main interest and activity is connected to abolishing electroshock use with teenagers, children and minors,” has been apprised of the dearth of awareness where his speciality is concerned, and we have asked him as a matter of urgency to input into the proceedings. The Committee would appear to have depended heavily on input from groups like ours for information. It is scandalous that they were not themselves on top of the issues on which they based their proposals. We chanced to supply material that made them stop and think. Had we not been up to the job, the Committee may well have gone ahead on the assumption that their proposals on ECT were acceptable. What about other areas, perhaps equally iffy, where nobody has quite managed to hit the nail on the head? In our opinion, pockets of unawareness are bound to remain, given the Committee’s starting level of ignorance!

The report containing the Mental Health Legislation Scoping Study Review Team’s draft proposals runs to many pages, and is wide-ranging. ECT Anonymous personnel collaborated on a response, attempting to input on issues that were likely to matter most to our membership. A letter arriving with the report expressed the aim, “we wish to assess the practicability of our proposals” and, as will be seen, between us we have questioned the very foundations of the proposals where practicability is concerned.

The ECT Anonymous response stresses that contradictions surround the nature of mental disorder. Some of these are only possible because they go unacknowledged, and illumination shows them for what they are. To suffer from something called a ‘personality disorder,’ it looks as if, like Stone, you have to have ‘previous’ – where psychiatrists have diagnosed you, and / or treated you. The psychiatric history is the thing here. A question asked by Matt Muijen of the Sainsbury Centre for Mental Health suggests either that the move to incarcerate individuals by virtue of a personality disorder is poorly thought through - or else what is highlighted is that the opinion on which all else will hinge is psychiatric opinion. “Will there be a differentiation between the “normal person” with violent tendencies and the “personality disordered” person?” Matt wonders. (*Open Mind*, May/June 1999) The answer is, “Yes” - though differentiation will be arbitrary and according to the clinical judgement of psychiatrists. It might even be the case with some illnesses that they are ‘mental’ depending on whether or not the patient is a mental patient!

Then, too, such a disorder matters significantly more where you are the perpetrator, rather than the victim, of violence – as in ‘Cyclist murdered vagrant,’ where a drunk “who had previously suffered several mental breakdowns, died from multiple injuries” after being stamped on while unconscious by a normal, i.e. non-personality disordered, cyclist who had also been drinking. (*The Times*, 2/5/98). This story merited a brief mention on page 10, whereas ‘Drink-drive huntmaster keeps his licence’ made page 4. In fact, the issue of prejudice against the mentally ill is a core issue. Quite recently, the police were charged with institutionalised racism, and the heart of such a charge is

police officers treat those with whom they come into contact; the problem of prejudice is far wider than that. Likewise, it isn't just the police who practice institutionalised prejudice. The press do it; Angela Ferriman does not try too hard to hide whose views she preferred – the ones expressed by 'superior' psychiatric spokespersons. Her attitude was that those critical of the practice of ECT, by which Ms. Ferriman made clear she meant survivor groups (i.e. the mentally ill), are petulantly set on stirring up trouble.

(In fairness to the press, if support for our claims were as keen as it ought to be, accusations of hysterical media attention would doubtless ensue. When we do see successful court actions, press attention will probably change

– after which high profile cases gaining a lot of coverage will be denigrated as a stick the press is using to beat psychiatrists, just as there are claims that with so much reportage of the Lawrence affair “the case has been effectively used as a stick to beat the police force.” (*The Times*, Letters, 30/1/'99))

The medical profession itself is institutionally prejudiced against the mentally ill, as is the system supposedly geared to the protection of fragile people. That revisions to the Mental Health Act won't stop institutionalised prejudice if they go through as planned is yet another criticism, articulately tackled under 'Discrimination' in the Survivors in West Suffolk submission, the text of which follows our own, below.

The ECT Anonymous response stresses that contradictions surround the declared purpose of ECT. We have done our best to emphasize that anything built on the myth that “ECT can be... (possibly) even life saving” is readily refutable. As Smith, 'Shock Treatment – A Criminal Assault,' (1986) has so succinctly stated, “...follow up studies show no effect on suicide rates between treated and untreated groups and neither E.C.T. nor any other psychiatric intervention has influenced the national statistics which wane in wartimes, wax in hard times and correlate not at all with the application of electricity.”

Another sort of contradiction will make for flaws in the legal sense. Prime among these is the point that the more physical mental disorder becomes – and biopsychiatrists stress the physical, at least in ways it suits them to do – the thinner will be the ice of legislation as proposed in respect of mental illness. In fact, if the Committee's proposals become law in their present form, lawyers could have a field-day exploiting contradictions. As is implied in our response, a head-on collision between the psychiatric and the legal professions looks set to happen, and it seems almost as if the legislation being proposed is tailored to be torn apart should ever a particular brand of eager beaver legal shark decide to sink their teeth into the flesh of it. Perhaps it is felt that lawyers will have their own agenda in the same way members of the press seem to have and, in this context, we cannot ignore the existence of lawyers who milk the legal aid system for their own ends, rather than primarily for the client's benefit. Yet a public mood of disillusionment with doctors means we are seeing plenty of adverts from lawyers who have boarded the 'medical negligence' bandwagon – so hopefully, some of them will have the right motives and the enthusiasm to tackle mental health injustices.

To be taken into account, too, is what has been happening elsewhere in the world. A 200-page thesis – of which 'Shock Treatment – A Criminal Assault, (quoted above) is a synopsis – submitted to the University of Auckland for the degree of Master of Jurisprudence (awarded), examined the law in New Zealand as it relates to the administration of ECT and the handling of mental patients. The author, Mrs. L. O. Smith, discovered that ECT is in fact criminal assault by New Zealand law, and suggested that any person administering ECT is liable to prosecution even if consent is obtained, as an illegal act is not made legal by consent to it. Her finding was based on the arguments: **“Stephen's statement that everyone has a right to consent to the infliction of bodily harm not amounting to maim has...been qualified by Donovan in that if the act is in itself unlawful, consent cannot convert it into a lawful act. Thus the element of legality is critical in a discussion of the lawfulness or otherwise of any given treatment. ... It is submitted that consent cannot convert Electro-Convulsive Therapy into a lawful act because the act is not a treatment as envisaged by the Mental Health Act. Although no definition is given of the term “treatment,” the legislative intent is that a patient will at least benefit from it. The words “treatment” and “therapy” used in conjunction with “electric shock” are typical of the redefinition of words and concepts which seemingly justify its use.” According to Smith, “...what is a reliable guide to medical treatment are the findings from the medical profession itself. A Minnesota psychiatrist writing to another psychiatrist in 1976 stated,**

“Getting back to your analogy of the surgeons who do amputations without the need for outside regulation; if the surgeons had been doing amputations for angina pectoris because it would decrease the cardiovascular demand, or if they had been doing amputations because individuals walked into their offices and requested to be rid of a useless, albeit functional limb, or if the surgeons had been amputating limbs because patient's relatives had requested it,

then perhaps there would be an equal outcry from the public and from other agencies requesting control over those surgeons and procedures. The psychiatric profession has been doing just that in that they have been using it as a symptomatic treatment in character disorders with no substantial benefit and increased risk to the patient, and they have been using E.C.T. as an elective treatment when patients and / or families have requested it, in spite of the fact that the psychiatric diagnosis would not warrant it. It is obvious to me that the use of this treatment

does need some regulation....” (Dr. Butzer, Staff Psychiatrist, St. Paul-Ramsey Hospital to Dr. G. Duncan, President, Minnesota Psychiatric Society, Rochester State Hospital).”

Clearly, Smith's declaration of the illegality of ECT did not make it illegal in law. Mrs. Smith was aware that there would be an uphill struggle ahead and even remarked, “If the Legislature is not prepared to declare electro convulsive therapy to be an unlawful treatment, then legislation along the lines of the Californian amendment to its Welfare and Institutions Code would be a giant step forward.” Nevertheless, this woman laid a firm basis of explanation on which to build ECT cases in New Zealand.

Research By ECT Anonymous – Document Available:

crafted by linking psychiatrists' own words there is no doubt but that ECT is other than a medical treatment for mental illness. Indeed, the evidence of these quotes suggests that mental abnormalities can be shown to be present after ECT but not before it. A long time ago, the EEG pioneer W. Grey Walter (*The Living Brain*) admitted that, "mental illness is usually accompanied only by the most subtle and evanescent changes in the EEG." In other words, where the tracings show anything at all, they suggest psychiatric unease that is transitory, fleeting, short-lived.... The ECT victim, on the other hand, is *set* into disease. **There is no solid mental illness for psychiatrists to treat until 'treatment' has created it** – and that's the crux of the matter. Mrs. L. O. Smith's 'Myths of ECT' rounds off the ECT Anonymous compilation based on research references. This document, which runs to approx. 20 pages, is particularly useful to anyone considering litigation and to the student and researcher. Cost: It can be had from Head Office, priced £2.

As for ECT in the Committee's proposals, the subject covers precisely a third of a page – 3 inches of text in 9 inches – of the draft. Where "specific areas on which comments would be most welcome" were sought by the Review Team, the text is highlighted. No highlighting of text occurred in relation to ECT, which must therefore have been judged dealt with and the matter closed. ECT Anonymous has sought to disabuse the Team of that notion!

Although we do not have the space to copy the review document in full, these were the proposals for ECT:

140. The Committee has received many powerful submissions urging the removal of ECT from those treatments which can be imposed in the absence of consent. The Committee has been influenced by such views but appreciates also the views of those, both clinicians and users, who feel ECT can be effective, possibly even life saving.
141. The Committee intends to recommend:
- a) that ECT be never imposed on any patient who retains capacity and is not consenting;
 - b) in the case of patients without capacity, whether under a compulsory order or not, ECT cannot be administered without the express approval of the tribunal through its medical member;
 - c) that ECT should not be available on the equivalent of section 62.

We were fuming and, accordingly, set about compiling the confrontational response given in full below, which was sent by Royal Mail Special Delivery, just in time to meet the 7th May deadline. The scurrilous nature of the affair can be seen in the unseemly haste with which consultation was effected. We were surprised by the call from a member of the Committee as we did not expect to hear anything further. Survivors are fighting their corner with increasing determination, and it's unlikely ours was the only highly critical response to be submitted – so the possibility that others have made an impression is exciting. We are not naïve enough to suppose we can stop the steam-rolling, of course. If we made waves sufficiently high to cause consternation, we doubt we created a tsunami. Sadly, it would be unrealistic to expect that our concerns have struck a chord such that the final outcome will turn out to be user-friendly. Realistically, the more likely scenario is that the Committee will continue to forge ahead, finding ways to negate valid objections that can't be ignored, in order to strengthen the right of the clinician to treat and – being made overt for the first time – the ominous right of government to incarcerate / enforce treatment should it see fit.

THE ECT ANONYMOUS RESPONSE:

It is noted straight off that the Scoping Study Committee (hereafter referred to as 'the Committee' or 'Team') is not asking for comments on its skimpy and ill-considered recommendations re. ECT. For what it is worth, the comments of ECT Anonymous are nevertheless appended and we wish to make absolutely clear our rejection of the ECT and related recommendations in their totality and our disgust at the disregard for concerns generated not out of thin air but because of *psychiatric* research findings. Our intention to publicise the objections to follow. It is also our intent to withdraw from this process failing a specific reply to our concerns (rather than the rather ignorant sending of a 'round robin' style generalised letter without the courtesy of even being addressed correctly), and considerable revision of the proposals.

We would demand that you quantify the number of "users" who have supposedly claimed that ECT can be "lifesaving." We suspect that this is nothing but a transparent attempt to disguise what is essentially, with respect to compulsion, a clinician v. user issue. We can provide hundreds of user testimonials to the damaging effects of this process. We very much doubt you can do likewise with respect to the opposite view. Crucially, you would have to do this immediately, with evidence of post-dated correspondence, to substantiate that your present claim is not misleading. Please don't attempt to evade the issue by citing "confidentiality" as an excuse for non-disclosure. Many of our members are quite happy to go public about this, and are increasingly doing so. If your pro-forced ECT users (assuming they exist in substantial numbers – which we doubt) feel so strongly about the issue, perhaps they too would not object the facts being examined in the open? Equally, we would demand that you provide qualitative and quantitative evidence from the clinicians consulted, to show that ECT is lifesaving.

Failure to do this will result in, at best, claims being made in the public domain that you have been amateurish in conducting this exercise, in that you have not fully examined the facts and, at worst, questions will be raised about the integrity of this whole exercise. In any event, the fact that this review may be considered as inexpertly handles is evidenced by the complete contradictions that are apparent in paragraph 107, for example, and by recording that the overview must be that of an evidence-based one whilst, at the same time, citing unqualified observation like that of ECT being "possibly even life saving."

If you counter these requests with the observation that you said ECT is "*possibly* even life saving" – rather than it is lifesaving – then by your own admission you negate any justifiable argument for its continued use without consent. The RCP's own Benbow report records that ECT can kill. The term "possibly" is starkly missing in this context. We would advise you to run this past the legal profession representatives on your team, lest you and the Government are embarrassed when this insistence on forced shock is ultimately challenged in Europe. As you know, they are not too happy about forced ECT in Europe.

Of course, there are other reasons for the appeal of ECT:

One of these is Robert Kendell, President of the RCP, a passionate supporter of forced ECT regardless of his own findings that ECT affects the blood-brain barrier. Yet despite even this, he is on record as saying; "no one in their right mind would have ECT unless they were ill" – when challenged to have it himself, coldly telling those damaged by it to take their complaint to court. More chillingly still, he is on record as saying in a memo to the Select Committee on Health in December 1997,

As a result “bedblocking” is a constant problem, particularly on medical, geriatric and psychiatric admission wards, and a permanent source of irritation to NHS staff.”

It is no secret that ECT is used primarily on elderly women and is considered as being rapid in its effect. Its use, as a powerful political tool to empty beds cannot be underestimated.

Yet, if in hospital, they are “already safe and adequately cared for.” So says the President of the RCP to a Government that knows just how useful ECT is, regardless of the cost to the individual, and regardless that the patient is already safe.

It seems to us a sub-text of the draft document is that the official position as disseminated by the RCP and others is pretty much a sacred cow, such that psychiatric practices have had to be raised beyond controversy and sources discrediting such practices deflected. It is the belief of our members that many individuals are coerced into compliance by threat of sectioning. This gives a politically handy method of dressing up many forced treatments as consent-based. Imagine our horror to read that you, in effect, condone “persuasion” on a persistent basis. This is totally dishonest and unethical. We believe that if ECT were made a consent only-based process, such that coercion could not be used, a significant drop in its usage would be evident. This would, of course, frustrate Government interests in keeping “headline grabbing” beds empty. In a similar way to the situation that exists for psychosurgery (nsmd), you would hardly get people lined up for it in significant numbers, certainly not be comparison to its present use.

The only way to combat this systematic abuse would be for the level of capacity to be established on admission to hospital and if capacity was confirmed, the patient informed of all possible treatment options, THE INTERVIEW TAPED, AS IS NORMALLY THE RIGHT OF SUSPECTS IN POLICE CUSTODY AND THE PATIENT GIVEN ACCESS TO A LAWYER and, finally, the patient given the right to issue advanced directives concerning those treatments he finds objectionable. If found not capable, the tribunal would be transparently involved from the outset. This would greatly reduce abuse in this respect and introduce more honesty concerning compulsion. We cannot see how the Team could object to this, especially as bearing in mind that pledge to avoid discrimination.

NB It is unjust and discriminatory to limit access to a lawyer to cover only the oral stages in a Tribunal.

Incidentally, we note reference to the 1997 Stationery Office publication, ‘Who Decides?: Making Decisions on Behalf of Mentally Incapacitated Adults’ If the Team were to advocate any move of neurosurgery for mental disorder (nsmd) from section 58 or allow its use without consent then this would guarantee co-ordinated outrage and the most bitter of court fights from which neither politicians nor members of the Team would emerge unscathed. The same applies to any consideration given re. experimental procedures on non-consenting adults or children.

Your definition of “lacking” capacity is so broad-based as to be meaningless. To force a person to undergo a possibly dangerous process on the off-chance they may have reached a different decision when they were well is outrageous. The only way this could be applied would be to deny patients the right of redress if in fact the doctor was wrong, on the patient’s recovery. This would be even more outrageous and probably even illegal if examined by the European Court. If this policy was implemented it could only be done with an automatic right to compensation if the doctor was wrong. It is thus unworkable.

The question, “What is mental health legislation for?” is indeed fundamental and the decision to adopt a limited model seems remarkably tongue-in-cheek. Looking at service quality and provision might at least have allowed the Committee to appreciate more of the contradictions inherent in what is being proposed - even, perhaps, something of the rottenness at the system’s heart. We state categorically that the Mental Health System is built on sand and to address the mechanics of compulsion without exploring its unsafe foundations begs many questions, some of which are touched upon below. >From our point of view, the blinkered approach envisaged makes clear to us no meaningful consultation has happened. Information highlighting the falseness of claims by medical professionals, which should have fostered a radically different, far less smug approach, is treated as irrelevant. Please be clear that we are unable to countenance any references giving the false impression that we were consulted and our views taken into account. The heading of Appendix 1 currently implies that actual consultation has taken place. We also refuse permission, as sought, for the names of the individuals involved to appear in Appendix 1, as these are marginalised by the failure actually to look at and take seriously complaints of consequences, including iatrogenesis, from a treatment where usage is fostered by a tissue of lies. The unseemly haste with which this exercise has been conducted bodes ill. Rapidly drawn up legislation is invariably bad legislation, and from what we have seen so far there is every indication that this is going to be the case.

I. General Principles

B. Other Principles / Paragraphs 19 and 21

ECT Anonymous proposes that the Committee has been seriously misled by psychiatrists about the nature of ECT and, despite receiving information expressing grave reservations, has largely taken the official (RCP) position at its face value. It is our urgent contention that except the nature of ECT becomes properly recognised, special safeguards, even though becoming defined in legislation (Para. 19 ‘Treatment’), could not be appropriate, nor effective. The Committee declares themselves attracted to the principle of ‘evidence based medicine,’ but articulating such a principle would necessarily involve recommending that evidence be forthcoming concerning the treatments currently in use in psychiatry. For starters, the phrase “safe and effective” used of ECT is improperly applied as ECT, unlike a vaccine, carries no requirement that safety and efficacy is proven. Until such time as a requirement comes into force for the safety and efficacy of ECT to be proven, the ideal of “least restrictive alternative (Para. 19 iv), of treatment in the least invasive manner is unattainable.

Let’s be realistic, although psychiatry regularly issues the same old statements, these *are* belied. For example, it is commonly claimed that ECT is used as a treatment of last resort, yet the ‘Making Sense’ MIND publication on ECT points out that in the U.K. “around 20,000 people have ECT every year.” In fact, there is little regulation of ECT governing when and on whom it can be used and why. The bottom line is ECT is given because psychiatrists control the psychiatric situation – and all such claims as that it is a treatment of last resort are so much hot air.

Paternalistic dictum, not rational scientific basis, establishes ECT as the medical treatment is has not been independently validated as being. All areas are controversial – knowledge lacunae psychiatry actively encourages, the idea being that ECT will remain forever empirical with much supposedly still to be learnt.

After 61 years, isn’t it peculiar that so few hard facts are being acknowledged? Clinical indications – to say nothing of a considerable non-clinical component – contra-indications, therapeutic aim and agent, the necessity (or otherwise) for a convulsion, method of

evidence based medicine, then the whole question of ECT ought not to be settled already, as seems to have taken place, but should be declared the difficult issue it is with discernment a prime necessity.

Further, to articulate the principle of evidence based medicine in practice would be to open a can of worms not merely in connection with ECT but also about the nature of illnesses that are ‘mental.’ Certainly, for evidence actually to matter, the pretence that psychiatry knows far more than is actually known about disturbed or disturbing people would have to go. (Or are we dealing here primarily with what is politic and political?) Psychiatrists have too often been unable or unwilling to impose upon themselves the limitation of saying no more than they know, or the humility to admit uncertainties. Nevertheless, exaggeration and immodesty fail to provide them with the external validating criteria for illnesses that are not subject to measurement, even if psychiatrists are in denial about the impossibility of deriving data from impartial physical mechanisms. Although the history of psychiatry is riddled with claims that the body fluids of psychiatric patients show abnormalities or that specific anatomic lesions have been discovered, replication of findings proves elusive. Where there are genuine attempts to disprove hypotheses – rather than uncritical presentation of data – acknowledgement is eventually made that blue urine or enlarged ventricles do not operate as antecedents for schizophrenia or any other major mental illness. In truth, the breakthroughs consistently prove illusory. It is appreciated, naturally, that the Committee might after all prefer to keep the lid on this particular can, but choosing that option means buying into a theoretical hoax.

It isn’t just that classifications of mental diseases glaringly do not adequately represent the person with a problem. There is also the matter of public misinformation, where biochemical imbalances are claimed to be responsible for mental conditions, and where the impression is given that theories are proven and treatments therefore soundly based. Besides, the realignment-of-neurotransmitters hypothesis currently favoured by biopsychiatrists who condone the use of ECT and toxic chemicals to ‘bring back to normal’ an allegedly malfunctioning physiology is the product of distorted reasoning when we are talking about ‘illness’ that is ‘mental.’ As for brain disease, there is no evidence confirming the brain disease attribution. Really, it is imperative that these facts are openly declared relevant and acted upon. At present we are guilty of allowing psychiatrists arbitrarily to decide that a condition they say is a mental illness actually is, whereas consistency demands that biologically based brain and other diseases are acknowledged as the province of branches of medicine other than psychiatry.

II. Framework for Compulsion

A. The Diagnostic Criterion / Paragraphs 35 – 37

It is especially noteworthy that “mental illness,” the diagnosis identified in 97% of NHS formal admissions (Dept. of Health Statistical Bulletin 1994/5, para. 2.4.1), is not defined and is not to be defined (which is understandable, given the impossibility of a viable operational definition). As mental illness is what is almost invariably meant by “mental disorder,” that the favoured definition proposed by the Law Commission is one not restricted to psychiatric disorder would seem to be an attempt to insert other considerations by the back door. As the Introduction to DSM IV makes clear, what the professionals are actually keen on is that the term mental disorder should not imply a distinction between mental disorders and physical disorders.

There are strong objections to this business of an unethical introduction of the inaccurate and unreliable biomedical model of mental illness, which will have the effect of strengthening the marriage of psychiatry to somatic medicine. Needless to say, the idea that specific biological defects underlie mental illnesses is known to be the one which provides the rationale for ECT and physical treatments generally – so we suggest there is recognition of compelling objections or the move would be being effected openly and explicitly. Regarding underhanded dealings, it’s strange indeed that these ‘treatments’ and their biological justifications are, in effect, a means to an end – which isn’t to make sick people well, physically or mentally, but to oblige them to behave themselves and do as they are told. If ill health were the criteria, logically there would have to be compulsion to treatment for all serious health problems.

One obvious form objections take is that there is continuing and predictable absence of consistent biochemical or neurological data in support of the involvement of biophysical causes for the mental illness component of which the category ‘mental disorder’ is overwhelmingly comprised. Seemingly the intention is to proceed *as if* reliable, properly interpreted, associations are demonstrated, and that this somehow strengthens the notion of a “diagnostic trigger for compulsion,” which will be to claim, implicitly, that the value of the construct ‘mental disorder’ has been established. Yet the apologia in the Introduction to DSM IV, xxi, makes clear “it must be admitted that no definition adequately specifies precise boundaries for the concept of “mental disorder.”” In fact, all definitions of the term are arbitrary, as, ultimately, is that all-important diagnosis ‘triggered’ by the definition.

C. Assessment

1. The Right to Assessment

Of note is that the right to assessment is in relation to *mental* health. This in spite of the fact that a wide range of neurological, endocrine, toxic, neoplastic and metabolic conditions produce psychiatric symptoms and are often misdiagnosed as mental illness and thus inappropriately treated. Moreover, the treatments offered in psychiatry may induce physical illness, including diabetes, hypothyroidism, systemic lupus erythematosus, liver disease, tardive dyskinesia / tardive akathisia and sexual dysfunction – and these, the acknowledged iatrogenic conditions, are the tip of the iceberg. For some reason, there exists reluctance or inability to detect physical illness in psychiatric patients. This may come about partly as a result of the discrimination such patients note – but this does not exonerate the physicians from failure to differentiate or to see the whole clinical picture and treat accordingly. Quite honestly, what is being perpetrated is rank disregard for the realities of so called mental illness. Para. 38 (‘Exclusions’) mentions the likelihood of changes in connection with dependence on alcohol or drugs. Blurring of the clinical picture is even more likely to occur with the substance dependent individual, where few doctors spot symptoms unrelated to the substance abuse or see beyond the rare likelihood that the chronic alcoholic, etc., will respond to treatment.

Section G. 3. ECT

Paragraph 140

While ECT Anonymous agrees with the Committee’s finding that some clinicians *feel* ECT can be effective, we wish to see specifically addressed the issue of whether or not shared idiosyncratic belief in this matter is sufficient. Firm indications of absence of a

absolutely clear – via the pens of psychiatrists – that statements made nowadays, if not downright untruthful, are certainly both misleading and partial. In short, the professional opinion on ECT is not capable of withstanding logical analysis, nor could it bear close scrutiny for veracity.

The disappearance from mode-of-action explanations of references to *known and understood* adverse effects upon the limbic system relating both to amnias and homeostatic dysregulation effects is singularly revealing. It would hardly be prudent for the clinicians who *feel* ECT can be effective to admit that the price of a random and short term euphoric reaction, in itself indicative of damage, is an increased risk of everything from nonconvulsive status epilepticus and hypothermia to susceptibility to rape, now would it? Unfortunately, such outcomes are not minor – and nor can they be dismissed as “subjective,” given a big danger with hypothermia is that the apparently fit sufferer doesn’t usually realise what’s happening and that by its nature nonconvulsive epilepsy usually requires an EEG to confirm the diagnosis. Logically, no patient, even if 100% retentive of capacity, can ever give *informed* consent, where the hidden risks have become unacknowledgeable so, clearly, will not be disclosed.

We are cognisant of the centrality to what is decided of the law relating to consent and the Committee must be only too conscious that *adequately* informed consent is what prevents the charge of battery. Our understanding is that a failure to warn of a known risk falls within the Bolam test for negligence. The body of medical opinion that fails to warn of a known risk must be able to provide justification on a logical basis, establishing reasonableness for the failure to warn. ECT Anonymous very much doubts that those clinicians who *feel* ECT has its uses will have established reasonableness for the non-disclosure of risks which psychiatry dares no longer mention – but which haven’t gone away simply because nowadays unstated. However, this isn’t simply a matter of a cavalier approach by psychiatrists. There is the possibility that a treatment which was once openly known to have an actively sought permanent and adverse effect on a person’s overall health is arguably unlawful, especially in that current legislation does give people the right to an informed choice and to forego treatment that entails what for the person are intolerable consequences.

The defence in the past was that it was considered acceptable to compromise physical health in order to get at unacceptable behaviour or thinking – an argument that isn’t sustainable in the current climate where emphasis is increasingly on human rights, which is doubtless why acknowledgement of somatic harm has ceased. This does not alter the fact that consent may be vitiated if obtained by deliberate failure to mention risks, particularly grave risks. Clearly, therefore, for those users who claim ECT is beneficial, the right *knowingly* to choose compromised health is one thing but, as matters stand, just because ECT has its supporters that does not fundamentally legitimise it – even if the Committee appears to think differently.

Likewise, it is reprehensible of the Committee to make the assertion that ECT is possibly life saving, without also stating the existence of research indicating that ECT decreases life expectancy and clinical findings that it increases the risk of suicide. Please be absolutely clear it isn’t merely that the treatment can be imposed in the absence of consent which is objected to, but also the level of flagrant dishonesty surrounding the subject of ECT – which dishonesty the Committee, seemingly happy to remain sublimely ignorant, is guilty of perpetuating.

Paragraph 141

>From the point of view of what the Committee acknowledges is an essential right to autonomy, the statements in this sub-section lack the necessary precision and are therefore totally inadequate because they skim over the possibility of abuse by paternalistic clinicians firmly of the *opinion* they should place minimal reliance on the patient’s expressed wishes regarding treatment and primary reliance on their clinical *judgement*.

What that is meaningful in terms of outcomes is being done about the continuing likelihood that patients will be labelled as without capacity purely because of a decision to refuse ECT? The issue of clinicians moving from their disagreement with the decision to refuse treatment to a label that characterises someone as sufficiently incompetent at whatever level of capacity they’re talking about has not been addressed. Indeed the myth continues to be promulgated that such beings, i.e. patients *without* (!) capacity, actually exist. However, let’s be clear about it, if the standard for finding a patient not competent to refuse treatment were no less than generalised incompetence, including clear evidence that the patient is uninformable on emotionally neutral issues and cognitively incapable of making ordinary decisions on matters unrelated to the crisis at hand, few persons if any could legitimately be deemed “incapable.” So where the viable measures to safeguard the much vaunted patient autonomy, and where the requirement for a truly patient-friendly measure of capacity?

Replacing the present system with a tribunal is all very well, but the necessity for a second opinion from a doctor appointed by the Mental Health Act Commission has been widely condemned as little more than a rubber stamping exercise, with the SOAD in more than 90% of cases upholding the original decision. As well, current procedures were liable to circumvention by invocation of common law, with treatment claimed to be in the best interests of the patient effectively depriving someone of the right to refuse. Persons in authority decided something should be done to the ‘patient,’ and it was done, with little or no comeback until very recently. It didn’t appear to matter that the legality of such action was decidedly shaky, given the MHA trumped the common law. Likewise, the revised MHA shall supposedly take precedence, yet the principle of necessity is to mean that a flawed state of affairs can continue. Why does the Committee imagine concern is expressed about the potential for over reliance on emergency treatments? No matter how disturbed the person, if they offer objections, they have the right to a weighing up of those objections rather than it becoming possible, in an ‘emergency’ for everything they say to be ignored.

Take ‘emergency’ ECT; if nobody cares that evidence supporting the ‘necessity’ for compulsory ECT is missing, what about the person who insists it caused them, or a loved one, brain damage – and for a reason of the sort they don’t want it? Where ECT is concerned, what is there about the tribunal system as anticipated – that would have to expressly approve ECT through its medical member – which is strategically different from the prevailing situation? What about the major stumbling block consent to this procedure represents? That there can be valid consent to ECT, given the issues herein highlighted, is in doubt. Tribunals ignorant or dismissive of these issues would be worse than useless.

It seems clear that the Committee is proposing to reject survivors’ views on ECT which are unsupportive of professional interests, emphasising the likely irrationality of patients but not the inherent unreasonableness of ECT due to irremediable lacunae in knowledge and therefore in usage, nor the fallacious reasoning on which psychiatrists base the negating of patient autonomy. As ECT Anonymous has made clear, we do not accept that consequential consultation has taken place. Moreover, aside from mention of receipt of “many powerful submissions,” the absence of even token attempts to incorporate the essence of the opposition to ECT indicates that “consultation” existed to facilitate the drawing up of Appendix 1.

Section H. Incapacity

Paragraphs 154 and 155

In respect of lack of capacity, Paragraph 154 is both Machiavellian and nonsensical.

Despite the impossible nature of the quest for the elusive definition of mental competency, the making of irrational decisions should not be equated with lack of capacity. It is perfectly possible to have competently made irrational decisions – and the real problem here is that psychiatry is distinguished by its eagerness to override the wishes of patients whose decisions they have the power to view as irrational.

Isn't the Committee aware it's already the case that the clinical situation reflects the judgement that such patients not infrequently make irrational decisions that seem part of the disease and that they can be expected to reverse their wishes after treatment? Who says this is what happens? On the whole, not the persons whose decisions have been undermined by a piece of reasoning peculiar to psychiatry. The Committee should have the sense to appreciate that enshrining fallacy in law, without any comprehensive or long-term research to back the claim that mental illness is a special case, would be done for the wrong reasons and is not a good idea. The already too broad, Law Commission, definition being argued for, that in Mental Health would permit capacity to be negated by the back door, so to speak – strengthens coercive paternalistic intervention. If this is what is being advocated – which can be said to be primarily a product of the belief in a certain sort of disorder – the Committee should say so clearly. The Law Commission definition wasn't set up with mental illness in mind and reflecting such a definition strengthens the justification for treatment of mental illness through the expressly physical, as already mentioned.

In short, a Committee declaring themselves anxious to recommend a definition with which the professionals can feel at ease, closely resembling clinical judgement, is a Committee that will invariably end up with a definition which, despite claims for a principled approach, categorically fails to take into account the demand by patients for a greater say in their own healthcare. In the light of the foregoing with regard to ECT, this is irresponsible of the Committee. As those same professionals, armed with a definition of competency that suits them, are the ones who will play God and decide that a decision judged irrational is the product of the disorder and that it does not reflect the person's true preferences, the Committee offers little but window dressing. There has to be a burden of proof on those who allege a patient is not capable. Will a tribunal be truly vigilant and "alive to the dangers," as is *hoped* (Para. 115, 'The Specification of Conditions'), or would there be a high rate of acceptance of what the doctors say? Wouldn't it be embarrassing for tribunals generally to question too deeply, as that might undermine the whole ethos of the new-and-improved Act in which the public can have confidence?

Let's face it the philosophy of the 1983 Act was to "strengthen the rights and safeguard the liberties of the mentally disordered" (Bluglass, 1984); the same principles were being expressed then as are being expressed now. By and large, the mentally ill is a vulnerable group, so what absolutes would change for the better for them? Besides, like it or not, it is necessary that some pretty rigorous questioning be done, because mental health human rights issues (around capacity, informed consent / personal decisions concerning what treatment risks are acceptable and – above all – the nature of disorders those in charge insist be seen in a certain light) are becoming increasingly compelling. Those learned gentlemen whose role is that of senior legal chair to the panel are likely to find their work cut out as, apart from anything else, the revised Act will soon be seriously out of date.

Where the patient is a psychiatric patient proof as opposed to say so must be a stringent requirement if the person's full right to exercise autonomy is genuinely to be respected. As well, and given the tremendous difficulties surrounding agreement about what defines mental competency, a compelling reason, clearly articulated and legibly presented in the casenotes, to over-rule the wishes of any patient should be required of the psychiatrist. Because casenotes can be mislaid or tampered with, some system that guarantees proper recording procedures is essential (see above, re. 'taping of interviews'). However, this sort of thing having been said, in order to come up with an appropriate definition of incapacity, what's really necessary is to start with the whole basis for the alleged inability by many psychiatric patients to consent. There's more to this than a simple presumption for or against lack of capacity. Is examining the notion of illness that allows psychiatrists to get away with claiming there is such a thing as incapacity or unsoundness of mind (among other things) too radical a move for the Committee to countenance?

In respect of ECT itself, if this is, as the evidence from professional journals indicates, a procedure carrying inherently unacceptable risks which are kept secret, then that in itself places ECT beyond the range of rational choice – and nobody is ever in a position to make a rational decision to have or not to have it. Indeed, we put it to the Committee that the ostensibly irrational choice, to refuse ECT against a physician's clinical judgement, is arguably the reaction of a person of remarkably sound mind and clear judgement! On the test of whether or not we would allow a reasonable and autonomous person the right to opt for a possible chance of relief from depression for up to four weeks in order to spend the rest of their life dogged by ill health, changed personality, etc., the answer must be "No" because the evidence just isn't such that the choice can be shown to be reasonable.

The body of professional opinion that declares ECT safe, effective and no more risky than having a tooth extracted is neither reasonable nor responsible. We are led to believe it was past recipients of ECT who agreed that the ECT experience is no worse than a visit to the dentist – and in the absence of accurate information and the presence of anaesthesia this is certainly a superficially correct interpretation. After all, ECT patients see little and comprehend less. However, the difficulty is, ECT recipients are never told that their symptoms post-ECT – sometimes many years later and including depression, recognised to be common following brain damage – are not 'continuing mental illness' but only exist because their psychiatrist inflicted ECT. So fostering the 'no-worse-than-having-a-tooth-out' myth is deplorably irresponsible.

It must be emphasised that the issue of the rationality of consenting to ECT does not depend on obtaining any more factual information

to draw on scientific discourse invalidates psychiatry's concepts and thus the so called medical practices based upon them – but to no avail. Literally, a reversal of what goes on in science, where evidence is what effects changes and makes a difference, pertains here. It is even the case that negative evidence is either ignored or the findings distorted as necessary.

Psychiatrists are perpetrating a scam and crippling lives in the process. They are selling a package they know is irrelevant to healthcare as such. What about the Committee? The question is, on the basis of solidly viable evidence to invalidate the package – should it be allowed to carry on? Must we keep on pretending that psychiatrists are operating like doctors? Must the edifice of a revised MHA be a house of cards built on deceit? And, seeing as a central issue is that of compulsion, shouldn't apprising the public of where psychiatry and Mental Health care are coming from be compulsory? Needless to say, ECT Anonymous recognises that actual clinician basis for choice of diagnoses and treatments, not being the traditional evidence-based method, is 'clinical judgement.' In our informed judgement, it makes a difference that disposing of people on the basis of illness and disorder is backed only by weak opinion and ideas.

We should not be the ones obliged to point out that ECT falls outside the scope of rational choice, but apart from this there are no circumstances under which it is so necessary to use ECT that doctors should be permitted to countermand patient wishes by calling those wishes "irrational" or negating capacity. It is never true that ECT is the only alternative to an otherwise unacceptable future. Careful nursing by dedicated staff willing to speak and listen to patients would substitute even better for whatever benefits ECT is alleged to convey.

The Committee ought to have asked why psychiatrists are so insistent on their right to use a treatment *they* themselves have documented to be iatrogenically damaging. In the Fifties when a mood of authority prevailed, all that seems to have been necessary was for psychiatrists to give themselves permission to tinker with basic somatic mechanisms. As long as unacceptable behaviour and thinking were ostensibly reduced as a result (and knowledge was added to!), no one seems to have questioned what went on. Not surprisingly, psychiatry has since had to ditch the reasoning behind such tampering – but ECT does continue to inflict conditions linked to homeostatic dysregulation. Pathological brain wave patterns following ECT have been noted, but the fact that nobody appears to have scrutinised what was being claimed in years gone by and drawn some pretty damning conclusions about ECT should not lull the Committee into imagining that it could not conceivably induce disequilibrium, through creating a breakdown of the controlling mechanisms of homeostasis normally so carefully preserved by the autonomic nervous system.

Interestingly, the reputed mental illness that ECT reputedly treats is NOT accompanied by pathological changes in the EEG. Shouldn't it forcefully strike the Committee that ECT isn't just irrational in terms of consent – where risks not only aren't but can't be stated? It is irrational as well because it alleviates (*sic*) mental distress through destroying bodily health. Do any survivors for whom compromised health is an issue regard the outcome as worthwhile? In fact, if ECT really worked as a treatment in mental illness, one would expect to note pathological EEG rhythms prior to ECT, and afterwards an improvement – instead of which one gets rhythms within normal parameters only *until* ECT is given – after which the abnormalities appear. Accurate knowledge gathered about ECT has disappeared, a contrivance of paternalistic dictum where there is insistence on retaining use of ECT and through it control and privilege. The real reason ECT is given is because doctors think it should be.

Challenge to the validity of all consent to ECT in the present circumstances extends to many of the precepts upholding it, as these too are questionable. To the extent that the alleged outcome of saving life is raised above alternative values such as autonomy, the patient who makes decisions that appear contrary to his or her best interests is likely to be declared unable to decide in a rational manner. As is pointed out in Para. 171 ('Suicide'), where there is mental disorder "most clinicians would regard the patient as lacking capacity." The more cynical among the survivors of ECT would say that the way clinicians regard patients is more to do with self-interest than with the presence of mental disorder and / or incapacity. Leaving those who wish to die to the tender mercies of psychiatric regard, where clinical judgement and invasive treatment is the norm, is to deny a very basic human dignity – as anybody who has let a loved one go in the firm conviction that death is what the person prefers will testify. All the regulations and enforcements against self-harm in the world won't make the person in whom the desire for death is sufficiently powerful prefer life, whether or not mentally disordered.

Therefore, let us at least be open about whose interests are served by any insistence that the mentally disordered without capacity are going to have to accept being 'protected' from themselves. It isn't themselves from which vulnerable people most need protecting. There are survivors of ECT who make absolutely plain that they may as well have been allowed to succeed in their suicide attempt because the damage from the treatment which is claimed prevents suicide certainly doesn't leave them whole and able to live a quality life afterwards.

So what is going to be done to ensure that arrogant physicians as well as incapable or protesting patients are held accountable and that serious institutional failings are addressed? Of the Bristol heart babies' case, Sarah Bosely in 'The Guardian' (25.6.'98) noted the senior doctors involved had "told the parents what they thought fit to tell them, and did not always tell them the truth." This state of affairs is even more prevalent in psychiatry than in any other branch of medicine, and although Professor Robert Kendell has remarked the lack of major scandals in psychiatry, scandals in connection with ECT are beginning to surface and are not going to go away. Public demand for the truth in matters medical is a factor to be reckoned with in our litigious society and psychiatry isn't secure against the process.

D The New Tribunal

P. The case for the tribunal

Para. 84 i) by no stretch of the imagination is going to be what enhances the psychiatrist / patient relationship. If those who are or have been vulnerable to psychiatric abuses don't find this first statement credible, why should there be a great deal of faith in the rest of the claims made about a tribunal said to be independent, supportive of full participation (by allegedly less than capable and frequently inarticulate patients!), enabling consistency of decisions, etc. It remains to be seen if the introduction of judicial imposition would work significantly to improve the situation for patients, seeing as decisions regarding treatment are to be made by the medical member.

Where appropriateness of a treatment plan involving ECT is concerned, the contents of our urgent response here presented make unambiguous the impossibility of the tribunal obtaining accurate necessary advice, evidence and expertise. (As for guardians appointed for persons deemed incapable of making treatment decisions, they are liable to be just as misinformed about ECT as is a tribunal.) A lot of ECT can potentially be given to detained patients who have to comply with an approved treatment plan for up to 6 months. A set limitation on the number of treatments that may be administered is imperative, as extensive ECT is never in a patient's best interests. In the 1980s, Dr. Graham Shephard was insisting,

All such findings as Dr. Shephard's within psychiatry, that would restrict practice, are ignored – which should surely imply the necessity for proper regulation and stringent controls. If psychiatry had to show proof around safety and efficacy, ECT would be quietly phased out, it's as simple as that.

Therefore, although the Committee pays lip service to the importance it attributes to the principles of non-discrimination and autonomy, they are paper principles where ECT is concerned, given the Committee is largely content to make those principles subservient to the views of clinicians (abetted by a minority of users) who declare the autocratic belief that ECT can be life-saving. Thorough consideration needs to be given to some hard facts. Claims that ECT is lifesaving are unverified – as what the literature reveals is that ECT has no effect on suicide. They are literally unverifiable, seeing as they're fallacious. Apart from anything else, these unverifiable assertions, the claims of persons too long accountable to nobody, depend on the existence of a proven correlation between suicide and depression (with ECT said to prevent suicide by 'working' in depression). In the absence of such a proven correlation, a finding (quoted in 'Human Freedom and Mental Illness,' *Canadian Psychiatric Assoc. Journal*. Vol. 14, 1969) is telling. The author cites Wijssenbeck, who

“found an *exaggerated* sense of freedom in patients suffering from manic and schizophrenic reactions, suicidal reactions, personality disorders and acute brain syndromes. A *decreased* sense of freedom was found in patients presenting depressive, catatonic, chronic schizophrenic reactions, character neurosis and chronic brain syndromes.” (Italics added.)

If correct, suicidal reaction and depression do not 'fall together' on a continuum – but instead are being facilely placed together in order to justify ECT. It therefore need not surprise that a positive effect of ECT upon the suicide rate isn't demonstrated. Another criticism being levelled at psychiatry is that practitioners are prone to selecting those effects which fit their hypotheses and neglecting those that invalidate them. We won't mince words here; the claim that ECT is effective in preventing suicide is a falsehood it suits psychiatry to foster. The professional function that such a falsehood serves – permitting psychiatrists carte blanche to administer ECT virtually as they see fit – is unlikely to be duplicated by an alternative interpretation of the causes of suicide. ECT Anonymous rejects the notion of acceptable psychiatric practice, whose acceptability, as this submission repeatedly states, is based not on empirical evidence but on what psychiatrists claim – which, in turn, is tailored to policy.

Section 1. Medical treatment of the patient with capacity

Make no mistake, the personality disordered who retain capacity are likely to have temporal lobe damage. Some of this could even have been caused by ECT, which inflicts epileptiform brain wave patterns – found with personality disorders. To say such people are the most likely to present a significant risk to themselves or to others is convenient, but it puts the cart before the horse – and does not exonerate the Committee from a responsibility to recognise the existence of a dilemma.

It is imperative that the Committee exercise due care when proposing that these putative 'patients' be compulsorily treated under a revised MHA – when this means compulsory psychiatric treatment. We are informed in Para. 9 ('The Diagnostic Criteria') that “the Committee favours a broad definition of mental disorder which is defined as any disability or disorder of mind or brain whether permanent or temporary which results in an impairment or disturbance of mental functioning.” This catch-all definition perpetrates misconceptions and will lead to human rights abuses – but it actually is also far too loose. It really is risky to suppose simply implying that everything to do with disability or disorder of mind or brain which results in a disturbance of mental functioning is illness that couldn't possibly fall outside the designation 'presence of mental disorder.' Given people who suffer from a physical disorder are free to refuse treatment, what precisely will be the criteria entitling whoever makes the medical assessment to decide that a person unequivocally is mentally (rather than physically) ill? Might not misinterpretation, in the environment of concealment that prevails, render the doctor concerned liable for damages? Isn't there a risk of false imprisonment charges, where the experts deliver a sentence without trial? Do all the categories subsumed under the definition provided really render a person liable to compulsory treatment, given brain disability is NOT primarily psychiatric?

To recap, the crux of the argument being propounded is that the authority to treat an *incapable* person comes from a treatment decision that would not have been reached had the person been well. It is clear that we are into a unique ballgame here. If, for instance the disability or disorder is permanent, then, logically, the person is never going to be 'well.' Are we to understand that intermittent forced treatment over decades is a possibility? But the big 'if' is, What if the condition is not psychiatric? We trust it is evident that extending, as does the Law Commission's definition, the meaning of 'mental disorder' beyond the psychiatric is potentially fraught with legal and ethical pitfalls. To start with, anything that has a specific brain pathology becomes the province of neurology. Epilepsy is described by the National Society for Epilepsy as “the most common serious neurological disorder,” in which “A sudden temporary interruption in some or all of these functions may be termed a 'seizure.'” Yet a condition known as nonconvulsive status epilepticus (SE) is recognised, which

“...is often more difficult to detect clinically and is either absence (petit mal) or partial complex (temporal lobe) in nature.

Symptoms include acute changes in mental status.... A recent study found a high incidence of patients with psychiatric disorders...among those who have nonconvulsive SE. This type of SE often requires an EEG to confirm the diagnosis.”

(Daniel J. Lacey, MD, PhD, 'Status Epileptics in Children and Adults,'
J. Clin. Psychiat., 49:12 (Suppl), 1988)

How likely, one wonders, is it that psychiatric patients who have unrecognised nonconvulsive SE are exhibiting behaviours indicative of changes in mental status that have been designated part of a psychiatric disorder but which are, at least according to the National Society for Epilepsy, part of a “neurological disorder?” Just supposing, for the sake of argument, that instead of 'treatment' based on assumptions of psychiatric illness and therefore the possibility of wrongful diagnosis, which is what is being advocated, the assumption was to be of neurological disease, with the personality disordered individual given neurological assessments as an obligatory part of the assessment in relation to mental health needs. What happens when a neurological condition is found to underlie somebody's disordered state? Would this still legitimately fall within the province of the MHA? Bournemouth suggests not.

Despite the Committee regarding the principle of non-discrimination as central, the qualifier is non-discrimination “wherever possible” and there isn't to be a recommendation that non-discrimination be expressly included within the revised Act. Given the Mental Health Act's primary concern is with providing a framework for compulsory detention and treatment of particular sorts of person suffering from a mental disorder, and given the acknowledged impossibility of incorporating a principle of non-discrimination into an Act which seeks to empower authorities to compel treatment, at the end of the day we are still left with mental illness as a special and inherently discriminatory case. This is so because, where the illness is physical – including neurological – there is no right to treat merely because a person is designated “ill.” (It is of course doubtful that neurologists would be keen to be involved.)

emerges, perhaps as a result of ECT litigation, that many individuals have disorders caused by previous psychiatric treatments – will they be obliged to undergo more of the same? It would be short-sighted of the Committee to imagine that professional denial of damage effects can carry the day for much longer.

So are these difficult issues to be swept under the carpet, in the hope that the facts (i.e. that incurable personality disorders are more likely than not to be neurological and that a proportion of such disorders may have been iatrogenically induced) will remain largely unremarked? The problem here is that the Committee *has* been apprised of these matters. To whom is a Scoping Committee which fails to grasp the nettle answerable?

The option envisaged in Para. 161, where the patient, being “exposed to prolonged negotiation and encouragement on the part of the clinical team would eventually ‘consent’ to the offered treatment,” invites coercion. Prolonged negotiation about ECT would be nothing of the sort, because patients are never told the truth about ECT. The alternative proffered in Para. 162 b) is a thin-end-of-the-wedge type of option, which, given a gross want of insight into the realities of mental illness, presents a risk to patients of being fitted into “carefully defined circumstances” or threatened with it. As for c), again we encounter the note of invitation, in this instance to find that the patient has lost capacity, “as might *typically* be the case with regard to mental illness.” The Committee here betrays the material focus of their attentions.

Intellectual and scientific dishonesty pervades this whole business. As an example of the dishonesty complained of, which the Committee doubtless prefers to ignore, the first thing to be born in mind about the so-called “signs of relapse” mentioned in Para. 163 (2. ‘The person with a deteriorating condition’) or “history of relapse” (Para. 165) is that this sort of sign could be due to overuse of toxic chemical restraints, which involves some severe withdrawal symptoms. Where the admissions tardive dyskinesia and dementia are part of the “display” of so-called “signs of relapse?” Just how “appropriate” can treatments in psychiatry be shown to be? Crucially, would the public benefit from an increase in forced drugging of patients (and possible forced testing / forced incarceration in prisons hypocritically termed “hospitals”), or is it drug companies that are most likely to benefit?

Are treatments, however “appropriate the standard,” not in themselves part of the overall risk picture; furthermore, do they ‘work?’ If, as is implied in Para. 138, it has regularly been the done thing to “obtain a second opinion certification” after 3 *months* of medication, the conclusion to be drawn is that drugging frequently doesn’t improve the patient’s condition in the sense of ‘making better’ – though it doubtless creates docility. “A framework for the *authorisation* of medication” is all very well, but a framework for inspection of the role of medication throughout would be far more revealing – that is, if someone wished to examine the imposition of what are little more than chemical straitjackets. Then there’s the matter of what exactly is meant by “deteriorating conditions,” i.e. is this whole business largely about limiting inappropriate behaviour? If so, it is highly unscientific for actions to be taken as if behaviours are reliably associated with deterioration in social functioning. It is unmedical to allow ‘health’ to stand in for moral standards, where it is no longer fashionable to examine the evil that men do so there has to be a complex yet decidedly unsound ‘mental disorder’ framework in place for constraining the mad and bad. The notion that psychiatry is a branch of medicine, with what psychiatrists do and are permitted to do purportedly stemming from their allegiance to science, has worn decidedly thin.

In respect of personality disorders, the crux of the matter is that damage to the temporal lobes and limbic system results in untreatable pathological states – as psychiatrists have realised. Andrew Wilski, consultant psychiatrist, writing in ‘The Times’ (4.3.’99) makes absolutely clear it is generally recognised that the psychopathically personality disordered,

“...cannot be successfully ‘treated’ in the context of psychiatric systems – ie, that on the whole they do not significantly or lastingly change as a result of psychiatric procedures, while causing turmoil in psychiatric wards.” Clearly, psychiatry isn’t keen to be held accountable for such individuals. Moreover, all the options proffered by the Committee, built around the central tenet of ‘treatment’ with or without consent, singularly fail to take into account the nature of personality disorder, a condition notably unresponsive to treatment. A sensible way forward would be to make acknowledgement of neurological impairment as opposed to mental illness.

By the way, erroneous insistence on some definite category labelled ‘mentally disordered’ would make any likely definition of capacity / incapacity less than valid. The reasons for an insistence on treatment for mental disorder are also questionable in this context. Is it more a matter that a locking away for supposed medical treatment legitimises detention than that the interests of public safety justifies not only detention but the imposition of treatment? If there is to be insistence on treatment in such circumstances, let it be clear that the treatment is being used to appease the public, as well as clinicians, carers and the families of patients. Other than this, the pre-emptive approach favoured by the Committee is likely to lead to violations of human rights, especially as psychiatric treatment of personality disorder is known not to be a viable option. It would require changes to the law to implement, especially after the Court of Appeal finding of 15.6.’98 (Para. 37, Bournemouth) that patients with *neurological* conditions, such as Alzheimer’s Disease and learning disabilities, are being detained illegally.

In making recommendations in connection with filling the legislative gap revealed in the Bournemouth case, might not the Committee risk diminishing the rights of the majority of the long-term incapacitated in order to control a tiny minority? Revisions that make the Mental Health Act essentially backward-looking will perpetrate injustice. The few who really should be compelled may well prove incredibly wily, resulting in tightening of controls, scapegoating and intimidation for the many. In any case, supposing it were possible to “significantly or lastingly change” the patient, isn’t that to rob him of the right to his own personality – or at least a familiar one where his natural personality has been altered by psychosurgery or closed head injury, including that inflicted by ECT – a serious and destructive course of action, and of very doubtful morality?

Best Interests

Paragraph 174 a)

It is noteworthy that most if not all of the ECT medical negligence cases currently in the pipeline have arisen because doctors presumed to know better than the patient what was in that patient’s best interests.

P. Children

Paragraphs 237 and 239

ECT, there exists a singularly pressing concern that consequences be scrutinised to bring in the damage aspect. It is high time serious consideration was given to the impact of ECT on an immature and developing brain.

* * *

Enclosed with the ECT Anonymous refutation was an additional response expressing the opinion of The Survivors of Mental Health Services in West Suffolk:

Re. REVIEW OF THE MENTAL HEALTH ACT 1983

Discrimination

Because of the powers of the Mental Health Act, a user can lose his liberty and most of his rights as a human being. However, the Act does not provide any protection for the user. Mental Health workers can abuse users without fear of repercussion – **there are no penalties for abusing mental patients.** This is Discrimination.

This has led to widespread abuse over the years. (The Mental Health Commission's latest biennial report is just one long catalogue of abuse yet there is no mention of the Law being used to punish the abusers). Psychiatrists and psychiatric nurses can do virtually anything to patients and no matter how much damage they cause, the Mental Health Act does nothing to stop them – they will never be prosecuted. The Mental Health Act has always been the LAW as far as users are concerned but it has never been the LAW where staff are concerned; just something to be abused.

Unless penalties are added for breaches of the Act by mental health workers then it is just a farce - something created by the government to appease the public but in reality showing that both the government and the Law endorse the abuse of users. **Why should mental health workers be exempt from the Law? Does the Law endorse the abuse of users?**

The Mental Health Act is Discrimination at its worst.

ECT (Paragraph 141)

At present, the use of ECT is abused by mental health staff who threaten patients with being sectioned under the Mental Health Act unless they consent to ECT. While I agree in principle with what is being said in this paragraph, I think one loophole is being closed and another one opened. Instead of the threat of section, mental health staff will now threaten their patients with "incapacity" if they don't consent to ECT.

I do not believe that the medical member of a Tribunal would make any difference because he / she will go along with the opinion of the patient's consultant. The doctor in the Tribunal is no different from the 2nd opinion doctor supplied by the Mental Health Commission – he / she will not go against their own. The Mental Health Commission has never done anything of benefit for users; why should users expect this Tribunal to be any different? It is just another way of rubber-stamping their lack of rights.

Also, when there are no penalties, why should any psychiatrist or any other mental health worker pay the slightest attention to any of these laws when they don't suit them?

ECT is supposed to be a last-resort treatment so would it not make more sense to make it statutory that at least two other treatments must be tried before ECT is even considered and that these must have been tried for a period of at least 4 weeks each (anti-depressants take several weeks to work)? Although this may sound expensive, it is cheaper than keeping the patient for the rest of his working life – a high percentage of those receiving ECT never work again whereas those that have been treated humanely do return to work.

Also, if ECT is being considered would it not be a good idea to have any discussions taped or on video and the offer only made in front of the patient's representative? The patient's representative would be given a copy of the tape. This, at least, would provide some evidence if the user at a later stage wanted to bring court action for abuse of his rights.

If the psychiatrist was made criminally liable for any damage that might occur in an emergency treatment then there would be less reliance on these treatments. **The Law should apply to doctors as well as patients.**

The Diagnostic Criterion (Paragraphs 35-37)

This criterion could quite easily include everyone in the country. Anyone who has a drink on a Saturday night has impaired or disturbed mental functioning. **Is enjoyment going to be classified as a mental illness?** Those suffering from brain tumours, epilepsy or concussion would also fit this criterion. **Is someone suffering from concussion after an accident going to be taken to a psychiatric ward rather than Casualty?**

On the basis that the Health Authorities and Social Services are full of people who abuse the rights of patients and clients, I would have thought it wiser to restrict the damage they can do; not give them scope for doing more harm.

Incapacity (Paragraphs 149-158)

If you use the broad definition of Incapacity then it can be used as an excuse to give patients certain treatments as punishment. Paragraph 154 states:

"...there may be an argument saying that a person lacks capacity where, although intellectually able to understand and apply the information, that person reaches a judgement which he or she would not have reached in the absence of the disorder."

What if the patient refuses ECT and it is decided that he / she is incapacitated and would not have reached that decision in the absence of 'mental disorder'? When the period of incapacity is over and the patient is still saying that he / she would not have consented to ECT then obviously the Tribunal and the Psychiatrist and the Law were wrong in declaring that person incapacitated – he / she would have reached that decision in the absence of 'mental disorder.'

If the same patient has suffered memory loss or other damage then who is liable? If the patient cannot return to his occupation because of the damage caused, who is going to compensate him for the loss of earnings for the rest of his life – the Tribunal? the psychiatrist?

Or does liability not matter where mental patients are concerned?

Exclusions (Paragraph 38)

This was included in the 1983 Act because it was felt that these people needed protection. What has changed? If this is removed then the Mental Health Act will need to be re-written or amended in a couple of years time in order to prevent these people being abused.

Suicide (Paragraphs 171/172)

When patients are discriminated against by society and by the law for an illness they cannot help; when they are abused by those who are supposed (and paid) to help them; when they are forced to take drugs which do them more damage (e.g. tardive dyskinesia) than the original illness; when they cannot get work because of the stigma that has been attached to their illness and the damage that has been done to them by the mental health system, then suicide is the only true freedom they have left. Suicide is not necessarily a sign of mental illness; it may be the only sane option left. It is an escape from abuse, discrimination and inhuman treatments. It is also something which cannot be prevented.

Advocacy (Paragraphs 220/221)

While I am in favour of Advocacy in principle, there is a problem when the Advocacy service is funded by Social Services and the local Health Authority. I use our own situation as an example:

We are being asked to tender for funding to provide an advocacy service in Suffolk against a specification drawn up by Social Services.

Paragraph 6.6 of that specification states "where the service provider considers there may be a significant risk to the health or safety of the service user, or others, the circumstances should be notified to the Care Co-ordinator." This means that the client must always be very careful about what he / she says in front of the advocate in case it is reported back to the mental health services. This destroys trust and reduces the advocate to being a spy for the mental health services.

Paragraph 9.5 states "the service provider will discuss with the notified manager from Suffolk Health or Suffolk Social Services any declarations of criminal convictions (including spent convictions) prior to an offer of voluntary work being made." Since a considerable percentage of the population have some kind of conviction (even if only a minor traffic offence) this gives the Services control to a large extent over who the Advocacy Service can use as advocates; thus the Advocacy service is not independent but controlled by the Services. While they might argue that it is for the protection of users, a considerable number of the complaints we receive are against Service members so it could also be interpreted as them wanting control of the Advocacy service for their own protection.

The general trend of the document is that the Advocacy service is there to represent the user unless the needs of the user contradict the needs of the Services, in which case the advocate must put the needs of the Services first. This is against all principles of Advocacy. Needless to say, we will not be applying for funding and unless we can obtain independent funding in the next few months we will not be able to provide an Advocacy service after November '99, which is when current funding runs out.

There is nothing special about Suffolk Mental Health Services. If they intend controlling Advocacy, then other mental health services up and down the country are doing the same thing, which casts doubt on the usefulness of Advocacy services in the mental health field (i.e. they are being abused by the mental health services). As mentioned above, we are in favour of Advocacy, but Advocacy services funded by Social Services or the Health Authority can be manipulated and abused and have severe problems in maintaining their independence. Would it not make more sense to have Advocacy services funded from a source that was totally independent from the Dept. of Health or Social Services?

Also, where the Mental Health Act is being enacted for the purpose of forced treatment or to take away someone's liberty, it would be better if they had access to a solicitor rather than an advocate. **If the Law is being used then the patient should have proper legal representation.** After all, this service is provided for suspected criminals when their liberty is being taken away from them.

Forced Treatment in the Community (Paragraph 112)

A lot has been said about the patient being a threat to himself or others. However, mental patients tend to be more passive than those members of the public that don't have a mental health problem. Who then is going to protect mental patients from mental health workers? I use the following as examples:

The Guardian (23/1/99) revealed that psychiatric nurses in St. Pancras Hospital in London (Frank Dobson's constituency) were forcing their geriatric patients to bathe in freezing water, hitting them with shower heads, locking them in rooms with their hands tied behind their backs, striking them on the face, and verbally abusing and bullying them. This carried on for three years before they were eventually reported. Three of the nurses were sacked but were not banned from nursing, so they are now free to abuse others.

The Sunday Times (24/1/99) revealed that two psychiatrists, Dr. Michael Haslam and Dr. William Kerr, are being investigated by the police and by the General Medical Council (GMC) after multiple allegations of rape and sexual assault being made against them, over a period of years. Dr. Kerr was charged with 19 sex offences between 1968 and 1988; and almost 20 women are supposed to have been sexually assaulted or raped by Dr. Haslam since 1984. One woman claimed that Haslam had used excessive amounts of ECT (shock treatment) and 'carbon dioxide therapy' to ensure her agreement to his repeated sex attacks. Her complaints to hospital staff were ignored although she was given the impression by staff that they were being investigated – she was considered too vulnerable to talk to police herself.

If this can go on in a hospital, how much more are the patients at risk in their own homes when they are by themselves with just the nurse, or the psychiatrist, and no witnesses? How many more cases like the above are being covered up by the NHS? Who is going to protect the patients from the mental health service workers? What kind of protection is necessary? There would be no point in having two nurses; they would both beat up the patient; or help the psychiatrist to rape her! If the government is insisting on forced treatment in the community, then should it not be statutory for an independent person to always be present when the mental health worker is visiting the patient in the community? To prevent abuse, this person would have to be completely independent of the Health Services and Social Services. **If the LAW is going to force patients to be treated in the community then the LAW must also take responsibility for their protection.**

* * *

women wanted the vote (women are inherently unstable, etc.), Mrs. Thatcher did it with trade unions (banning them from GCHQ Cheltenham, etc.)... Now we are learning that due to the number of 'high profile cases' recently there will be a 'shake-up' of mental health care policy as 'care in the community has failed' and a more secure system is required.

The incredible image of the 'schizophrenic' that has been planted in the public's mind via propaganda organisations like Sane and The Zito Trust, where people go on the rampage killing all comers due to not taking some pills, is all quite deliberate. Such imagery appears regularly in television programmes ('Peak Practice,' 'Casualty') and is sheer political hype; it fulfils the same functions as stories about Jews being sly Orientals whose interests clash with those of the blonde Aryan master race. These ideas so permeate our culture that the image of someone becoming schizophrenic on 'Eastenders' and descending into a hopeless state of meaningless delusion causes very little surprise amongst the viewers. The sight of a man going berserk on 'Casualty' and rampaging around the streets eventually stabbing to death that symbol of innocence, a young mum with a child in a pushchair, is taken as a realistic image of 'psychiatric illness.' We were subsequently told this outburst was due to the gentleman "not taking his medication." The political symbolism of such imagery is intense - the dangerous amoral force embodied in the schizophrenic, the total innocence of the victim, the solution of psychiatric intervention symbolised in the 'medication.'

To understand present government thinking on these issues it helps to look at recent government policy. The Mental Health (Patients in the Community) Bill 1990 has got little to do with living in the community. It is concerned with 'after-care supervision,' which is a nice way of referring to locking people up from the inside with drugs by means of regular depot injections. The term 'care in the community' was actually coined in the USA in the fifties when the first psychiatric drugs were introduced (namely thiorazine - known here as largactil), the thinking then being to empty the psychiatric prisons (known as state hospitals) by such means. It didn't work, mainly due to psychiatric patients being like everyone else and wanting to enjoy life, a view that is at odds with sitting on the fringes of society in a state of poverty taking soul-destroying drugs. Stories about patients relapsing when they haven't taken 'their' drugs (cunningly called medication) usually relate to situations like this. Since the late sixties it has been possible to inject people with a slow release injection that dysfunctions them for a number of weeks (and eventually makes the recipient very ill indeed). This is the so-called 'depot' injection. Care in the community is based on the use of this.

When one has clearly understood that psychiatric care is merely a form of coercion one can see what the government is up to. It has been decided to build a bit more nastiness back into the system, just to keep psychiatric patients in line - and 'high profile cases' are the excuse. The psychiatric patient is going to be given a dig in the ribs. The concept of the 'psychiatric disease' is at the heart of psychiatry, and by medically diagnosing people as being "not responsible" this dustbin category of mankind serves a vital political purpose in that anyone in that psychiatric category can be easily controlled to the advantage of the more dominant sections of society. Having a politically controlled subculture of misfits is viewed as a valuable political asset, an aid to political stability for the coming century.

(Guy Legge)

A response by Mind to the MHA Review is printed in 'Open Mind' (May/June 1999). Within it there appears the statement, "As we go to print the Review Team have just issued a first draft of their proposals for consultation. These contain some welcome points, such as a ban on compulsory ECT...." In fact there is *no* proposal for a ban on compulsory ECT and Pat Butterfield wrote to Mind to express our concern that people who read the statement will be misled. Margaret Pedler, Head of Legal and Policy Development, who was responsible for writing the passage which Pat was querying, replied. She writes,

"Unfortunately, in an attempt to be brief, I do seem to have overstated the committee's proposals on ECT which are of course no compulsory ECT for those who retain capacity and are not consenting. Those without capacity will only be able to receive ECT with the approval of the medical member of the newly constituted independent Tribunal (paragraph 141). I apologise for this. I have discussed this with Sara [the editor] and she will publicise our correspondence in the next issue to clarify the position. Obviously the key issue in relation to the committee's proposals is the definition of capacity. ... Mind believes that the committee's proposals on ECT would be an improvement on the current position, although how much would depend on how capacity is defined."

Outraged By This 'Lock Away' Plan:

(The following letter was originally published in a Scottish Sunday newspaper):

I wish to comment on two excellent pieces from today's and yesterday's 'Herald,' ... [especially] Brian Meek's column about Jack Straw. Brian Meek as usual hits the nail on the head. He is about the only journalist who is as Outraged as I am with the proposal to lock away people who have committed no crime. (Shades of 'The Gulag' and 'One Flew Over The Cuckoo's Nest!')

In 1970 after two years when I hardly slept due to my wife of that time requiring renal dialysis on a kidney machine installed in our house, she was offered a transplant which was unsuccessful and late one Sunday the phone rang to ask me to go to the Western General Hospital here in Edinburgh. I was told that after a fight she had died of "a massive pulmonary embolism." I was some weeks later a victim of deep depression, which is sheer hell. I offered myself as a voluntary patient and went into the Andrew Duncan Clinic, and time and counselling cured me. I had recurrent bouts in the intervening years.

In 1985 I had major surgery. I had a bowel removed and was given what is known as an ileostomy. It was a huge success, until some time later when I again went into deep depression. I learned later that this was delayed post-operative trauma. I again went in as a voluntary patient, but that experience was very different from my first and I would be very reluctant to offer myself as a voluntary patient again!

I was pressed into having electro-convulsive treatment. I had seen patients after it, and on being offered it, I refused. However a doctor took me aside and talked me into having the treatment. I had four - or perhaps it was more, as a cousin of mine who got fairly high up in the nursing profession expressed concern to my brother at the amount of ECT I was getting. I do not know if it did any good at all. One day a young doctor asked me to follow him, saying I was to undergo a test. No explanation - just "a test." I went with him into a very small room where there was a chair like a dentist's chair, but of leather and very comfortable. The room was quite warm. I was asked to sit in the chair and a large pair of headphones were placed on my ears. I was aware of a low-frequency, fairly loud, hum. The doctor said I was to listen for bleeps of high-frequency tone and press a button at the side of the chair when I heard them.

I finished the test. I never was told what it was or why I was given it. When you are in a ward you become aware of how easy it is for doctors to restrict your freedom. They section you. That means the door of the ward is locked to keep the sectioned person in. I was never

If Jack Straw can get one judge to agree to a newspaper injunction, all he has to do is get the same judge to have Brian Meek locked away for exhibiting unusual and bizarre behaviour in calling Straw “a publicity-seeking prig.” (Alan A. Freckleton)

Note: Despite standard denials of any lasting harmful effects, “...most studies have either indicated that residual neuropsychological impairment follows ECT, or they have yielded mixed or inconclusive data concerning protracted deficits after ECT.” It seems researchers have been exploring listening tests, in low-key but determined efforts to find the definitive test for cognitive dysfunction from ECT!

Mr. Freckleton may have been a guinea pig in this programme, as

“...It has been found that in dichotic perception tasks [tasks divided into two strongly contrasted groups or classes] normal individuals usually exhibit right-ear superiority in the detection of verbal material and left-ear superiority in the detection of non-verbal material. Trauma to the brain in the vicinity of the temporal lobe in the right hemisphere has been found to result in deficits in the perception of material presented to the left ear.”

(‘Dichotic Perception and Memory following Electroconvulsive Treatment for Depression,’ Williams, Iacono, Remick, Greenwood, *Brit. J. Psychiat.* (1990))

The Temptations for the Medical Mafia:

(The following will resonate with ECT survivors, as well as all who are vulnerable and powerless - particularly the elderly, the disabled and those with a terminal illness affecting the mind.)

Food and drink are among the most basic of human rights., but doctors should be allowed to deprive patients of them “in their best interests.” Issued on or around June 22nd, the BMA’s Ethics Committee report recommends “that ‘artificial nutrition and hydration’ can be withdrawn from patients on the decision of doctors alone, and that doctors should not ‘routinely be obliged to seek court approval before withdrawing’ such nutrition. (After, of course, ‘consultation’ with the families and after taking into account such previously expressed views as the patient’s ‘living will’, etc, etc, etc.).

“...Under the guise of being compassionate, sensible, and in line with occasionally [!] current – but often unadmitted – practice, the report seeks to clarify the ethical issues facing doctors today. ...The BMA points out that ‘the **classification of artificial nutrition and hydration as medical treatment is now established common law**. The common law precedent is the Tony Bland case. ... A final House of Lords ruling agreed that this form of medical murder by starvation was to be permitted in PVS cases such as Tony Bland’s, but that future cases had to be overseen and assessed by the courts.

“... Had we broken a final taboo against medical murder? Would the ‘common law precedent’ eventually give doctors - and possibly venal families – legal permission to kill...? Alas, those...thin-end-of-the-wedge worries have turned out to be utterly justified. **The BMA report recommends that the withdrawal of food and water should be legal, not just in PVS cases, but also in the case of severe strokes and Alzheimer’s and judicial permission should be dispensed with.** ... What safeguards do the BMA propose? Oh, that ‘a senior clinician outside the treatment team’ should assess the decision. And do you suppose that this outside ‘senior clinician’ would be chosen from the ranks of doctors who don’t believe that starving a person to death is morally right? ...

“[Mrs. Carol Glass’s] 12-year old son David, a sufferer from hydrocephalus...went into hospital for a chest infection. The doctors decided that, in effect...David’s life was not worth living, and, according to Mrs Glass, administered diamorphine [pure medicinal heroin] to ‘let him die with dignity.’ The Glass family, when they realised he was dying because of the diamorphine, violently – and successfully – stimulated him back into life, to the horror of the medical team. David is back with his family and, according to Mrs Glass, he is happy to be there and his quality of life, although severely impaired as it always has been, is ‘good.’

“... The fact is that the able-bodied (as most doctors are) can be extraordinarily arrogant: surveys show that the vast majority of us able-bodied people believe that severely disabled people have lives which are not ‘worth living’; the vast majority of disabled people passionately disagree.

“... ...a Dutch survey, published earlier this year in the Journal of Medical Ethics, concluded that in the Netherlands euthanasia is now ‘beyond effective control’, One in five so-called ‘assisted suicides’ are conducted without the patient’s consent; in other words, ‘granny culls’ are flourishing in the Netherlands. According to widespread evidence, elderly Dutch people are terrified of going into hospital, lest an officious doctor decides to have them medically ‘snuffed’ without their consent (as apparently happened in at least 900 cases in 1995). As our population gets older (and therefore more of an expense to a hard-pressed health service) the temptation to push the boundaries of what is, and is not, permissible, will become overwhelming. All that stands in its way is the taboo against a doctor being a premeditated killer, as well as a premeditated healer.

“But thanks to the Bland case, that legal taboo has been broken. Medically and legally, it’s OK to be old and sick and dying and to be hastened on your way, whether you want it or not, by deliberate starvation in your own ‘best interest’. ...”

(Ann Leslie, *Daily Mail*, 26/6/99)

Doctor: You asked to see me. What’s the problem?

Relative: Mother’s having trouble with her breathing, doctor.

Doctor: We can give her something to stop that.

Last Word On The Subject of Mental Health:

A health minister yesterday urged television scriptwriters, broadcasters and journalists to portray mentally ill people more sensitively. Speaking in Manchester at a Mental Health 99 forum, part of a government strategy on “stigmatising attitudes”, John Hutton said that people with mental problems were too often shown, inaccurately, as violent and dangerous.

Mr. Hutton, Parliamentary Under Secretary for Health, said, “fear and misunderstanding of mental health problems can make people reluctant to seek help. Negative or distorted images of mental health add greatly to the suffering of those who have mental health problems and their friends, relative and carers.” (*The Times*, 19/6/99)

Opening Section of Ava’s Book, ‘Unrestrained:’

“They are playing a game. They are playing at not playing a game. If I show them I see they are, I shall break the rules, and they will punish me. I must play their game, of not seeing I see the game.”

(R.D. Laing from “Knots”)

acting upon the belief that the surest path through any seemingly senseless jungle is one of love, in our existing within the confines of someone else's -ism, in our misunderstood, feared passages ...in recovering, respiting, seeking sanctuary from childhood's pain, repressed, denied, in our resisting the lies, in insisting on action based in integrity, in holding on to the visions of the beauty we know can be, in remembering the was we've been taught to forget, We, wimmin and men, are labelled crazy, insane, nuts, loons, toons, incapable, incompetent, and branded as such are ridiculed, feared, neglected, forgotten, violated, abused, drugged, tied, re-abused, electrically lobotomized, and murdered. I am a part of the psychiatric Survivors movement.

Because I know we have the wisdom of knowledge and strength of character to resist the lies we've been taught about ourselves, to create a path of our own walking, to rediscover the path of our highest self, I am a part of this transcendence; painful; infuriating; beautiful; slow yet occurring always - during the midst of mindless wars, on empty battlefields, through losses uncountable; in courtrooms, classrooms, on the street corner, in voices freed to the wind, in the eyes of a child, the wrinkles of the old, in our grief, our rage, our hopelessness, our tenacity, our solidarity - and always, always, in our love; we shape, reshape, move, and transcend to become again what we've always been.

Because I know we can, because I know we will, because I know we are, I am a part of this movement. (Ava Chante de l'Esprit)

"There is more understanding and beauty in life when the glaring sunlight is softened by the patterns of shadows.

There is more depth in a relationship that has weathered some storms.

Experience that never disappoints or saddens or stirs up feelings is a bland experience with little color or variation.

When we experience confidence and faith and hope that we see materialize before our eyes, this builds up within us a feeling of inner strength, courage and security.

We are all personalities that grow and develop as a result of all our experiences, relationships, thoughts and emotions. We are the sum total of all the parts that go into the making of a life." (Kahil Gibran)

As a child of fourteen - a mother's nightmare of precocity, curious about the world and its inhabitants; deeply intuitive; and in emotional pain - Kahil Gibran's poem spoke to me, bringing solace. Although young in numbers, I'd lived enough life to carry a profound understanding of his wisdom. Yet it wouldn't be until years later that the meaning of his words would come to me full circle.

It was at the age of fourteen that the mental "health" system and I began our morose dance. I'd internalized that there was something innately wrong with me long before then; but it was in my teens that I got the "privilege" of connecting with a professional who assisted in confirming my suspicions. This didn't occur so much through words. On the contrary, I felt this first therapist - among a palette of many to come - was a mostly supportive ally in my struggles against being born into a family in which I considered it probable I was a full-blown alien. We were worlds apart, my blood-links and I. I must have come from another planet.

Steve was skilled at lending an open ear to the trials of being a too-wise-for-my-years teen. Yet still, the family focus was on me and "my problems." It seemed, therefore, only logical I must be sick - considering I was being treated. That is how the mental health system works, isn't it - healthy people caring for the ill? I figured I was pretty messed up. But sometimes I wasn't sure if it was I, or the rest of the world, that was askew. A part of me figured it was probably both. I and others uniquely out-to-lunch; uniquely wise. But that truth was easily distorted and reshaped so I came to believe that all problems were about me; my very essence itself the problem.

Depressed from incest, abuse, and its denial; different from my peers in interests, insights, and visions - "beyond my years," I was told - I didn't feel like I "fit" anywhere. And I should fit, shouldn't I? One should be like everybody else, right? I was a mechagon trying to fit into a square. At first I thought it made the most sense just to hang around and wait until I met other mechagons. I always figured they were out there somewhere. If I just hung on long enough surely I'd meet others like me. At 14, I even wrote myself a poem about it - a little reminder for when my philosophy seemed asinine. It was a reminder that it's better to be alone in the company of one's truest self, than with company in the aloneness of being false:

I'M ME, I'M MINE

I'M ME, I'M MINE, 'TIL DEATH DO ME PART!

I'M MY OWN PERSON, AND I ALWAYS WILL BE!

I'M A LOUDMOUTHED, NON-PREJUDICED, CRAZY, WILD,

LOVING, CONSIDERATE, INSANE, HAPPY GIRL,

AND I'M MINE, ALL MINE!

I WEAR "STRANGE" THINGS, I SAY "STRANGE" THINGS,

I DO "STRANGE" THINGS,

BUT ALL THE WHILE I'M BEING, I'M BEING ME!

I DON'T GO IN FOR SHIT CARBON COPY PEOPLE!

FOR PAINTED SMILES AND REPRESSED FROWNS.

FOR CLOTHES THAT ARE THREE SIZES TOO SMALL,

BUT YOU WEAR THEM ANYWAY,

"Because everyone else loves them,"

EVEN THOUGH YOU HATE EVERYTHING ABOUT THEM.

YOU ALL TELL ME THAT I'M WEIRD AND CRAZY BECAUSE

I ACT SO STRANGE. I DON'T ACT LIKE YOU.

YOU TELL ME THAT I WON'T GET VERY FAR, AND I WON'T

EVERYONE ELSE. WELL, HONEY, I DISAGREE! YA' SEE, I BELIEVE THAT IF PEOPLE ACT LIKE THEMSELVES, HOWEVER "STRANGE" OR "ABNORMAL" THEY MAY BE, THEY ARE BOUND TO ATTRACT PEOPLE LIKE THEMSELVES, WHO ACT LIKE THEMSELVES. BUT, EVEN IF THERE ARE NO PEOPLE IN THE WORLD WHO ACT LIKE ME, BY ACTING LIKE THEMSELVES, I SHALL NEVER BE ALONE BECAUSE I HAVE ME!! I AM ME, I AM MINE!!

But in the tiredness of isolation, I waxed and waned in my truth. In spite of my resistance, I found myself assimilating until eventually I was fully convinced I, the enigma, was incurably in need of a cure. *There is nothing wrong with the World and it's systems; only something wrong with me and my failure to graciously sell my Soul for the accumulation of all the riches offered; for my failure to thrive among the ashes of all I've endured - all I've internalized about myself. There is something wrong with me.* So I thought. So I was taught.

Not surprisingly, after twenty-eight years, I was exhausted; vulnerable; pliable; easily coerced. Six off-and-on years of therapy under my claustrum, three years feeding the drug companies - I "so incurably sick" - the "mental health" system and I met, "as a last resort," head to electricity; a battle of wills. But I wore no armour, and carried no weapons but those I'd learned to turn inward against myself

Asking for help, I no longer wanted to feel so anxious; so depressed; so suicidal. Coerced amidst a cloud of desperation, I tithed my brain, my Soul, my trust, to the religion of electricity. They took more than ten percent. Electrodes to my head, the psychiatrist stood over me as the anaesthesiologist drugged me into paralyzed submission and said in macabre fashion; "This is really good for people like you who are too intelligent and too creative. It'll help you fit in the world better. It'll curb things just the right amount." *Too intelligent? Too creative? Fit? Curb? What?! You said this would help with my depression! You said ECT was for depression! Curbing what?! I don't want to fit. I don't want to fit. Like everybody else? Not like everybody else! No. No. No! I just don't want to be so anxious and depressed any more. What do you mean I'm too intelligent; too creative? I'm depressed! My brother died! I'm suicidal! It makes sense for me to feel this way! Don't you think?! You're curbing what?*

The doctor's words echoed in my ears as I was drugged and electrocuted into silence. I didn't know what they meant when he spoke them; not tangibly, so I could wrap my fingers around them. But they sank into my being as a passenger on a sinking ship succumbs to a losing battle with the ocean; resisting in terror, they settled in my depths forever.

When I awoke from ECT, my intelligence and creativity were certainly curbed; and I was more depressed than ever. With each assault, I grew further and further from the possibility of actualizing any of the potentials with which I initially presented myself; merely seeking help. Brain damage and betrayal will do that to a person. Sneaking up on someone and crushing their skull with a baseball bat will do similar things to ECT to damage a person's brain and Soul. Except assault with a bat is illegal, and - if one survives - the scars left are obvious; believed. To mutilate one with electro shock, however, is legal; the scars hidden; most denied.

If I didn't "fit" in the world before I had my brain fried twenty times with electro shock, surely I'll never walk among the "normal" now that I have. But the truth is, I have no desire to be one of the walking dead. And I never did. I want, simply, to be the fullness of who I am; to feel the wonderfully diverse spectrum of all the emotions I feel - no matter the pains of being awake. I want to move through life in integrity, truth, and love; to maintain the depth and richness of my knowledge and wisdom - threatening or not to those who wish to curb my wakefulness - as is my right and is the right of everyone to stand in the fullness of their highest self. Through the mental "health" system, I've learned to greatly monitor the seeking of help from others. I've learned the art of extreme discretion and suspicion. I've learned that it is often best to censor the expression of what I know. I've learned the use of smoke screens and masks with more dexterity and calculation than I ever knew before.

I've learned that danger comes in many forms; that those proclaiming the desire to help are too often using the so-called "sickness" of others as a means of managing their own anxiety. A most dangerous form of help occurs when one denies getting from the giving. A most dangerous form of help occurs when one assumes the helplessness of another. Through the mental "health" system, I have witnessed and experienced those acting out of ignorance and greed; acting out of the greed born of ignorance. And from these places, I've seen the administration of slow destruction to another by individuals and a system proclaiming help. Murder comes in many forms. I carry the wounds of what I experienced, what I witnessed, what I escaped.

I've learned there's no one more capable of staying true to my own best interests than myself. Glad to have finally garnered the lesson, (with the wisdom of hindsight) - I'd have chosen a different teacher. Since my brain was fried, I know a depth of loneliness - of being different - I'd never before known. Yet in searching for a corner within myself in which to make sense of the twisted capabilities of humans, I've learned to look directly in the mirror at the shadows of myself and to view these, and the shadows of all humanity, with compassion, understanding, forgiveness, and love. In addition, though, I'll always remember the ways in which I was led to believe I'm insane - "Too intelligent. Too creative." Yet "insane." I'll always remember the ways in which I was coerced to sign my brain and Soul over to another. I'll always know how gravely detrimental, how deeply misplaced, was my trust. I'll always remember the individual who preyed upon my vulnerability to meet his own narcissistic needs, his own greed. I'll always know of the reality of all those out there who routinely take advantage of the ignorant trust of others to satisfy their own desires. I'll always remember these things. I live with these truths and the resultant scars, daily. And yet, I continue to search the depths of the eyes in the multitude of faces, those whose paths cross my own, for others who maintain the strength of will to remain awake among the masses of walking dead. I search for those who remain true to the beauty of their uniqueness, in spite of the dangers from those who force assimilation. And I continue to know, as "different" as I am, as alone as I feel, I am not alone.

And now I take the presumed insult of "crazy" as a compliment of high regard, smile at the bestower, and say, "Thank you."

Understanding fully what to be labelled each means. I hear the lie in ironic pride. I laugh at the labeler. I laugh at myself. And hold on to the

asked by others, "Why did I 'have a nervous breakdown?'" I imagine a sand dollar, small in the context of the vast ocean in which it lies, plain and intricate, delicate, fragile, yet usually strong and sturdy against the waves which thrash from moon 'til sun and over again, and I realize the answer is not a simple one.

I understand now I was never crazy. I was lost in the middle of an ocean, being tossed upon illusionary waves made real by the choreographers of society and myself, unaware I co-wrote my own script. Unaware I therefore could re-write my part, reject the paradigm completely, swim within waters of my own creation in which I wouldn't drown. I was responding as best I could to all the lies I had bought as truth - the ones I was told, and the ones I told myself. I was responding as best I could to unexpected ocean storms, to storms that built up their momentum and force over a lifetime until they came swirling at me, through me, as they crashed into my being, weathering my typically strong shell to near breaking. Standing sturdy against the blizzards, the rain, the freezing winds, I tried to weather each storm as it came at me, as it entered into me knocking my breath away, as it stole pieces of me and left laughing in the night. But I soon realized I could no longer stand alone and fight. I didn't have much me left.

So I buried myself, and tried to hide beneath the sand at the bottom of the ocean until the storm passed. But I couldn't bury myself deep enough to escape the hurricanes as they came tearing at the ocean bottom, the sand, the waves and me, flying around in dizzying circles, trapped in a whirlpool called hell. I thought if I killed myself, maybe then I could get away from what was consuming me anyway, from what, I was told, was not real. From what I knew was all too real. From what, surrounded by denial and too little true support, I could not possibly fight.

Exhausted, I finally made a determined choice. I tried to destroy my pain by killing myself.

But I was found. And after they found me, cleaned me up and saved my body from dying, they stamped me with labels and tried themselves to murder my Soul.

Where is the laughter within me now? Where is my spontaneous joy, my intense passion for a Puccini aria, or my simple love of a blooming flower? Where is my motivation, my dreaming, my wanting? Had I known when I tried to kill myself that eventually psychiatry would assist me, not in dying from the Earth, but in becoming so that I walk dead inside myself, a stranger within my own skin, I don't know if I would have tried even harder, or never tried to kill myself at all. There are many ways to tell a story, many ways to share a truth. I have struggled with choosing how in writing this book. Where do I begin? How do I tell you this journey I so desperately want to tell? I've written backwards and forwards and from the middle outward, forming circles with my story and around myself. As I write, I bring former pieces of self into this circle, recalling as I'm able, how this, my story, myself, all came to be. I grow from shaping my truth into words. A truth unseen, a past unspoken, invisible-like, until transformed from experience into language. I grow from age as these words patiently wait to be spoken. And I bring new pieces of myself into this circle as I evolve in the telling.

I meet strangers along the way of writing whom I've always known, as we've shared this pain together. We carry each other within our Souls, unknowingly knowing. I Survive to share my truth because of these people I've never met, and because of all whom I have. I am grateful.

I share this story with you in many voices, in varied tones. I fill these pages with many parts of an unfinished symphony, each staff with its own story to tell. Often, pieces of me rest as others have the melody. Other times, I'm speaking from many places of self simultaneously, and coherency may be shaded in the translation from internal reality to external reception as all instruments of this symphony of self sound together. Psychiatry labelled me crazy. But I understand the truth of being complex in a world fighting to dull complexity, fighting to maintain the status quo. I understand the truth of being awake in a world wanting sheep, following in slumber.

We who have Survived psychiatry's attempts to lobotomize our creative Spirits will not be silenced. We will stay awake. We will resist society's demands that we be "normal." We will work to create a place of safety on this Earth for all those generations of sensitive, creative beings to follow. We will speak our stories, show our art, write about the roads we've walked. And we will continue to sing truth from our Souls, for this is who we are, and who we will always be. And the World would be bleak and barren without us.

Psychiatry labelled me crazy. I declare I am unchained, feeling, and free.

Where is the laughter within me now? It is buried deep within the earth of my Spirit moving toward the sunlight to warm those seeds of love and joy psychiatry could only force into submissive retreat, damaged, but never destroyed. I tell my truth and sprout again.

(By Ava Chante de l'Esprit from "Unrestrained" © 1995)

Poems by Survivors:

This first poem was submitted by Margaret Jongeneel
(Advocate, Patients Rights Advocacy, Waikato, NZ)

All alone in a room like a tomb
Pressed in by dark solid walls.
Nowhere to go when nature calls
A mug of tea sloshed on the floor.

By a hand through a crack in the door
Heart beating faster, listening for sounds
They are coming on their rounds.
It must be time, I think with terror.

The executioners are coming nearer and nearer.
The door is flung wide. and in the blinding light

Is it real, or a bad dream I see?
The terror I feel makes me gasp for air.
Heart pounding hurts my chest, but no one cares.
The cold jelly rub on my temples, electrodes in place.

I wait in fear for a blast into space...
Soon I wake up, with ten times as much pain,
Fear and confusion are here again.
Like a drunk in a mind damaged stupor

I am propped up by a patient helper.
Have I had it, is the only thing I must know,
To plead with the nurse if this is so
And if in time my violent headache will go.

Zombie Mutant Hero

I am the brand new Frankenstein,
So I've just discovered,
'Cos I've been zapped with such a force,
And the facts, they've been smothered.

It left me like a Zombie,
Doing just as I was told,
But now that I'm recovering,
I'm starting to get bold!

I have the FACTS in front of me,
That really tell the truth,
I'm collecting them from everywhere,
Like a proverbial sleuth!

I'm the Zombie Mutant Hero,
One that has escaped,
To tell the truth to everyone,
That I've been legally (?) raped.

But I'm not just the only one,
There's thousands just like me!
Our brains were sizzled like a chip,
Then frozen like a pea!

Then packed away on D.S.S.,
In a tiny room somewhere,
Hidden away from humanity,
And feeling rather rare!

It is the legal torture,
To keep us in our place,
Forever to be hidden,
And never show our face.

It's a legal cattle-prod,
Which they connect up to your head,
They call it "a treatment,"
But you wished that you were dead.

They call this treatment ECT
Electro-convulsive *torture*,
Which fries your brain nice and crisp,
It really is a 'scorcha!!'

So now I'll get you politicians,
And connect you to the mains,
I think 450 volts will do

Fifteen if you're bad.
You'll be a paranoid schizophrenic
And your wife'll think you're mad!

So you'll be told to go away
And have another lot.
'Cos the first zapping didn't work –
But that, you have forgot.

You'll end up a Zombie,
A hero just like me.
'Cos I'm leaving my brain to *science*
To see what they can see.
It might be worth some money,
Not to me, as I'll be dead.
But one thing's for bloody sure,
Nor more will they zap head!

They continue blaming Hitler,
For atrocities he caused,
But *he* had the guts to kill himself
When they had him by the balls.

But AT LEAST there was a war on,
In which many millions died.
I wonder too, if like me and you,
Their brains were also fried? Simenes (pseudonym)

REMEMBER? By Elaine Tasker, 1999
(ECT victim sometime in 1987)

Do you know what they did to me? Do you know?
They plugged my mouth with rubber and they put me fast asleep
Then with hardly any thought to it
They fried my brains.

It was done for my own good, you see.
I was depressed and very ill
I was crying out in-side really
But those people never knew.

They thought they'd made me better
But it wasn't them at all
Time healed me as it always will.
The real 'treatment' ... was to come

It started slowly, hardly there
Little things, forgotten this, forgotten that
A big gap here and then another
The doubt starts to appear.

INDEX:

ECT, for all. It wasn't just to me.
How deep inside it gets, you know too.
How do we concentrate? How do we cope?
With memos and jotters and photos and hope.

I'll cost them in time if not in hard cash.
They will end up keeping me there is no doubt
I'll end up in 'care.' My children won't cope
But before that occurs I won't mope.

But I'll not be shut up. I'll stand and tell
Until ECT is only a memory
From hell.

Famous Last Word:

He don't look a bit scared. He keeps grinning at me.

They put the graphite salve on his temples. 'What is it?' he says. 'Conductant,' the technician says. 'Anointest my head with conductant. Do I get a crown of thorns?'

They smear it on. He's singing to them, makes their hands shake.

"Get Wildroot Cream oil. Cholly..."

Put on those things like headphones, crown of silver thorns over the graphite at his temples. They try to hush his singing with a piece of rubber hose for him to bite on.

"Mage with thoothing lan-o-lin"

Twist some dials, and the machine trembles, two robot arms pick up soldering irons and hunch down on him. He gives me the wink and speaks to me, muffled, tells me something, says something to me around that rubber hose just as those irons get close enough to the silver on his temples – light arcs across, stiffens him, bridges him up off the table till nothing is down but his wrists and ankles and out around that crimped black rubber hose a sound like *hooeee!* and he's frosted over completely with sparks.

And out the window the sparrows drop smoking off the wire.

They roll him out on a Gurney, still jerking, face frosted white. Corrosion. Battery acid."

('One Flew Over The Cuckoo's Nest,' Ken Kesey, Picador, 1973)