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*THE VOICE OF THE PSYCHIATRIZED*

*Jamsde*

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# SCHIZOPHRENIA

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**EXPLODING THE MYTH**

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# phoenix rising

*Through the fire*



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# Sane Response to an Insane World

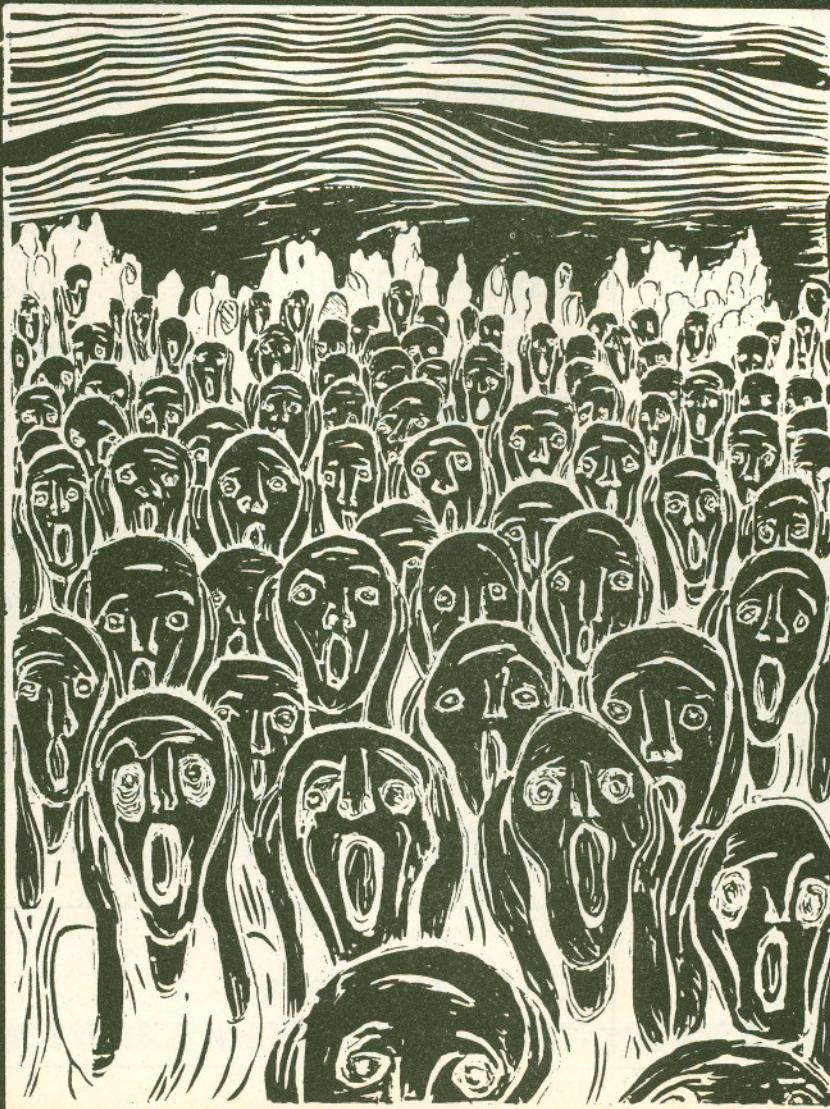
**EDITORIAL**

Once upon a time, we all chanted, "Sticks and stones will break my bones, but names will never hurt me." It wasn't true then, and it isn't true now. Names and labels such as "schizophrenia" are designed to discredit our past, invalidate our present, and obliterate our future. The term "schizophrenia" is usually used to imply that a person is insane and incompetent, and it thereby becomes the social equivalent to leprosy. But in reality, "schizophrenia" is just a catch-all phrase used by psychiatrists to identify and control any kind of behaviour that doesn't conform to their notions about "normal" behaviour.

We believe that many people labeled "schizophrenic" are simply acting out some of the rage, confusion, hopelessness and fear that come from living in a society where people are rarely allowed to express their true feelings. In this sense, "schizophrenia" can be seen as a very necessary survival instinct and perhaps it is even a testament to the strength and will of the survivor. Instead of locking up people who need to express their deepest feelings, we should be providing them with a place where they can freely act out these feelings. "Mental hospitals" such as Queen Street and the Clarke Institute are nothing more than control centers where people's behaviour is inhibited and modified.

As you will see from reading this issue, "Schizophrenia" is not a "mental illness" at all, but is actually a euphemism for "unwanted conduct" which violates or threatens certain moral values. Though psychiatrists have tried to use the medical model of disease to validate "schizophrenia" as a legitimate diagnostic term, "schizophrenia" continues to be nothing more than a myth masquerading as a disease.

We encourage all people who have been labeled "schizophrenic" to reject thinking of themselves as "mentally ill" or "diseased", and to demand their right to be treated like human beings who are unable or unwilling to suppress what they really feel.





# write on

**NOTE TO READERS:** *Phoenix Rising assumes any correspondence sent to us may be reprinted in our letters section unless otherwise specified. Please tell us if you would like your name withheld if your letter is printed. Letters without names and addresses will not be accepted.*



I had an idea that there was a magazine for prisoners yet never realized there was a publication for prisoners of the mental health "care" system. I find myself wanting to side with the proponents of this magazine and myself enter the debate. It appears clearly, very clearly to me that the system needs a revamping to truly provide for the needs of the patients, but at this point it is more concerned with sustaining the needs of the authorities, the people who are provided with employment to keep such activities going. I think the politics behind the sustaining of the system are far too complex to enter into lightly, but a study of psychiatric patients could reveal a lot of potentially "dangerous" information.

I am a prisoner of Brockville Psychiatric Hospital. Here I have been psychologically tortured, beaten, locked up and drugged. I find the environment to be anything but conducive to our mental health. One must be very strong to survive this prison. This strength does not come from outside, and I myself encourage patients to locate their source or strength. I believe that only a radical approach will solve the situation. People must be willing to get out to the media their thoughts and beings, to expose the sickness of the system. It must be dealt with, it cannot be left to fester. A cure can come only with the raising of the public's consciousness.

Lawrence Alan Evans  
Brockville, Ontario



Let us be realistic about schizophrenia, a so-called mental disorder. Perhaps this condition develops because a person, possibly of a varied rather than uniform background, reaches a point where, having attempted to communicate with those around him, whose life and experiences do not coincide with his, reverts to living in the only area available to him, that of the mind and his thoughts.

Those around him may not realize that he was trying to communicate with them, but because their own understanding and communication skills were not particularly well developed, and perhaps because they felt they had neither the time nor the patience to attempt to understand him, he was socially cut off. He had nowhere to go but to his own mind. Because there was no one who could or would relate to him, he learned to turn to whatever mental resources he possessed, further cutting himself off from the everyday world of reality. Many a small child or someone of more mature years, has had this experience. The mind, spirit, emotions are largely enhanced by social interaction, even in a very simple form. Mental isolation in a world with people all around us, leads to a reduction in social skills, chiefly language, the means of social communication.

The condition named schizophrenia and described by Thomas Szasz, M.D., in his book, "Schizophrenia: The Sacred Symbol of Psychiatry," does not come to full maturity overnight. It occurs in many little instances of rejection, perhaps over an entire lifetime. Gradually, even in early childhood, a person realizes that no one is interested in his thoughts, and so he learns not to express them. This is not an uncommon phenomenon in our society. Many people learn to keep their thoughts to themselves because they know that these thoughts are of no interest to anyone else. I believe that the habitual practice of this principle will, in time, isolate a person from any meaningful social interaction.

We know, at this stage in history, that when an infant is born into the world, it is important that he be loved,

nurtured physically and psychologically, that he be encouraged to express himself, within socially acceptable limits. As a result, many young people grow up unable to understand that there are those who have not always had this support.

Two generations ago, many of the needs of children were not understood in this way. Often, at that time, and still, in many families at this time, raising children meant no more than providing them with very meagre necessities of food (not necessarily nutritious food), and enough clothing to ensure the minimal legal requirement of not being naked in summer, and clothing inadequate for warmth in winter.

A child in any generation who is not given basic, necessary, physical nurture as well as encouragement to grow mentally, spiritually, and socially; in whose life no one has time to listen to his thoughts; will naturally socialize within himself. His thought life will be his only life. Of course, he will be required to obey certain rules governing his physical life and his behaviour; he will learn to give certain appearances of being normal; but to him his real life will be his thoughts. Since there is no one to whom he can communicate those thoughts, his social life will be his in-mind life. I think it is not unusual that because this social life is internal, he may come to hear, or to think he hears, a voice or voices in response to what he is thinking. It may even be a mental repetition of something previously said to him.

The same can be true of an adult, and many adults may have been moving in this direction for many years. The psychiatric profession has chosen to call (or label) this condition "schizophrenia". In a current newspaper article, the writer states that both cause and cure of this disease are mysteries. And why should they not be mysteries? How many people who purport to "treat" the "mentally disabled" have personally experienced the many conditions which are loosely grouped together under the heading of "schizophrenia"?

I attended a meeting of the Friends of Schizophrenics Society (F.O.S.S.). As only half-truths and generalities were given by the professional organizers to the attending friends and relatives of so-called schizophrenics, it would appear that these organizers were attempting to manipulate those attending to aid in the regimentation of the unfortunate "schizophrenics."

These so-called "symptoms" of "schizophrenia" may be many and varied, changing, according to what I have been taught, to accommodate the social system at a given time in history. Twenty years from now, the symptoms will be quite different from what they are today. Perhaps these symptoms may be described as any social activity which is outside the realm of what people who consider themselves to be normal have experienced. Perhaps in twenty years you, the reader, will have an experience considered to be outside the norm, and will be diagnosed as "schizophrenic." If these symptoms are deemed to require treatment; and if you are admitted to one of our "excellent" psychiatric facilities, it may be that you will be encouraged to undergo electroconvulsive therapy (ECT; shock treatments) because it will "help" you, "brighten you up."

The treatments certainly will "brighten you up," if not immediately, then at some time in the future when you realize what has been done to you. According to a doctor quoted in a 1976 edition of the *Toronto Star*, each shock treatment damages fifty thousand brain cells, supposedly not very many. If you have had twenty-four shock treatments, then one million, two hundred thousand of your brain cells have been damaged, or the equivalent of brain damage incurred by a person who has been dead drunk (completely unconscious) once a week, every week, for two years. It is my understanding that the brain consists of approximately ten million brain cells. A person who has incurred damage to over a million is quite obviously, "not all there." His mental illness is considered to be "in his head" and, of course, it is. Where else would brain damage take place?

The physical results of electroconvulsive therapy (which may also cause damage to the spinal cord leading to back trouble) will often cause, in addition to physical brain damage, other physical symptoms, such as mild convulsive symptoms or fainting, low blood pressure, resulting in a shortage of the oxygen supply to the brain, petit mal seizures (sometimes only a flickering of the eyelids caused by too rapid a firing of neurons in the brain),

as well as other symptoms related to the central nervous system. A person who has undergone ECT may have the ability to remember skills necessary for living which he was formerly able to perform, but will ruefully realize that he no longer possesses these skills. It is only by a process of trial and error that he is able to redefine his areas of ability and of disability. Brain damage is a whole new ball game. It is very depressing to realize that the work you put into learning throughout your life has been swept away, that in many areas you must learn again, if you can, an adult body learning at the level of a child. How disconcerting!

Although I would be the last person not to want to help those who have been labelled "schizophrenic", I would suggest that removing the label and the disabling effects of ECT would be a good first step toward people who, perhaps for many and varied reasons, do not live up to a standard designated by some in society to be "normal." It is my understanding that some people currently being trained as "mental health" professionals have been taught to listen to the point of view of the "patient." This is most commendable, and I believe the elimination of ECT would enhance the possibility of successfully helping people who have somehow, in the corporate mind of society, strayed from the beaten track. The elimination of the scourge of ECT would undoubtedly also eliminate the practice of turning natural and psychological problems into a permanent physical disability.

Cathy Furtenbacher,  
Hamilton, Ont.



Sorry to have delayed our renewal to your fine magazine. I'm just back from a three-week trip to France. I was able to go because our group, Auto-Psy, got a \$1,000 grant from the Quebec government. The occasion was a four-day film festival in Nice on "Psychiatry and Culture" from October 27 to 30. Helen Doyle's latest video production won first prize. Entitled "Les maux/mots du silence", its theme concerns women, madness and creativity.

After Nice I went to Auch, near Toulouse. I have friends there who run a house for children with emotional problems. There are a lot of these houses in France intended for young people. It is far better than an institutional setting.

In Paris, I met people from a new ex-psychiatric inmates' group called "Treames". With the new socialist

government, it's far easier for them to get funding. There is also a new group in France called "Le cheval bleu" ("The Blue Horse"), in reference to the one which existed in Trieste, Italy. The International Reseau of alternatives to psychiatry is also regrouping.

The video made at the last conference (10th International) is finished and now available. It's called "Psychiatry Is Gonna Die", runs 30 minutes long, is available in 3/4" colour cassette and costs \$120. If some groups find this too expensive, there is a possibility of transfer to 1/2" black and white cassette. We would also like to obtain permission from the groups involved to enable us to eventually sell the video. The money from this would serve to videotape next year's conference.

Paul Morin,  
Quebec City, Quebec



SPRED (Society for the Protection of Rights of the Emotionally Distraught) is continuing its efforts in the Niagara Region. Though we have been forced into limiting our role as rights activists due to a lack of funding, we still have support networks operating in Niagara, St. Catharines, Welland and now Hamilton.

Jean Hamilton with the devoted support of her husband Doug, have done a great job in Welland building support and keeping the lines of communication flowing with newsletters, support meetings, etc.

A few of us are now in the market to buy a small hobby farm. It should be a good experiment in self-sufficiency and rural peace of mind. Also, with welfare payments lagging behind the rate of inflation, it certainly could help if people could come out and grow and store their own food supplies.

Shirley and I have been asked if we would be willing to speak to social work students at McMaster University but as of yet no definite plans have been made.

Recently, I completed work on a couple of fully orchestrated demo tapes and have begun promoting them. A number of major recording companies expressed potential interest in previous recordings so it should be interesting to see what happens.

Music, art, poetry, etc. are great avenues of expression. It's a sad thing when the inspiration is reduced to a form of illness and not allowed to grow and enlighten others, as is the case with the talents of so many people today.

Fred Serafino,  
Hamilton, Ont.



# SCHIZOPHRENIA:



## EXPLODING THE MYTH

BY DON WEITZ

*It is time to critically examine some of psychiatry's so-called facts and assumptions about schizophrenia. Basically, we shall challenge psychiatry's application of the medical model to schizophrenia. Specifically, we shall challenge psychiatry's justifications for labeling schizophrenia a disease by examining the validity and reliability of some of psychiatry's common diagnostic criteria. In this task, we shall rely mainly on two excellent sources: Schizophrenia: Medical Diagnosis or Moral Verdict by Theodore Sarbin and James Mancuso (1980), and Schizophrenia: The Sacred Symbol of Psychiatry by Thomas Szasz (1976). (Sarbin and Mancuso are outstanding research psychologists; Szasz is an internationally recognized psychiatrist and critic of institutional psychiatry.)*

For many survivors of the psychiatric system, being labeled schizophrenic is like being permanently damned. Schizophrenia is psychiatry's equivalent of leprosy. As "schizophrenics", millions of people have been stigmatized and invalidated as non-persons over the past fifty years or longer. When labeled, committed to and "treated" in psychiatric institutions, most people are just very confused, frightened or angry — not "sick". Nevertheless, under the banner of "mental health" or "psychiatric treatment", such people have often been treated against their will and unjustly denied their freedom and other fundamental civil and human rights — for their "own benefit".

The vast majority of psychiatrists and other mental health professionals sincerely believe there is a "mental illness" called "schizophrenia". They keep telling their patients that schizophrenia is "just like any other physical illness"; that it has recognizable signs and symptoms; that it can be accurately and reliably diagnosed and treated. At the same time, however, these professionals openly admit that they still don't know the cause or cure of schizophrenia — after almost seventy-five years of research.

So-called epidemiological studies of schizophrenia show that roughly 1 in 100 people or 1% of the population in North America (1 in 25 in Western Ireland) will develop schizophrenia sometime in their life.<sup>1</sup> In Canada in 1978, for example, 30% of the people discharged from psychiatric institutions and roughly 15% discharged from psychiatric wards of general hospitals were diagnosed as schizophrenic. That amounts to slightly over 18,000 people. It's also a fact that schizophrenic inmates, compared to non-schizophrenic inmates, are locked up for longer periods of time. If you're labeled schizophrenic in a Canadian "mental hospital", your average length of stay is two months; for other types of "psychosis", your average stay is about one month. However, if you're labeled schizophrenic in a general hospital, your average stay is much shorter, roughly three weeks.<sup>2</sup>

So far, there's no satisfactory medical explanation for these differences, except perhaps for the alleged fact that schizophrenia is more severe than other types of "mental illness" and requires longer treatment. Social and political factors are more relevant in explaining how people get labeled, involuntarily committed, treated and stigmatized as schizophrenic or mentally ill, but these are seldom voiced publicly by mental health professionals.<sup>3</sup> For example, the well-

documented class bias among mental health professionals helps to explain why proportionately more working class or poor people than middle and upper-class people are diagnosed schizophrenic or psychotic, more frequently treated with the dangerous physical therapies such as "anti-psychotic" drugs and electroshock and locked up longer.<sup>4</sup> One thing is certain — "schizophrenia" is a very strange "disease" indeed, since it has no specific cause, no definite signs or symptoms, no predictable course or outcome and no cure.

### **The Medical Model — Brief Historical Sketch**

In medicine, a disease or illness traditionally means a disturbance or set of disturbances in the *body*, not the mind. In the mid-1800s, the great German scientist and physician, Rudolph Virchow, discovered and proved that a disease always involves significant re-

*"... more than any other psychiatric diagnostic term, schizophrenia carries with it the implication that the person so 'diagnosed' is crazy, does not know what he is doing, is not responsible for his behavior, and should be so 'treated'. This explains why schizophrenia has been justified, and continues to justify, the imposition of involuntary interventions on the patient."*

—Dr. Thomas S. Szasz  
Schizophrenia: The sacred symbol of psychiatry (1976)

cognizable changes in body structure, specifically pathological *changes in the cells*. Virchow's "cellular-pathology" theory of disease revolutionized medicine and is now universally accepted in modern medical research and practice.<sup>5</sup> In other words, to be called a disease, the disturbance must show at least some evidence of pathology at the cellular level. Furthermore, the disease must show certain specific, identifiable signs and symptoms (e.g., fever, inflammation, paralysis, etc.), ability to respond to treatment, a definite or predictable course and cure. The sequence of cause — signs and symptoms — diagnosis — treatment — prognosis (outcome) — cure is what the medical disease model is all about.

However, in the middle nineteenth century, as psychiatry was beginning to be accepted as a medical specialty, psychiatrists and neurologists changed the criteria for disease. Changes in body structure at the cellular level were no longer sufficient. Pathological or abnormal changes in body *function* were added, so that the disease model was greatly expanded to include "functional disease". In other words, non-medical behavioral conditions were medicalized.<sup>6,7</sup> This signalled an ominous change.

Hysteria, for example, is not a physical disease, but it often resembles or mimics certain "organic" brain symptoms because of the appearance of anaesthesia (loss of feeling) or paralysis of the arms or legs in the absence of any brain lesion or neurological disorder. Charcot, the famous French neurologist in the nineteenth century, redefined hysteria (then called "malingering") as "hysterical illness". Freud later labeled it "hysterical neurosis".

In the middle and late 1800s, dramatic advances in neurology together with the observation that pellagra (a neurological disorder caused by severe vitamin deficiencies) and general paresis (syphilis of the brain caused by a spirochete) caused "mental symptoms" convinced psychiatrists that there must be many other types of "mental illness" which produced such "mental symptoms". New, non-medical disturbances were pathologized as types or symptoms of mental illness: "compulsions", "obsessive-compulsive neurosis", "hypochondria", "homosexuality" (no longer classified as a disease by the American Psychiatric Association 4-5 years ago), "depression", "mania", "manic-depressive psychosis", "masturbation psychosis" (also no longer classified as a disease) and so forth. Virtually any kind of "irrational" or "abnormal" behavior was automatically assumed to be caused by a disease of the brain. It is important to realize that these types of mental illness were not discovered — they were *invented*. Schizophrenia was no exception.

In 1896, the German psychiatrist Emil Kraepelin classified and described a broad range of mental diseases. He labeled one "dementia praecox" (dementia-deterioration, praecox-early). Kraepelin believed that "dementia praecox" was a single disease which began in adolescence or early adulthood and inevitably led to deterioration or death. In 1911, Eugen Bleuler, a Swiss psychiatrist, coined the term "schizophrenia" which replaced "dementia praecox". Although Bleuler strongly disagreed with Kraepelin's

deterioration hypothesis, he still agreed that schizophrenia was some kind of disease or syndrome, a "group of schizophrenias" with many different symptoms.<sup>9</sup> According to Bleuler, schizophrenia's chief defining characteristic was a "splitting" (schizo) of the mind (phrenia), a split between thinking and feeling (not to be confused with "split personality", which is quite different and refers to two or more personalities in the same person — it's still not fully understood and is rare.)

## Diagnosis — The Labeling Game

However, Bleuler honestly admitted that he was having great difficulty with the disease of schizophrenia. In 1911, he wrote:

It is not yet clear just what sort of entity the concept of schizophrenia actually represents . . . the real disease process is unknown to us . . . true schizophrenic symptoms . . . are distortions and exaggerations of normal processes . . . In no other mental disease is it so uncertain whether or not a specific symptom will be present at any given moment.<sup>10</sup>

Despite these serious doubts and uncertainties, Bleuler classified schizophrenia into five major subgroups along with their major characteristics or symptoms: 1. "Paranoid" (suspiciousness, delusions, hallucinations); 2. "Catatonia" (stupors, delusions, hallucinations, agitation, negativism . . .); 3. "Hebephrenia" (no specific symptoms, includes grimacing or silliness); 4. "Schizophrenia Simplex" (a wastebasket term which includes many different types of eccentric and anti-social behaviour); 5. "Latent Schizophrenia" (another wastebasket term including "all the symptoms and combinations present in the manifest types of the disease"). Bleuler also divided schizophrenia into two broad classes of symptoms, "fundamental" and "accessory". The "fundamental" ones included the primary "thought disorder" or "loose associations" (illogical/bizarre thinking, "distractibility"); "emotional flatness"; "ambivalence" (positive and negative feelings or thoughts toward the same thing or person); "autism" (wish-fulfilling thinking, fantasies, social withdrawal or "detachment from reality"). The "accessory" symptoms were more dramatic and included: hallucinations,

grandiose and persecutory delusions, catatonic behavior (stereotyped movements or odd postures, unpredictable or violent outbursts). Bleuler further assumed that schizophrenia had a gradual or "insidious" onset and started, as Kraepelin also believed, in the middle or late teens.

More recently in the early 1970s, the United Nations' World Health Organization (WHO) somehow managed to get a number of psychiatrists from nine different countries to agree on fifteen diagnostic criteria or "psychopathological characteristics" of schizophrenia. The "concordant group" or base sample of 306 patients in this pilot study was found to exhibit these symptoms which are listed by rank: 1. "Lack of insight" (97%); 2. "Auditory hallucinations" (74%); 3. "Verbal hallucinations" (70%); 4. "Ideas of reference" (70%); 5. "Delusions of reference" (67%); 6. "Suspiciousness" (66%); 7. "Flatness of affect" (66%); 8. "Voices speak to patient" (65%); 9. "Delusional mood" (64%); 10. "Inadequate description" (64%); 11. "Delusions of persecution" (64%); 12. "Unwilling to co-operate" (57%); 13. "Thought alienation" (52%); 14. "Thoughts spoken aloud" (50%); 15. "Delusions of control" (48%).



First, notice that many of these "symptoms" overlap and are repetitive, e.g., "delusional". Secondly, some of these diagnostic criteria were not even mentioned by Bleuler, e.g., "lack of insight" or "unwilling to co-operate". Thirdly and most important, virtually all of these terms are so vague and ambiguous that they can mean almost anything, which is typical of psychiatric jargon. For example, what does "lack of insight" (into what? into whom?) really mean? Everyone lacks insight or awareness into themselves, others or countless situations sometime. Furthermore, what do terms such as "inadequate description" and "unwillingness to co-operate" specifically refer to? Although the WHO investigators mention that it's the pattern, and not the single symptom that counts, that doesn't help much either. It's difficult to seriously accept these vague and highly subjective terms as valid and reliable diagnostic criteria of schizophrenia.

The same problem of vague and ambiguous language plagues the diagnostic criteria of schizophrenia as stated in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published and endorsed by the American Psychiatric Association (1980). According to this standard psychiatric reference, a person is diagnosed schizophrenic if s/he shows "at least one" of these criteria or symptoms:

- (1) bizarre delusions (content is patently absurd) and had no possible basis in fact, such as delusions of being controlled, thought broadcasting, thought insertion, or thought withdrawal;
- (2) somatic, grandiose, religious, nihilistic, or other delusions without persecutory or jealous content;
- (3) delusions with persecutory or jealous content if accompanied by hallucinations of any type;
- (4) auditory hallucinations in which either a voice keeps up a running commentary on the individual's behavior or thoughts, or two or more voices converse with each other;
- (5) auditory hallucinations on several occasions with content of more than one or two words, having no apparent relation to depression or elation;
- (6) incoherence, marked loosening of associations, markedly illogical thinking, or marked poverty of content of speech if associated with at least one of the following:
  - (a) blunted, flat, or inappropriate affect

- (b) delusions or hallucinations
- (c) catatonic or other grossly disorganized behavior.<sup>12</sup>

It's difficult to believe that these and many other psychiatric terms can pass the standard tests of clarity, logic, reliability and validity. Of course, they can not.

In 1974, the National Institute of Mental Health (a prestigious, US government agency) honestly admitted in an editorial that schizophrenia could not be adequately defined or diagnosed: "... it is not possible to validate a diagnosis of schizophrenia.

*"Like the accused heretic, the accused mental patient commits the most deadly sin when he denies his illness and insists that his deviant state is healthy. Accordingly, the most denigrating diagnostic labels of psychiatry are reserved for those individuals who, although declared insane by the experts, and confined in madhouses, stubbornly persist in claiming to be sane. They are said to be 'completely lacking in insight,' or described as 'having broken with reality,' and are usually diagnosed as 'paranoid' or 'schizophrenic.'*

—Dr. Thomas S. Szasz  
The Manufacture of  
Madness (1970, pp. 52-53)

There is no test which can independently confirm that the individual so designated is, in fact, schizophrenic".<sup>13</sup> There is still no independent or valid diagnostic test of schizophrenia, even with the assistance of the WHO's "psychopathological characteristics" or the APA's "diagnostic criteria". However, this fact hasn't stopped psychiatrists from diagnosing people "schizophrenic".

### Theories of cause — The Search For The Schizophrenic Agent

Kraepelin speculated that "dementia praecox" was caused by a "metabolic disorder" or some sort of infection. Bleuler admitted he didn't know the cause but guessed that perhaps "here-

dity does play its role". Bleuler is not alone in his ignorance. Hundreds of psychiatrists and psychologists who have investigated schizophrenia over the last seventy years also don't know its cause.

Nevertheless, many different theories or hypotheses (probably close to fifty to date) have been proposed and tested — more or less. The major types of theoretical assumptions put forward at one time or another are: psychological, sociological, inter-personal or communicational, physical environmental (including pollution), familial, dietary or nutritional, viral, neurological, genetic and biochemical.

One major communication theory stated that people become schizophrenic because they receive mixed or contradictory messages from their parents or close relatives to which they cannot respond without being punished or rejected. This is the "doublebind" theory, the "I'm-damned-if-I-do-and-damned-if-I-don't" experience. This hypothesis stimulated considerable research 10-15 years ago but it's seldom mentioned today.

Also worth mentioning is R.D. Laing's well-known experiential or existential theory which asserts that schizophrenia is basically a sane response to an insane world, a survival strategy arising from the person's identity crises, usually with disturbed family members. Although this theory challenged psychiatry's traditional disease model of schizophrenia, Laing and other "anti-psychiatrists" still wrote as if schizophrenia exists and can be diagnosed and treated (in the community rather than a psychiatric institution).<sup>14</sup>

Within the last five or six years, biochemical and genetic hypotheses have sparked more research interest. However, because of the lack of substantial scientific evidence, they remain only guesses, wild guesses.

The so-called orthomolecular theory, for example, aroused some interest in the 1960s and 1970s. Investigators such as psychiatrists Abram Hoffer and Humphry Osmond confidently claimed that schizophrenia is a "physical disease" caused by a "metabolic error".

This defect, probably inherited, causes the production of a poisonous substance that affects his brain and creates marked disturbance in perception and radical changes in thought, personality, and behavior.<sup>15</sup>

The "scientific evidence" has not been impressive. In fact, in 1973, the hyper-conservative American Psychiatric Association challenged or discredited many of Hoffer and Osmond's claims.<sup>16</sup>

The dopamine (DA) hypothesis has also stimulated particular interest among biological psychiatrists and pharmacological researchers. Dopamine is a natural chemical in the brain, a "neurotransmitter" which is known to speed the flow of nerve impulses to certain motor areas of the body. Very simply, the hypothesis states that schizophrenics suffer from "too much dopamine" which somehow causes their "psychotic" behavior or "schizophrenic" symptoms. Reducing the dopamine level in schizophrenics should, according to the theory, make them feel better, perhaps eliminate their "symptoms". This hypothesis arose from psychopharmacological research which showed that "antipsychotic" drugs such as chlorpromazine (Thorazine) blocked dopamine. The apparent relief brought by these drugs, it is reasoned, is due to their "dopamine-blocking" action. However, the research evidence for the DA/schizophrenia connection is at best "indirect" and "scant".<sup>17</sup> Another investigator is more blunt in concluding that "no biochemical lesion has been demonstrated beyond doubt to be linked to schizophrenia".<sup>18</sup>

There is also little or no solid sci-

tific evidence of a genetic cause of schizophrenia. In the late 1930s and early 1940s, German psychiatrist Franz Kallman carried out studies on the incidence of schizophrenia in identical ("monozygotic") and fraternal ("dizygotic") twins. Kallman tried to prove that schizophrenia was inherited and pointed to the alleged fact of a 40%-50% "rate of concordance" in his identical twin subjects, as compared to a 5%-10% rate in the fraternal twins. In other words, if one identical co-twin had schizophrenia, there's a 50/50 chance the other twin would also have it. However, if schizophrenia is truly an inherited condition, then the "rate of concordance" in identical twins should be 100%. Most investigators have found much lower rates. In fact, they have so far failed to discover a genetic explanation for schizophrenia. Nevertheless, in a critical review of the literature, one investigator concluded that what's probably inherited is a "vulnerability . . . (or) capacity for schizophrenic illness," which says little if anything.<sup>19</sup> Of course, all this genetic research may be irrelevant, since it's useless to talk about the elimination of "psychotic" or "schizophrenic" symptoms if investigators "cannot first

agree on which items of conduct are to be classified as 'psychotic symptoms'".

Perhaps psychiatrist Manfred Bleuler (son of Eugen Bleuler, inventor of schizophrenia) says it best when he concludes:

. . . all the somatic theories of schizophrenia are open to most serious criticisms from biologists . . . It seems not to be good medical policy to maintain that schizophrenia is a symptom of a somatic disturbance, if one cannot demonstrate this somatic disturbance. . .<sup>20</sup>

### Treating the Untreatable

The "treatment" of schizophrenia remains inconclusive and controversial, to say the least. There is still no "cure", although some psychiatrists claim that certain treatments give relief, if only temporary, to their patients. Bleuler recommended re-creation and outdoor exercise, but he wasn't sure either worked. Metrazol convulsive therapy, insulin coma and sub-soma therapy, electroshock, hydrotherapy, lobotomy or psychosurgery, megavitamin therapy, various types of psychotherapy and "chemotherapy" have all been used at various times to "treat" "schizophrenia" with little or



no success. With just about any of these treatments, one-third get worse, one-third show no change and one-third show "improvement". However, "improvement" is so poorly defined in psychiatric research and practice that it's become as meaningless as most other psychiatric terms.

"Chemotherapy" — the drugging of people with "antipsychotic" or neuroleptic drugs — has been the most common treatment for schizophrenia and other "psychotic" conditions during the past twenty-five years. The powerful neuroleptic drugs such as Thorazine, Stelazine, Mellaril, Haldol and Moditen or Modicate (Prolixin in the US) are assumed to be effective in lessening or eliminating some schizophrenic "symptoms". However, these drugs have caused their own disorders or illnesses (psychiatry calls them "side effects", medicine calls them "iatrogenic"). Tardive dyskinesia (T.D.) is probably the most serious effect of such drugs; it's a grotesque disorder of the central nervous system (brain damage) and is generally permanent. Since the prevalence of T.D. is extremely high (25% to 50% in various patient populations), it is justifiable to speak of a T.D. epidemic, particularly in North America and Europe where these drugs are frequently prescribed.<sup>21</sup> The phenothiazine drugs (Thorazine, etc.) are also responsible for causing many deaths.<sup>22</sup> Under these circumstances, the "cure" is worse than the "disease".

For almost thirty years, insulin (appropriately given to diabetics only) was also administered (usually forcibly) to thousands of schizophrenic inmates in the 1930s and up to the 1960s. Insulin coma therapy or sub-coma insulin treatment was once considered to be the "treatment of choice" for schizophrenia. It should be pointed out that insulin coma treatment consists of a series of deliberately induced comas which invariably cause some degree of brain damage. This dangerous shock treatment, invented by psychiatrist Manfred Sakel in the early 1930s, was assumed to be effective through its alleged capacity to destroy the "hyperactive" or "diseased" nerve cells, which Sakel believed were a major cause of schizophrenia. Insulin shock caused many serious complications including death. It was finally banned in most psychiatric institutions by 1970, because the "safer, easier . . . and less costly" phenothiazine drugs were available.<sup>23</sup>

During the past 40-45 years, people diagnosed as schizophrenic, particularly "chronic schizophrenic," have also been subjected to the dangerous, experimental

psychiatric procedure called psychosurgery (previously called "lobotomy"). This brain-mutilating "treatment" consists of the deliberate destruction of healthy brain tissue or certain nerve pathways in various parts of the brain. The most common effect of psychosurgery is the flattening or "blunting" of virtually all feelings and emotions. According to psychiatrist Peter R. Breggin, an outspoken opponent of psychosurgery and electroshock, the massive effects of psychosurgery are horrendous:

. . . global psychological losses in all the higher human functions: abstract reasoning, judgement, insight, imagination, creativity, emotional sensitivity, moral awareness. (*Electroshock: its brain-disabling effects*. Springer, 1979, p. 111)

*"The so-called symptom of schizophrenia is what happens to us when the perceptions we have of our environment are attacked and ignored and denied over and over again. Ironically, our perceptions are accurate. Even after we are terrorized, drugged or socialized out of expressing ourselves directly we do it symbolically and the feelings are right. I believed as a child that my soul had been stolen from its rightful body, that my real parents lived on a satellite of Betelgeuse. That was not an insane delusion. It was a poetic and actually logical way to handle the unliveable environment that I had the ill fate to be born into."*

—Judi Chamberlin  
On Our Own (1978,  
p. 113)  
*Former psychiatric  
inmate*

Psychosurgery has been performed on thousands of "schizophrenics" as a last resort, frequently after all other psychiatric "treatments" have failed to bring "improvement" or conformity. However, psychosurgery has also been performed on many other types of conditions, including neuroses, alcoholism

and epilepsy. Like electroshock, psychosurgery "works" by causing brain damage and permanent emotional and intellectual impairments. Psychosurgery is still being done in the United States (about 500 a year) and other countries, including Canada, where it's usually covered up or simply not reported in the literature. Since 1978, the *Mental Health Act* has outlawed the use of psychosurgery in Ontario for "involuntary patients". But who would voluntarily consent to this medically sanctioned murder of the mind or soul?

Note: Also see P.R. Breggin, "The Second Wave" in S. Hirsch *et al.* *Madness Network News Reader* (Glide, 1974, pp. 89-95), and *The Crazy from the Sane* (Lyle Stuart, 1971).

Electroshock ("ECT") is still being widely used as a treatment for schizophrenia, although it is more frequently administered for depression and other "affective" disorders such as "manic-depressive psychosis". Like insulin shock, electroshock is also dangerous. It is common knowledge that electroshock frequently causes permanent loss of memory and impairments of other intellectual abilities. It always causes some degree of brain damage.<sup>24</sup> A recent report by four investigators from Toronto's Clarke Institute of Psychiatry shows that over a 16-year period (1966-1981), 37% of people diagnosed as schizophrenic were given electroshock. Much lower percentages were reported for other hospital and national populations of schizophrenics: 17% in the USA (based on the APA Task Force Study, 1978); 13% in Great Britain; 21% in Veterans' Administration hospitals in the USA. It should also be noted that on the average the Clarke schizophrenic patients were given a longer course of shock treatments than most other psychotic patients. (10 vs. 8).<sup>25</sup>

## The Denial

### The Medical Model "Crackup"

Psychiatry's use of the medical-disease model is not only inappropriate but irresponsible and unscientific. As Szasz has repeatedly asserted, "there is no such thing as 'mental illness'." What psychiatry has labeled as 'mental illness' or "symptoms of mental illness" are actually types of conduct which violate or threaten a social norm or moral value. In this light, according to Sarbin and Mancuso, schizophrenia is essentially "rule-violating" conduct or "unwanted behavior".

Take hysteria, for example. Szasz points out that people labeled "hysterical" (usually women, which reveals the traditional sexism in psychiatry) generally show a lot of helplessness, powerlessness and manipulative behavior, which is essentially aimed at getting other people to take care of them or give them what they want. However, this behavior is not an indication or symptom of "mental illness" — it's just behavior which is damn annoying to other people. By having redefined or interpreted hysteria as a form of mental illness — thanks largely to Charcot and Freud — psychiatrists felt justified in "treating" it by hypnosis or psychotherapy.

The situation is similar to other non-medical but disturbing conditions, including everyday emotions. In the hands of psychiatrists, they all get pathologized: sadness is diagnosed "depression"; joy is diagnosed "mania"; excitement is diagnosed "euphoria"; anger is diagnosed "hostility"; eccentric behavior is diagnosed "neurosis", and non-conformist behavior is diagnosed "schizophrenia".

Sarbin and Mancuso rightly point out that "unwanted behavior" has been cast into the medical-disease model of schizophrenia. However, the medical model, based upon the mechanistic world view of direct cause-and-effect, was never meant to explain "norm-violating behavior". By misappropriating the medical model and imposing it upon social or moral behavior, psychiatry has seriously distorted and strained the model. Within psychiatry and other mental health professions, this has led to widespread confusion, embarrassing contradictions and major inconsistencies in diagnosis and research, and the "literalization" of concepts or metaphors, i.e., the belief that "mental illness" or "schizophrenia" actually exist as disease entities.<sup>26</sup> Further, as a psychiatric weapon, the disease model of schizophrenia has been used to justify locking up and forcibly treating people against their will, thereby denying many people their freedom and other legal or constitutional rights.

## **Psychiatric Diagnosis as Moral Judgement — The Diagnostician as Stigmatizer**

It is a well-known fact that psychiatrists rarely agree on a diagnosis, inside or outside a courtroom. In various studies (summarized by Sarbin and Mancuso), a number of investigators have shown that psychiatric judgements are notoriously invalid and unreliable.<sup>27</sup> Of course, part of the problem

is the obvious vagueness and ambiguity in the so-called diagnostic criteria of schizophrenia.

The classic study by Rosenhan in 1973 clearly and dramatically exposed the subjectivity and bias inherent in psychiatric judgement. The study caused a minor uproar within the psychiatric establishment.

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*"Schizophrenia" is a strategic label, like "Jew" was in Nazi Germany. If you want to exclude people from the social order, you must justify this to others, but especially to yourself. So you invent a justificatory rhetoric. That's what the really nasty psychiatric words are all about: they are justificatory rhetoric, labeling a package 'garbage'; it means 'take it away!' 'get it out of my sight!' etc. That's what the word 'Jew' meant in Nazi Germany; it did not mean a person with a certain kind of religious belief. It meant 'vermin!' 'gas him!' I am afraid that 'schizophrenia' and 'sociopathic personality' and many other psychiatric diagnostic terms mean exactly the same thing; they mean 'human garbage,' 'take him away!' 'get him out of my sight!'*

—Dr. Thomas Szasz  
"Interview with  
Thomas Szasz" in  
The New Physician  
(1969, p. 460)

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In the study, eight normal healthy people posed as psychiatric patients or "pseudopatients". The "pseudopatients" consisted of a psychiatrist, three psychologists, a psychology graduate student, a pediatrician, a painter and a housewife. When these pseudopatients presented themselves at twelve different psychiatric institutions on the east and west coasts of the United States, they were promptly admitted and diagnosed as schizophrenic. During the admission examination, all pseudopatients told the psychiatrists that they heard voices like

"thud", yet all gave truthful accounts of their own family histories. Three to four weeks later, most of the pseudopatients were released and all were given the discharge diagnosis of "schizophrenia in remission", which meant the psychiatrists believed they were still schizophrenic. (One pseudopatient was on a locked ward for 52 days — many others were drugged.

As if having admitted sane people to psychiatric institutions and diagnosing them as schizophrenic wasn't bad enough, the psychiatric staff were further embarrassed to discover that many of the real inmates sensed or knew that the pseudopatients were faking mental illness — the staff didn't. Another embarrassment awaited the staff at another "research and teaching hospital". Rosenhan simply announced to one staff member that sometime within a 3-month period, one or more of the pseudopatients would try to get admitted to his institution. The staff were sure they'd be able to detect any pseudopatient which Rosenhan sent them. A total of 193 patients were admitted to the psychiatric institution during this follow-up period. One psychiatrist diagnosed 41 or 21% as pseudopatients "with high confidence", another psychiatrist diagnosed 23 or 12% as pseudopatients, and still another psychiatrist "suspected" 19 or 10% as pseudopatients. Actually, *not one* pseudopatient came to the hospital during this period.

One of Rosenhan's major conclusions is most relevant: "It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals."<sup>28</sup>

Labeling people "schizophrenic" or "psychotic" is a stigmatizing act. Sarbin and Mancuso aptly describe the psychiatric diagnostician as a "stigmatizer", partly because psychiatrists label people "mentally ill" or "schizophrenic" in the absence of clear, strict and scientifically supported criteria, and partly because many diagnostic terms have acquired negative meanings. "Paranoid schizophrenia", for example, is generally considered to be the most stigmatizing or damning diagnosis in psychiatry. It is no exaggeration to assert that people labeled schizophrenic suffer the same sort of stigma and invalidation as the Jews experienced in Nazi Germany where they were forced to wear badges labelled 'JEW'. It should also be pointed out that it is psychiatry, not the public, which is chiefly responsible for creating and maintaining the stigma associated with "mental illness" in general and "schizophrenia" in particular. As many presently incarcerated and former

psychiatric inmates know all too well, the power to label and treat people against their will is the power to oppress and stigmatize them — usually for life.

It's also important to realize just how easily psychiatrists and other mental health professionals can be influenced by social or political factors in making their diagnoses. In a major study by Braginsky and Braginsky (summarized by Sarbin and Mancuso), professional staff members were asked to diagnose various psychiatric inmates on the basis of what they said during videotaped interviews. Some inmates voiced 'New Left' political views, others openly criticized the staff, while others complimented or praised the staff. Those inmates who criticized the staff were typically judged as more "pathological" than those who didn't; the 'New Left' inmates were also judged sicker than those who didn't express this ideology. "The most spectacular change" in professional judgement occurred when one "very disturbed mental patient was suddenly perceived as . . . normal" after he praised the staff.<sup>30</sup>

It is now clear, according to Sarbin, Mancuso, Szasz and other psychiatric critics, that "schizophrenia" is actually conduct that differs from or violates certain moral standards and that psychiatric diagnoses are *moral judgements* of such conduct. If this is so, on what basis or by what authority are psychiatrists empowered to make these judgements?

## **Psychological Studies of . . . ?**

Impairments in attention and thinking have not been as frequently found in schizophrenics as generally assumed or predicted by theory. For example, investigators have found attentional disturbances in various samples of both schizophrenics and "mixed" neurotics. Perceptual weaknesses or "cognitive deficits" have just been assumed, mainly because many people diagnosed as schizophrenic generally take longer times to respond to the various test stimuli or tasks. Sarbin and Mancuso list the major criticisms of the "attention deficit" studies, which could easily apply to most other psychological research into schizophrenia: 1. The techniques used are complex and ill-defined; 2. As an independent variable, schizophrenia is confounded by hospitalization effects (i.e. length of incarceration, effects of drugging); 3. Different intellectual skills interfere with differentiating schizophrenics from non-schizophrenics; 4. Many findings are contradicted; 5. Lab-based

techniques have been uncritically applied to clinical and social situations.<sup>30</sup>

In addition, the basic assumptions of most researchers are often hidden, such as one which states that people diagnosed as schizophrenic are inherently "flawed". The main but hidden assumption that schizophrenics will invariably "perform more poorly" than others can easily become a self-fulfilling prophecy in research. Another serious methodological weakness in schizophrenia research is the failure to specify which item of behavior or task is related to which variable or "symptom". Further, the concepts used in psychological research are rarely, if ever, clearly defined and specifically related to general psychological theory. Sarbin and Mancuso point out that less than one-third of the studies they reviewed (100 out of 374) "show any effort to link any psychological malfunctioning to one or another of the behaviors that lead a person to psychiatric referral."<sup>31</sup>

Sarbin and Mancuso raise a number of important questions which remain unanswered by research. For example: "How do strange, illogical or uncommon associations handicap people? How do they result in getting people into hospital? Why does over-generalization lead to *faulty conclusions* and why are faulty conclusions labeled *delusions*? Everyone over-generalizes. Everyone draws faulty conclusions, but not everyone is judged delusional or schizophrenic."<sup>32</sup>

## **Summary — Conclusions — Implications**

After critically examining various research findings and informed opinion, we must conclude that there is no such disease or mental illness called "schizophrenia". Psychiatry's diagnostic concept of schizophrenia does not meet the standard criteria of disease in medicine. Psychiatry's illegitimate and irresponsible use of the medical-disease model of schizophrenia, the alarming lack of clarity, validity and reliability of the diagnostic criteria of schizophrenia, and the many contradictory and inconclusive findings in psychological and medical research justify our rejecting the psychiatric concept of schizophrenia.

Schizophrenia is actually a euphemism or metaphor for non-conformist behavior or "unwanted conduct" which violates or threatens certain moral values. Like many other psychiatric terms, schizophrenia was invented by psychiatry. As Dr. Thomas Szasz has asserted, "Psychiatry creates schizophrenia . . .

if there is no psychiatry, there can be no schizophrenia."<sup>33</sup> Schizophrenia is a myth, a very dangerous myth masquerading as disease. Doctors who treat myths or non-existent diseases are charlatans or quacks.

Schizophrenia has been used by psychiatry to degrade, humiliate, stigmatize and invalidate people as non-persons.

Schizophrenia has been used by psychiatry to manipulate and control people.

Schizophrenia has been used by psychiatry to forcibly treat and incarcerate non-dangerous people who have committed no criminal acts.

Schizophrenia has been used by psychiatry as a justification to deprive people of their freedom and other civil or human rights.

Schizophrenia has been used by psychiatry to stifle or invalidate legitimate political dissent by medicalizing such dissent as "symptoms of mental illness" or "psychosis".

Schizophrenia has been used by psychiatry to deceive the public into believing that strange, non-conformist conduct or unpredictable outbursts of anger are "symptoms of mental illness and dangerousness".

Schizophrenia has been used by psychiatry to discredit people, (particularly the poor) by labeling their conduct "sick", "pathological" or "deviant" according to middle-class standards of morality.

Schizophrenia has been used by psychiatry to give credibility to its illegitimate and unscientific applications of the medical-disease model.

Schizophrenia and similar diagnostic concepts in psychiatry must be exposed and challenged for what they are: unethical or illegal attempts to socially control or punish non-conformist conduct and to invalidate people who assert their individuality and human rights.

*See notes on page 42.*





# personal stories

## "I've always had people telling me what to do:"

*Two people who have been diagnosed as "schizophrenic" talk about their "schizophrenia" as a response to a society that robs them of their autonomy.*

INTERVIEWS BY ROBBYN GRANT

KAREN

To understand schizophrenia you practically have to be schizophrenic yourself. Nobody knows how you feel. You feel different from other people. The symptom my schizophrenia takes is mostly hallucinations. I hear voices. They say that they are just my own thoughts, but some of the things the voices tell me are true. They'd tell me things that I never knew about before. They'd tell me things that were really happening. Like the time they told me someone was trying to break in, and they were.

I was first diagnosed as schizophrenic when I was twenty-three. I was living with my husband, and I had three kids who were aged 3 years, 18 months, and 8 months old. They were all in diapers, and I washed diapers day and night. My husband was late paying the rent every month. The landlord got fed up, and one day came and demanded his rent. I didn't know where my husband was, and I didn't have the money, so he kicked us out. I had three little kids, I didn't know where my husband was, and I had to move in three days.

We left the furniture there, just took a few clothes, and moved in with a friend. In a couple of weeks we got an apartment. I was just shaking and nervous all the time because the kids were running around, and I was trying to keep them quiet—it was a flat, there were people downstairs, and I couldn't keep them quiet. I got my notice after I was there for two weeks.

Then my husband came and moved me to a place on Ontario Street. It was terrible. There was literally an inch thick of dirt on the floor. I tried to clean up the place, but it was impossible. My husband went on booze, and he was gone. I started hearing voices again. I didn't know that they were voices. I thought I was just reading the mind of the lady next door—that I could hear what she was thinking.

I woke up one morning, and my oldest son had gone into my housecoat pocket, had gotten the aspirins, and all three of the kids had taken them. I rushed to the hospital. After that I started hearing voices really bad. Everywhere I went I was hearing voices—loud, loud voices. I came back, phoned the Children's Aid, and asked them to come take my kids because I was sick and had to go to the hospital. They wouldn't come.

My voices were telling me that someone was trying to break into the house. (Somebody was trying to break into the house. The police caught him after I was in the hospital.) I phoned the police who came over several times, but found no one. The last time they came I was standing at the front door with a butcher knife in my hand, and they took me to the hospital. The Children's Aid sent a worker to look after my kids, but the place I lived in wasn't fit to live in, so they took my kids. That was 15 years ago.

I went into the hospital then for three weeks. At that time they diagnosed me as schizophrenic, but I didn't know what that meant. After three weeks they said that I was just about cured, that I was well, and that I could go home without any medicine or doctor's appointment or anything.

My mother took my oldest son, and the Children's Aid took the two younger ones. I went to live with my mother and my son and got a job in Towers. After I had lived with my mother for a while, my son and I went back with my husband. He got a job, but was still drinking. One weekend he didn't come home, so I packed everything and moved out. Then I got a flat with my son, and I kept him there for a couple of months. The Children's Aid said that I could have my kids back if I could find a place to live (I had applied for Ontario Housing but never got it). So I got a three-room flat. It was very small. There was just enough room for a pull-out bed couch in the living room and the kitchen was so tiny. I plastered and painted it. I was on Welfare and they let me take the kids home. We were all fine for about a month. But the people downstairs drank a lot, and when my husband came over to see the kids he'd go there and drink. I didn't drink at all. I was very nervous. I was on no medication at all then. The people downstairs didn't have a phone and kept coming up in the middle of the night to use ours.

Finally I moved out of there. I decided that I didn't want anything to do with my husband. This is what the Children's Aid told me to do. They advised me to bring up the kids on my own and not let him see them. I began going out with a

man who I later discovered was married, so I broke off with him.

I began forgetting things again. One morning my 16 month old baby, who was hyperactive and used to get up at 5 a.m., got up and turned the gas stove on. There was a frying pan on top of the stove, and it started a grease fire. We would have all been dead if the woman across the street hadn't seen the fire coming out of the kitchen window. She woke me up, and I got all the kids out. I had to go back into the rubble and live for three months. The Children's Aid knew, but wouldn't help me. They talked to me on the phone, but that's all they would do, talk to me on the phone. Everything was ruined and covered in smoke. There was no way I could clean it up. Everything I had worked for was wrecked. We stayed there for about three months, and at that time, I was hearing voices again. I don't remember much about being there. I don't even know how the kids ate.

I went into St. Michael's, and the Children's Aid took the kids. After that I got out of the hospital, found out where my husband lived, got a room, and he got one across the road. We were going to get married (we hadn't been legally married before), but the Children's Aid talked me out of it. Children's Aid said I should be dating and could find someone else to support me, but the next guy I met was married too. I broke off from him, and then I started hearing voices again.

I got an apartment and a job and was doing fine, but I was alone. I didn't know anybody, and my relatives were all too busy for me. I was alone with no husband, no boyfriend, no kids, all I had was a job, and I wasn't doing very well at it. I got sick again. The Children's Aid and my doctor said I should give my kids up for adoption.

I went back into the hospital and they put me on Moditen, which made me very depressed. I'm not usually depressed. Even before I was psychotic I wasn't really depressed, certainly not like I was after I was on Moditen. I was alone, and I just couldn't function. Everything was just so negative.

I was very depressed when I left, being on the medicine, and I couldn't get a job, couldn't work, couldn't do anything. I wanted my kids back. But I couldn't. I was so depressed because of the Moditen. Children's Aid said I couldn't support my kids. I couldn't work; the Moditen had made me like a vegetable. I stiffened up. I couldn't move my hands or my legs. I couldn't have sex. I couldn't work. I couldn't even walk. All I could do was eat and sleep.

After about six months of this I had to go to court for my kids. Of course, I hadn't made any progress. How could I? The Children's Aid said I should give my kids up for adoption. The doctor wrote a letter to the judge which I was never allowed to see. I gave them up. I was so depressed and lethargic from the Moditen that I would have said anything. I would have said "OK" if they'd said they were going to kill me. So they are gone now, and I never see them. It's had a terrible effect on me to lose my kids. I blame the medication for it. I would never have lost my kids but for the medication. It made me a vegetable.

They said I should give my kids up because I didn't have a husband. Ironically, about 6 months after I gave them up I went back to my husband. I got off the Moditen, I got a job, and I was fine for years. Then I had another baby. The doctor told me to have an abortion, but I said "they've already taken three of my children, you can't take this one." Everything went fine until he was about two years old. Then I got nervous and depressed. I began to think. If we could take such good care of Jason then why couldn't I have my other kids back? I began to hear voices and to believe that my kids were coming back. I got melancholy. They put me on Trilafon. That's really wild stuff, it makes you so high. In a matter of a year and a half I was in Whitby for three years, and again, diagnosed as a schizophrenic.

They put me on Moditen again. They took me off it, eventually. I got better, got out, and I went to a boarding home. I was still hearing voices. It was like a whole war going on in me. I thought everybody else could hear the voices too and that they knew what I was thinking. My husband had kept my son all this time. Children's Aid wanted to take him but he kept them away.

I live in a boarding home now, and I'd like to go home, but I'm afraid. Living in a boarding home, you are very sheltered, and after being in a hospital for three years I'm very afraid to go out on my own.

I feel able to work now, but I can't get a job. I can't tell them that I've been in the hospital or that I live in a boarding home. I'd have to keep all this stuff to myself. It's a lot to keep bottled up and would affect my work. I couldn't tell people the truth. Just the fact of having been labelled "mentally ill" or "schizophrenic" keeps you isolated from everybody else, and isolation reinforces your condition.

To be schizophrenic means to be different. But society doesn't accept a schizophrenic. The label has had an effect on me. It has changed my attitude, made me feel different about myself. It has made me feel that I'm not as strong as everybody else, that I have a weakness. The rest of the world views it that way too. If I was to go out and look for a job and say I'm schizophrenic and that I had spent three years in Whitby, I'd have less chance of being hired than if I went out and said that I'd been in prison for three years and was reforming. Schizophrenia is something that people see as incurable, dangerous even. I've never hurt anybody in my life. Maybe I hurt my kids when I gave them up for adoption, but I was told that I should for their own good.

I've always had people telling me what to do. I've never done anything on my own. Even my husband treats me like I don't know how to do anything. I lived with my father and two brothers (all men). They thought women were weak and always treated me that way. I was treated like I needed to be told what to do. They kept me from thinking for myself too.

## The compliant schizophrenic.

Why  
keep this  
patient in a  
chemical  
strait-  
jacket?

ORAP

And now I'm thirty-six, and I don't know how to think. If they had ever let me think for myself, make my own decisions, then I would have been able to learn to think for myself. It handicaps me being treated like I'm not capable. It makes me feel like I'm not capable.

The three years I spent in Whitby didn't do me any good, not one bit. I was isolated, locked away. When I got upset or said how I felt, they'd lock me up in the quiet room, which is about 3 feet by 6 feet with a bare floor, and shut the door. When I got back to the boarding home and back to Toronto and back to seeing people that I cared about, then I began to get better. If you want someone to have self-respect you must treat them with respect. Not getting that respect is a lot of what can drive a person "mad." (Karen Jones)



#### **JOHN**

I am forty-four years old. I was first diagnosed as a schizophrenic in the 50s. My symptoms were that I seemed to be in a world of my own, withdrawn and staring at things. I lost my mother when I was four, and I was passed around to aunts and uncles quite a bit. Then finally, when I was about ten, my father married again. My parents were very domineering. They have tried to run every aspect of my life, even as an adult, from my job to how I dressed and where I lived.

When I was about sixteen, I was taken to the Toronto Psychiatric Hospital and diagnosed as a schizophrenic. They kept me in the hospital for three months, but they didn't do anything for me. Finally they let me out. When I was about eighteen I got a job at Loblaws', and later I got a job as a floor boy. At about twenty years of age, I went into printing which I didn't like, and I wanted to get out of it, but my parents kept pushing me to stay in. They were constantly telling me what to do, even on my job. They didn't respect my privacy. They thought I was too secretive; I thought they were prying. I didn't want to answer all their questions.

Finally I got to be manager of the printing department. I worked there for fourteen years. My mother did everything for me, so that now it's more difficult to learn to do things for myself so late in life. I've seen psychiatrists and family service social workers, and they didn't offer much help. They even put me down and said that I couldn't do anything and that I knew nothing. I got the same thing from my parents. They all said that I couldn't take care of myself. I think that having the doctors label me as a schizophrenic gave my parents an excuse for treating me as if I was helpless.

My father was unhappy because I didn't become an engineer or a university graduate. But I'd be unhappy doing that. I wanted to do something with my hands. I'd like to have worked with furniture or making patterns in a foundry. But my parents always put me down for the things I wanted to do. They never considered my likes and dislikes. They wanted me to live my life their way. I never got any support for the things I wanted to be. At times I just turned inward and began staring at the closed door and that sort of thing. When I was a kid I didn't have anyone to go to with the things I felt. I was alone and isolated with them. All I could do was go for walks. I did talk to my minister and started going to his church, but they started trying to run my life.

I don't know if I'm schizophrenic or not, but the medical profession labelled me that, and my parents told me that too. The psychiatrists and social workers would interview them before me. They took away my autonomy and right to speak for myself. My parents were always contradicting and discounting what I said and felt. It's been a struggle for me all my life not to allow people to boss me and own me, and to develop some sense of autonomy without alienating people, and now I'm tired.

My doctor and the social worker I was seeing and even the personnel manager at work all agreed that I should get out of

it, leave home. Finally I had a bout with my mother when I was about thirty-eight years old, and I packed up and moved out. Got my own place. I've completely cut myself off from my family now because they only undermine my independence and want to tell me what to do. I've been on my own ever since, and I'm doing very well although it's hard to forget about the past.

I think that's true for all the disabled, especially the mentally ill. We're lied to and generalized about by the doctors and social workers as well as our parents and the society in general. The social workers and doctors told my parents that I couldn't do anything, that I'd always have to be taken care of. It feels like a triumph to me to have overcome and overthrown the messages of failure that were foisted on me all my life. I'm surviving now and doing fine. I have problems sometimes but I can cope. My problem was being put down and told that I couldn't do anything. When you get put down enough you begin to believe those messages and, when you begin to believe that you are incompetent then you act that way.

When people believe you are handicapped either physically or mentally, they treat you that way and it's crippling. I just want the right to live my own life the way I want to, and I respect the rights of others, too. Queen Street is nothing but a jail, and that doesn't help. Public attitude towards schizophrenics has to change too. People have to be allowed and encouraged to be as independent as possible.

Being schizophrenic means to me that you are different. I forget that I've done little things sometimes, and I talk to myself and people make remarks, and it makes me embarrassed. I feel different, I also feel like a "normal" human being in society, but when people know that you've had a nervous breakdown they think you are second-class. You're made to feel that you can't do things, that you are nothing. And so I feel second-class a lot of the time, even though I've proven that I can do things. I've held responsible positions, and for the last six years I have lived entirely on my own and have taken care of myself. I can cope and deal with life. I've learned to be an assertive and effective person. I've won the battle. (John Bedford)

**The  
non-compliant  
schizophrenic.**

A better  
way to help  
this patient  
develop  
a new  
outlook.

IMAFORTE

## *Excerpts from the Discharge Summary of Don Weitz: McLean Hospital 1951-1953 (unedited)*

In 1950 the patient first sought psychiatric help because of his inability to select a vocation. He was seen in the Cleveland Jewish Vocational Service and it was apparent that a vocational choice was impossible because of severe emotional conflicts. Prior to this the patient had finished a year at Dartmouth where he had some feelings of depression and wanted to leave, but he was not able to admit to himself that he could not work through the problems.

The patient finally saw Dr. Greta Bibring in Boston, where she recommended that he enter the Austin Riggs Foundation where he was admitted March 31, 1951; he was discharged November 6, 1951. The psychological test reports at the Austin Riggs Foundation revealed insidiously developing schizophrenic processes far enough progressed so that the patient was regarded as schizophrenic on his admission there. Chief diagnostic indication was his fluidity or confusion of thinking, combined with marked fragmentation of thoughts. Fluidity manifests itself in a relatively frequent inability to maintain a frame of reference, starting point and direction. Fragmentation manifests itself in spasmodic, incomplete, perseverative verbalizations such that it often seems that he is unable to let go of an idea or word and unable to develop it further. In this fragmentation there are obvious manifestations of obsessional trends. Perfectionism, extreme doubting with transient paralysis of thought. The obsessional character features show rigidity, repression, and isolation of a reaction formation against hostility were evident along with underlying regressive turning to an old passive feminine mode of object relationships. Anger was directed against himself for his own failings. While at the Austin Riggs, he showed many violent mood swings and outbursts of temper and it was felt that he would do better at a closed hospital and the patient was transferred to the McLean Hospital on November 6, 1951.

When he was admitted to this hospital, he had considerable insight

into his condition and would ask questions such as, "How sick am I really?" He gave the impression of extreme anxiety and tension. His talk was rapid, a little overactive, but was coherent. He was upset with the idea of his own failure, with a hopelessness of it all, and was acutely aware of the great distance between his ideals and goals and his present achievement level. Much of his time was spent in fantasy life where he imagined himself to be a great composer, such as Beethoven, or a great artist or genius. He was also aware of the fact, however, that he projected his feelings and attitudes towards others, particularly towards his parents, and he stated that they did not bring him up as well as they should have and that they were probably sick themselves. He has never shown any evidence of hypochondriasis or hallucination. His retention memory and orientation and recall are all adequate. On his psychological reports here in the hospital, he showed a verbal IQ of 140, performance of 119; and a full IQ of 132. During the Wechsler-Bellevue test, he showed a low frustration level; he set goals too high and expects perfection in his performance. On his Rorschach and TAT tests, it was noticed his rigidity and his inability to adjust to new situations, to modify his ideas and to accept suggestions. He depends greatly upon his superior intellectual endowment but this does not function adequately in emotionally charged situations. The specific types of situations in which his emotions are overwhelming are those concerned with his parents, sexual matters, or personal failure. The patient has very certain negative ideas concerning his parents, his solution to his parental problems seems to be to get away from them; in other words, to avoid the problem. Regarding his sexual adjustment, there are indications that he is unsure of his role and he cannot accept his aggressive feelings concerning sex. Thus, he is confused and bewildered in this sphere.

During the first few weeks in the hospital, he showed characteristics of hysteria, temperament, and confusion about himself. From time to time in his

temper tantrums he would be destructive of furniture in his room, and he implied that nobody loves him and that his future is hopeless. He constantly tried to be the center of attention with the nursing staff and the medical staff. He was untidy about his clothes and personal hygiene and when seen in psychotherapy he went into long dissertations about his past and the injustices which his parents had perpetrated on him. The patient was finally placed on sub-coma insulin and after a month of sub-coma insulin three times a day, he showed tremendous improvement in his general over-all picture. There was no longer the outbursts of temper and he showed much better social relationships with other patients and nursing staff. He was finally discharged from the hospital on February 2, 1953 at which time he enrolled in the Boston University in order to complete his college work.



## Reactions to and Translation of My Discharge Summary

**BY DON WEITZ**

I was very lucky to get a copy of the discharge summary from my psychiatric records at McLean Hospital. A psychiatrist in Toronto helped me get the copy. Although I wanted a copy of my entire file, it was never mailed. Psychiatric inmates and ex-inmates, as well as medical patients, are still legally denied the right to see, copy or correct their medical or psychiatric files in Canada and the United States. The only way you can get a copy of your records is through a sympathetic doctor or lawyer, and then only a small part of your records is available. The hospital owns your medical records.

It's often maddening but enlightening to read what your doctor or shrink has written about you in your file, because it's typically full of many serious distortions, omissions and lies, as well as the usual psychiatric jargon which very few people can understand. I'm convinced the vast majority of psychiatrists use arcane, pseudo-medical language to mystify people, to conceal their real feelings and intentions from inmates and their families, and to convince themselves and the public that they're being professional or scientific.

After years of thinking it over, I finally decided to publish parts of my discharge summary for the chief purpose of exposing and demystifying the psychiatric bullshit written about me and other people who have been diagnosed and "treated" against their will.

Like millions of other sane but angry people, I was once labelled "schizophrenic", psychiatry's equivalent of medicine's leprosy. "Schizophrenia" is the most damning swear word in psychiatry; you're not supposed to recover from "schizophrenia", there's no "cure". It all happened 30 years ago when I was 21.

In 1951, I was involuntarily committed to McLean Hospital, a prestigious private psychiatric institution, a few miles outside of

Boston, the teaching-research hospital for Massachusetts General Hospital and Harvard University Medical School.

Although the discharge summary states that I was a voluntary patient and insane, I was neither. In fact, my parents and/or sister, with the help of a psychoanalyst at the Austin Riggs Foundation, involuntarily committed me. Furthermore, I never considered myself "schizophrenic" or "sick" — just angry. I was becoming more openly resentful and rebellious toward my parents and the upper middle-class values and life style they represented (which they tried to impose upon me), and I deeply resented being locked up against my will in a "closed hospital" (psychiatric prison). Sure, I was angry as hell and started throwing around and breaking furniture in my room at McLean's, an indirect and safer expression of my fury. The psychiatrists minimized and dismissed my anger. They never saw it as legitimate, assuming I should accept my parents' values, and so they never addressed the reasons and causes behind it.

In the discharge summary my psychiatrist implies that I have "negative ideas" about my parents and that my solution to "avoid" my parents is a symptom of my "illness." As a matter of fact, my decision to live apart from my parents has proved to be a very sane and constructive solution.

I insist I never admitted that I was "sick", although my psychiatrist chose to interpret my question, "How sick am I really?" to mean that I believed or accepted this diagnosis. I simply asked that question at the time because I seriously doubted that I was "sick" in the medical sense of the term and because I was justifiably worried that the shrinks would label me "insane", which of course they did.

The psychological test results as stated in the discharge summary are good examples of psychiatric or psychoanalytic bullshit. In reality, I was just damn angry with my parents, confused as hell about what I wanted to do

with my life, where I was going, and what I wanted to be. These fundamental human issues or problems were interpreted as "symptoms" of "schizophrenia" by psychiatrists at both Austin Riggs and McLean Hospital.

For example, how or why is "fluidity" in thinking or "inability to maintain a frame of reference" an indication or "symptom" of "schizophrenia"? Shifting or flexible frames of reference or perspective can just as easily be interpreted as indications of indecisiveness or even creativity. And how does "fragmentation . . . unable to let go of an idea or word and unable to develop it further . . ." indicate "schizophrenia" or sickness? And notice the clarity and precision in other psychiatric terms such as "obsessional character", "repressive", "isolation of a reaction formation against hostility", or "regressive turning to an old passive feminine mode of object relationships." To top it off, the psychiatrist who examined me admitted I never hallucinated; there was also no clinical or test evidence of delusions, both of which are common "symptoms" of "schizophrenia".

Furthermore, I'm convinced the real reason I was given insulin shock ("sub-coma insulin") was to stop my rebellious, non-conformist or disturbing behavior on the ward. Insulin shock succeeded in stopping this behavior — temporarily.

Just before the insulin shock treatments started, my psychiatrist gave me absolutely no explanation or justification for such treatment. Insulin shock "worked" by terrorizing me into becoming a co-operative and conformist patient. This is a classic example of the real but hidden purpose of all psychiatric institutional "treatment" — social control by fear. Since I stopped being so angry or rebellious after insulin shock, I was labelled "improved".

# Schizophrenia

BY J. JOEL JEFFRIES

Schizophrenia is a serious mental illness. Although it may be latent for long periods, it is a severe psychosis when fully developed. Psychosis is the medical word which roughly corresponds to the lay words "craziness" or "madness".

This illness most commonly affects young people between 15 and 30 years of age although a childhood form is seen and it may also appear later in adult life. It occurs in all races, in all cultures, in all social classes and in both sexes.

What causes schizophrenia is not definitely known but most Canadian psychiatrists now agree that it is basically a biochemical disorder of the brain. Also, the majority now agree that vulnerability to the illness is inherited, although the genetics are still unclear. Most authorities now disagree with those who consider schizophrenic psychosis an understandable response to severe stress. However, symptoms may get worse when the patient is upset, in particular when there is great tension in the home.

One of the fascinating aspects of schizophrenia is how diversely it presents. Indeed, the early symptoms are often minor behavioural or emotional changes similar to those commonly seen in the stressful years of adolescence. The illness cannot be definitely diagnosed until more serious symptoms appear — these include thought disorder, delusions, ideas of reference, hallucinations, peculiarities of mood and poor reality testing.

Thought disorder is a disturbance of the continuity of thinking in which the person cannot carry through a line of thought in a way that makes sense to other people. It is very difficult for the person who has the problem to be aware of it but it is easily seen by others.

Hallucination is when someone hears, sees, feels, smells or tastes something that does not in fact exist, truly believing that he has had this experience. In schizophrenia the hallucination is commonly that of hearing a voice.

A delusion is a false belief and in this illness it is commonly about bodily changes or persecution by others. It is common for patients to misinterpret the words or actions of others, believing that they are personally aimed at themselves: these are called ideas or references.

During an attack of schizophrenia it is common for the patient to feel a variety of moods including anxiety, anger, bewilderment, joy and sadness. These moods may be unusual either because they occur with great intensity or because they occur out of the blue and are not related to anything else the person is thinking about. Some people have difficulty distinguishing fantasy from reality; they spend a great deal of their time daydreaming and may start to believe their daydreams.

When these symptoms are intense the illness is described as "acute schizophrenia". The essential treatment for this is anti-psychotic medication and the drugs commonly used in Canada

are: Chlorpromazine (Largactil, etc.); Thioridazine (Mellaril, etc.); Trifluoperazine (Stelazine, Solazine, etc.); Perphenazine Decanoate (Modicate); Pimozide (Orap); Loxapine (Loxapac); Haloperidol (Haldol); Thiothixene (Navane); Fluspirilene (Imap); Flupentixol (Fluanxol) and Pipotiazine (Piortil). Hospitalization may relieve the patient's distress and the family's anxiety, as well as help the doctor to reach the best dosage level of medication. Electroconvulsive therapy (ECT) speeds up the removal of symptoms and may be used in addition to medication.

Less commonly used drugs are: Fluphenazine Enanthate and Fluphenazine Hydrochloride (Moditen), Thioproperazine (Majeptil) and Methotrimeprazine (Noztran). Imap, Fluanxol, Piortil and Modicate are worthy of special mention as they are long-acting intramuscular injections, lasting one to four weeks. They may be more reliable than tablets, which many patients neglect to take.

As well as resolving the acute illness, these anti-psychotic drugs will prevent further attacks if taken prophylactically in adequate dosage. Unfortunately, they do produce unpleasant side-effects for which extra medication may be necessary.

Although there have been claims that vitamin treatment is useful, these claims have not been supported by independent researchers.

Persons suffering from schizophrenia in the "chronic"

stage, after the acute symptoms have subsided, often suffer from unpleasant mood changes such as anxiety and depression. These often reflect perfectly understandable reactions to the implications of the illness such as fear of insanity, fear of further breakdowns, and feelings of failure and self-blame. They may be helped by anti-depressant and anti-anxiety drugs.

It is important that people recovering from schizophrenia get adequate psychotherapy, education about their illness, and intensive vocational and social rehabilitation when necessary. Day hospital, group, therapy and workshop opportunities are often helpful at this time.

Throughout the illness there is a need for careful liaison with the family, to keep them informed, to deal with any consequent distress and to assist them in the reintegration of the schizophrenic member. On occasion family members have benefitted from ongoing support groups.

Schizophrenia is not the dreaded disease it was about 30 years ago. Now, with early diagnosis, speedy initiation of treatment, careful monitoring of medication and psychotherapy when considered appropriate, the long-term outcome is quite favourable. Even in severe cases the illness may remit spontaneously after a few years, so that even when the course of illness seems particularly frustrating one can be hopeful of a good long-term outcome.

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Revised, March 1982



# what's happening

## *A victory for human rights*

It was a victory on November 25 for handicapped and/or institutionalized people everywhere when cerebral palsy victim Justin Clark was declared mentally competent and free to live his own life. The decision handed down by Judge John Matheson followed over a year of legal skirmishing and — the judge's pleas and all other efforts toward an out-of-court settlement failing — an internationally broadcast six and a half day trial in Perth, Ontario. Ronald Clark of Ottawa, Justin's father, initiated the case by seeking an application to declare his 20-year-old son mentally incompetent so that a legal guardian — probably his parents — could be put in charge of his affairs. Justin sought instead the independence to make fundamental decisions about his own life and, in particular, to choose to leave the Rideau Regional Centre where he has lived since he was two and to seek a more independent and full life at a group home run by a friend and special education teacher in Ottawa.

Justin Clark's courageous appearance in Lanark County courthouse was only the most recent of his efforts to gain autonomy, respect and experience as an individual. For example, David Baker, Executive Director of the Advocacy Resource Centre for the Handicapped (ARCH) and Justin's lawyer, pointed out that just last year, although the Rideau staff had felt Justin capable of deciding in favor of a trip with three others to Quebec City, his father had judged otherwise and permission was refused at the last minute. Until recently, Justin's parents had not visited or answered letters from their son for sixteen years. In court, too, authorities brought by the prosecution sought to invalidate Justin's claim to both mental competence and personal maturity. Justin responded to the examination and testified in his own defence using the Bliss communication system that he has been taught since he was twelve by his friend and teacher Carol MacLaughlin. Judge Matheson commented sardonically on the quality of the medical evidence marshalled against Justin:

Considering that a young man had only commenced to communicate at thirteen years of age and had lived in the society of seriously retarded patients at Rideau on the multiphasic unit all his life, is it reasonable that he should be exposed to vocabulary tests which distinguish serpent from snake, cascade from waterfall or faucet from tap? It would seem to me as reasonable to test Tarzan's intelligence by tests appropriate to the environment of Jane. Nor are tests which depend in large measure upon muscular dexterity appropriate for a person so grossly disabled with cerebral palsy. It seems from the evidence that Dr. McCreary's lengthy examination was a physically painful ordeal for Justin . . . He reports Justin's ability to write and read his own

name, to answer questions generally and to remember exactly the date of his last interview some fourteen months earlier. Dr. McCreary records a number of spelling failures. I felt his approach to the examination to be tendentious and unsympathetic.

The testimony of Justin's friends, on the other hand, Judge Matheson called "noteworthy for insight, approach and commonsense . . . Justin has the great gift of friendship . . . I see his extraordinary gifts of sincerity, trust and cooperation conjoined with his helpfulness as assets in any L'Arch type community, and one such is now operated by Normand Pellerin (in Ottawa)."

The final judgment lay with Judge Matheson, whose words are as consistently outstanding as his judgement:



Sir William Blackstone in Book the First of *Commentaries on the Law of England* stated in 1809 that the principle aim of society is to guard and protect individuals in the proper exercise of their individual rights. Such rights be characterized as absolute. I believe a courageous man such as Justin Clark is entitled to take a risk.

With incredible effort Justin Clark has managed to communicate his passion for freedom as well as his love of family during the course of this trial. We have recognized a gentle, trusting, believing spirit and very much a thinking human being who has his unique part to play in our compassionate interdependent society.

So, in the spirit of that liberty which Learned Hand tells us seeks to understand the minds of other men, and remembers that not even a sparrow falls to earth unheeded, I find and declare Matthew Justin Clark to be mentally competent.

These are heartening words, and action, in these none-too-heartening times. Our best tribute is to take courage from them that the labeling and denial of rights that still frustrate the lives of all handicapped people are, increasingly, giving way to respect and recognition for the wonder and living reality that each "Justin Clark" can be — and is.

## *Psychiatrists are "shocked"*

By STEVE TWOMEY  
Knight-Ridder News Service

The end was near. The voters had interfered, but Dr. Martin Rubenstein was still at it. He would get in all he could.

Just that morning — Wednesday — he had driven from his office in nearby Oakland to Herrick Hospital here to do it once more, to one more patient: inject the sleeping drug, attach the wires, send the electricity coursing through the patient's brain, induce the convulsions.

Certainly it seemed an unpleasant and even cruel treatment, he acknowledged. But it was necessary for the patient's well-being, he insisted; it makes the depressed less so.

In fact, it was done 485 times at Herrick last year, to 45 patients. Perhaps they even ought to do it more. "I think electro-shock is underutilized," he said.

And then he became angry.

Because starting Saturday, Rubenstein's professional thoughts will not count for much. Starting Saturday, Herrick Hospital will not be able to use electro-shock even once a year, let alone 485 times. Starting Saturday, it will be a crime for any doctor to shock any patient in Berkeley.

For, in this university community famous for its anti-establishment ways, it is the patients and the people who have shocked the doctors, at the polls.

Led by a coalition of social activists and former mental patients, many of whom had received shock treatment, the voters of Berkeley last month overwhelmingly approved an initiative banning such treatment at Herrick Hospital, the only facility in Berkeley that provided it.

Actually, the vote will have little practical effect. Any psychiatrist in Berkeley who believes a patient is so depressed and suicidal that shock therapy is necessary can easily obtain it at Providence Hospital in Oakland, or Walnut Creek Hospital in Walnut Creek or St. Francis Hospital in San Francisco, across the bay. Rubenstein, in fact, already has started making arrangements to shift some of his patients.

But to the victors, it was a symbolic initial victory in what they hope will become a nationwide attack on what they term a "barbaric" practice that they believe does more harm — to body and spirit — than good.

"I think it's great," said Ted Chabasinski, 45, a coalition leader who received several years of shock treatment when he was young. "What kind of a way is that to treat human beings? How can permanent brain damage make people feel better?"

To the psychiatrists, it was a troubling vote of no-confidence, a triumph of fear and ignorance over reason and medicine. "It is what I call pathological consumerism," Rubenstein said. "The city of Berkeley has once again besmirched itself!"

But the issue goes beyond shock treatment itself. For what might be the first time in U.S. history, the residents of a community have stepped into the field of medicine to rule a specific medical treatment out of bounds.

For that reason, the medical community in California and across the nation has been stunned by the vote and is mobilizing legal challenges to have it overturned. A suit is expected to be filed in California next week that will contend that the state, not voters by direct vote, has pre-eminent powers of licensing and control in medical matters.

But for now, the psychiatrists are, to put it mildly, "shocked" by the landmark decision.

## *The Case of Eldon Hardy*

Like thousands of other psychiatric inmates, Eldon Hardy is a victim of Ontario's "mental health system." Eldon has been locked up and abused for roughly eleven years—ten years in Penetang (Oak Ridge) and fourteen months in Toronto's Queen Street Mental Health Centre. Since last September, Eldon has been incarcerated in Queen Street's medium security unit, which is more oppressive than METFORS (Queen Street's forensic unit run by the Clarke Institute of Psychiatry) where he was locked up for the previous ten months without any fresh air, exercise or outdoor recreation. (Even prisoners in solitary or maximum segregation are allowed thirty minutes a day of outdoor exercise.)

In 1972, Eldon was charged with two offences, committing buggery and indecent assault on a boy. Instead of being sentenced to prison (in which case he would have been released in about three years), Eldon was sentenced to Penetang under a Warrant of the Lieutenant Governor, which legally allows the government to imprison any person indefinitely after they've been judged unfit to stand trial or not guilty by reason of insanity. (For a discussion of the injustice of this warrant, see prison issue no. 1, no. 2.) At that time, Eldon was judged not guilty by reason of insanity. However, according to at least three psychiatrists who examined him within the last year and testified at his eleventh Advisory Review Board hearing in November of 1981, Eldon is sane. Furthermore, two senior psychiatrists in METFORS wrote essentially the same thing in an official report last spring.

While locked up in Penetang, Eldon suffered many physical and psychiatric abuses including forced drugging. In the summer of 1981, he laid twenty-six criminal and civil charges against the Penetang staff including staff psychiatrists. To date, these charges have been blocked by the criminal justice system. In addition, the administration of 'Queen Street,' particularly Administrator Michael O'Keeffe, has consistently and unreasonably refused to release Eldon during the day,

despite the fact that a change in Eldon's warrant last spring has allowed 'Queen Street' to release him during the day for rehabilitation purposes—to get a job or enrol in an educational program in the community.

Eldon's twelfth Advisory Review Board hearing was scheduled for November 25th but it was postponed, because the Board (chaired by Justice Edson Haines) claimed it needed more recent psychiatric assessments on Eldon. The board apparently didn't approve of Eldon's refusal to talk with any psychiatrists in 'Queen Street' a few months prior to the hearing; however, it had already received favorable reports about Eldon from the psychiatric staff in METFORS within the last six months. The hearing finally took place on December 20th; it lasted over eight hours. Eldon's lawyer, John Gorman, ON OUR OWN member and Alderman David Reville and Ontario Liberal Party health critic Sheila Copps were there to support Eldon—they recommended that he be transferred to an 'open' ward where he could be released

during the day. A group of Ministry of Health officials, Administrator Michael O'Keefe and Queen Street's Medical Director, Dr. Andrew Malcolmson, opposed Eldon's release. Eldon read out a personal statement which was favorably received.

It's anyone's guess when the Board will notify Eldon and his lawyer of its decision—it could be months. (The Board hears complaints or appeals from inmates under warrant for criminal behaviour; inmates under warrant are allowed only one hearing a year. There is no appeal of the Board's decision.)

**NOTE:** We urge people wishing to support Eldon Hardy to sign a petition in the ON OUR OWN drop-in. If you wish to visit Eldon in Queen Street, please call first: 535-8501, loc. 127 and leave your name and phone number so Eldon can call you back. Thanks.

Here is *Phoenix Rising*'s revised and updated list of Canadian psychiatrists who administer or authorize shock treatments. Listed psychiatrists who no longer use ECT, or who have been mistakenly included in the list, may ask *Phoenix Rising* to remove their names.

If you, a member of your family, or a friend, have been shocked by a Canadian doctor and want his/her name added to our list, please send us the doctor's name and hospital affiliation. We will of course withhold the informant's name, but doctors' names submitted anonymously will *not* be included.

Allodi, Federico. Toronto Western Hospital, Toronto, Ont.

Ananth, Jambur. McGill University School of Medicine, Montreal, P.Q.

Arndt, Hans. Northwestern Hospital, Toronto, Ont.

Boyd, Barry. Penetanguishene Mental Health Centre, Penetanguishene, Ont.

Brawley, Peter. Toronto General Hospital, Toronto, Ont.

Conn, Bert. Belleville General Hospital, Belleville, Ont.

Cornish, David. Alberta Hospital, Edmonton, Alta.

Eades, B. Riverview Hospital, Port Coquitlam, B.C.

Eastwood, M.R. Clarke Institute of Psychiatry, Toronto, Ont.

Furlong, F.W. Sunnybrook Medical Centre, Toronto, Ont.

## Shock doctors up to date

Giles, Charles. Alberta College of Physicians & Surgeons, Edmonton, Alta.

Gray, Trevor A. St. Michael's Hospital, Toronto, Ont.

Gulens, Vlademars, Jr. Chodoke-McMaster Hospital and St. Joseph's Hospital, Hamilton, Ont.

Haden, Philip. Kingston Psychiatric Hospital, Kingston, Ont.

Heath, David S. Kitchener-Waterloo Hospital, Kitchener, Ont.

Hoffman, Brian. Clarke Institute of Psychiatry, Toronto, Ont.

Jeffries, Joel. Clarke Institute of Psychiatry, Toronto, Ont.

Jenney, Leslie. St. Joseph's Health Centre, Toronto, Ont.

Kolivakis, Thomas. McGill University School of Medicine, Montreal, P.Q.

Lehmann, Heinz. Foothills Hospital, Calgary, Alta.

Littman, S.K. Clarke Institute of Psychiatry, Toronto, Ont.

McFarlane, W.J.G. Riverview Hospital, Port Coquitlam, B.C.

Mitchell, Wallace. Greater Niagara General Hospital, Niagara Falls, Ont.

Pankrantz, Werner John. Lions Gate Hospital, North Vancouver, B.C.

Peacocke, J.E. Clarke Institute of Psychiatry, Toronto, Ont.

Pivnick, Bernard E. St. Joseph's & University Hospital, London, Ont.

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Rodenberg, Martin. Kingston Psychiatric Hospital, Kingston, Ont.

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# cruel and usual

## The CIA and Mind Control

BY JOHN MARKS

From time to time little snippets of information come to the surface about the case of Val Orlikow, wife of Winnipeg MP David Orlikow, who was brainwashed in a Montreal hospital under an experimental program funded by the U.S. Central Intelligence Agency.

Last year *Phoenix Rising* reported (Kids and Psychiatry issue, Vol. 1, No. 2) that Mrs. Orlikow had accepted \$50,000 and costs in an out-of-court settlement of her lawsuit against the Royal Victoria Hospital. She is also suing the CIA itself for \$1 million, and so are four other Canadians treated at the Allan Memorial Institute, a separate wing of the Royal Victoria.

In 1973 the CIA destroyed several key documents in an attempt to thwart research being done by the American writer John Marks. However, under the newly-passed Freedom of Information Act, Marks was able to prevent the shredding of further documents and gain access to a mountain of material — some 16,000 pages of classified information about the CIA's experiments in mind control and "psychological torture," as it was described in court.

The full story of what happened to Val Orlikow, and to so many others, will probably never be told. But this is as close to it as we have seen — reprinted by permission of the publishers

Call her Lauren G. For 19 years, her mind has been blank about her experience. She remembers her husband's driving her up to the old gray stone mansion that housed the hospital, Allan Memorial Institute, and putting her in the care of its director, Dr. D. Ewen Cameron. The next thing she recalls happened three weeks later:

They gave me a dressing gown. It was way too big, and I was tripping over it. I was mad. I asked why did I have to go round in this sloppy thing. I could hardly move because I was pretty weak. I remember trying to walk along the hall, and the walls were all slanted. It was then that I said, "Holy Smokes, what a ghastly thing." I remember running out the door and going up the mountain in my long dressing gown.

The mountain, named *Mont Royal*, loomed high above Montreal. She stumbled and staggered as she tried to climb higher and higher. Hospital staff members had no trouble catching her and dragging her back to the Institute. In short order, they shot her full of sedatives, attached electrodes to her temples, and gave her a dose of electroshock. Soon she slept like a baby.

Gradually, over the next few weeks, Lauren G. began to function like a normal person again. She took basket-weaving therapy and played bridge with her fellow patients. The hospital released her, and she returned to her husband in another Canadian city.

Before her mental collapse in 1959, Lauren G. seemed to have everything going for her. A refined, glamourous horsewoman of 30, whom people often said looked like Elizabeth Taylor, she had auditioned for the lead in *National Velvet* at 13 and married the rich boy next door at 20. But she had never loved her husband and had let her domineering mother push her into his arms. He drank heavily. "I was really unhappy," she recalls. "I had a horrible marriage, and finally I had a nervous breakdown. It was a combination of my trying to lose weight, sleep loss, and my nerves."

The family doctor recommended that her husband send her to Dr. Cameron, which seemed like a logical thing to do, considering his wide fame as a psychiatrist. He had headed Allan Memorial since 1943, when the Rockefeller Foundation had donated funds to set up a psychiatric facility at McGill University. With continuing help from the Rockefellers, McGill had built a hospital known far beyond Canada's borders as innovative and exciting. Cameron was elected president of the American Psychiatric Association in 1953, and he became the first president of the World Psychiatric Association. His friends joked that they had run out of honors to give him.

Cameron's passion lay in the more "objective" forms of therapy, with which he could more easily and swiftly bring about improvements in patients than the notoriously slow Freudian methods. An impatient man, he dreamed of finding a cure for schizophrenia. No one could tell him he was not on the right track. Cameron's supporter at the Rockefeller Foundation, Robert Morrison, recorded in his private papers that he found the psychiatrist tense and ill-at-ease, and Morrison ventured that this may account for "his lack of interest and effectiveness in psychotherapy and failure to establish warm personal relations with faculty members, both of which were mentioned repeatedly when I visited Montreal." Another Rockefeller observer noted that Cameron "appears to suffer from deep insecurity and has a need for power which he nourishes by maintaining an extraordinary aloofness from his associates."

**The psychological torture of Val Orlikow**

When Lauren G.'s husband delivered her to Cameron, the psychiatrist told him she would receive some electroshock, a standard treatment at the time. Besides that, states her husband, "Cameron was not very communicative, but I didn't think she was getting anything out of the ordinary." The husband had no way of knowing that Cameron would use an unproved experimental technique on his wife — much less that the psychiatrist intended to "depattern" her. Nor did he realize that the CIA was supporting this work with about \$19,000 a year in secret funds.

Cameron defined "depatterning" as breaking up the existing patterns of behavior, both the normal and the schizophrenic, by means of particularly intensive electroshocks, usually combined with prolonged, drug-induced sleep. Here was a psychiatrist willing — indeed, eager — to wipe the human mind totally clean. Back in 1951, ARTICHOKE's Morse Allen had likened the process to "creation of a vegetable." Cameron justified this *tabula rasa* approach because he had a theory of "differential amnesia," for which he provided no statistical evidence when he published it. He postulated that after he produced "complete amnesia" in a subject, the person would eventually recover memory of his normal but not his schizophrenic behavior. Thus, Cameron claimed he could generate "differential amnesia." Creating such a state in which a man who knew too much could be made to forget had long been a prime objective of the ARTICHOKE and MKULTRA programs.

Needless to say, Lauren G. does not recall a thing today about those weeks when Cameron depatterned her. Afterward, unlike over half the psychiatrist's patients, Lauren G. gradually recovered full recall of her life before the treatment, but then, she remembered her mental problems, too.<sup>1</sup> Her husband says she came out of the hospital much improved. She declares the treatment had no effect one way or another on her mental condition, which she believes resulted directly from her miserable marriage. She stopped seeing Cameron after about a month of outpatient electroshock treatments, which she despised. Her relationship with her husband further deteriorated, and two years later she walked out on him. "I

just got up on my hind legs," she states. "I said the hell with it. I'm going to do what I want and take charge of my own life. I left and started over." Now divorced and remarried, she feels she has been happy ever since.

Cameron's depatterning, of which Lauren G. has a comparatively mild version, normally started with 15 to 30 days of "sleep therapy." As the name implies, the patient slept almost the whole day and night. According to a doctor at the hospital who used to administer what he calls the "sleep cocktail," a staff member woke up the patient three times a day for medication that consisted of a combination of 100 mg. Thorazine, 100 mg. Nembutal, 100 mg. Seconal, 150 mg. Veronal, and 10 mg. Phenergan. Another staff doctor would also awaken the patient two or sometimes three times daily for electroshock treatments. This doctor and his assistant wheeled a portable machine into the "sleep room" and gave the subject a local anesthetic and muscle relaxant, so as not to cause damage with the convulsions that were to come. After attaching electrodes soaked in saline solution, the attendant held the patient down and the doctor turned on the current. In standard professional electroshock, doctors gave the subject a single dose of 110 volts, lasting a fraction of a second, once a day or every other day. By contrast, Cameron used a form 20 to 40 times more intense, two or three times daily, with the power turned up to 150 volts. Named the "Page-Russell" method after its British originators, this technique featured an initial one-second shock, which caused a major convulsion, and then five to nine additional shocks in the middle of the primary and follow-on convulsions. Even Drs. Page and Russell limited their treatment to once a day, and they always stopped as soon as their patient showed "pronounced confusion" and became "faulty in habits." Cameron, however, welcomed this kind of impairment as a sign the treatment was taking effect and plowed ahead through his routine.

The frequent screams of patients that echoed through the hospital did not deter Cameron or most of his associates in their attempts to "depattern" their subjects completely. Other hospital patients report being petrified by the "sleep rooms," where the



NO REALLY! . . . IM A DOCTOR . . . SAY AHHH.

treatment took place, and they would usually creep down the opposite side of the hall.

Cameron described this combined sleep-electroshock treatment as lasting between 15 to 30 days, with some subjects staying in up to 65 days (in which case, he reported, he awakened them for three days in the middle). Sometimes, as in the case of Lauren G., patients would try to escape when the sedatives wore thin, and the staff would have to chase after them. "It was a tremendous nursing job just to keep these people going during treatment," recalls a doctor intimately familiar with Cameron's operation. This doctor paints a picture of dazed patients, incapable of taking care of themselves, often groping their way around the hospital and urinating on the floor.

Cameron wrote that his typical depatterning patient — usually a woman — moved through three distinct stages. In the first, the subject lost much of her memory. Yet she still knew where she was, why she was there, and who the people were who treated her. In the second phase, she lost her "space-time image," but still wanted to remember. In fact, not being able to answer questions like, "Where am I?" and "How did I get here?" caused her considerable anxiety. In the third stage, all that anxiety disappeared. Cameron described the state as "an extremely interesting constriction of the range of recollections which one ordinarily brings in to modify and enrich one's statements. Hence, what the patient talks about are only his sensations of the moment, and he talks about them almost exclusively in highly concrete terms. His remarks are entirely uninfluenced by previous recollections — nor are they governed in any way by his forward anticipations. He lives in the immediate present. All schizophrenic symptoms have disappeared. There is complete amnesia for all events of his life."

Lauren G. and 52 other subjects at Allan Memorial received this level of depatterning in 1958 and 1959. Cameron had already developed the technique when the CIA funding started. The Agency sent the psychiatrist research money to take the treatment *beyond this point*. Agency officials wanted to know if, once Cameron had produced the blank mind, he could then program in new patterns of behavior, as he claimed he could. As early as 1953 — the year he headed the American Psychiatric Association — Cameron conceived a treatment he called "psychic driving," by which he would bombard the subject with repeated verbal messages. From tape recordings based on interviews with the patient, he selected emotionally loaded "cue statements" — first negative ones to get rid of unwanted behavior and then positive to condition in desired personality traits. On the negative side, for example, the patient would hear this message as she lay in stupor:

Madeleine, you let your mother and father treat you as a child all through your single life. You let your mother check you up sexually after every date you had with a boy. You hadn't enough determination to tell her to stop it. You never stood up for yourself against your mother or father but would run away from trouble... They used to call you "crying Madeleine." Now that you have two children, you don't seem to be able to manage them and keep a good relationship with your husband. You are drifting apart. You don't go out together. You have not been able to keep him interested sexually.

Leonard Rubenstein, Cameron's principal assistant, whose entire salary was paid from CIA-front funds, put the message on a continuous tape loop and played it for 16 hours every day for several weeks. An electronics technician, with no medical or psychological background, Rubenstein, an electrical whiz, designed a giant tape recorder that could play 8 loops for 8 patients at the same time. Cameron had the speakers installed literally under the pillows in the "sleep rooms." We made sure they heard it," says a doctor who worked with Cameron. With some patients, Cameron

<sup>1</sup>Cameron wrote that when a patient remembered his schizophrenic symptoms, the schizophrenic behavior usually returned. If the amnesia held for these symptoms, as Cameron claimed it often did, the subject usually did not have a relapse. Even in his "cured" patients, Cameron found that Rorschach tests continued to show schizophrenic thinking despite the improvement in overt behavior. To a layman, this would seem to indicate that Cameron's approach got only at the symptoms, not the causes of mental problems. Not deterred, however, Cameron dismissed this inconsistency as a "persistent enigma."

intensified the negative effect by running wires to their legs and shocking them at the end of the message.

When Cameron thought the negative "psychic driving" had gone far enough, he switched the patient over to 2 to 5 weeks of positive tapes:

You mean to get well. To do this you must let your feelings come out. It is all right to express your anger... You want to stop your mother bossing you around. Begin to assert yourself first in little things and soon you will be able to meet her on an equal basis. You will then be free to be a wife and mother just like other women.

Cameron wrote that psychic driving provided a way to make "direct, controlled changes in personality," without having to resolve the subject's conflicts or make her relive past experiences. As far as is known, no present-day psychologist or psychiatrist accepts this view. Dr. Donald Hebb, who headed McGill's psychology department at the time Cameron was in charge of psychiatry, minces no words when asked specifically about psychic driving: "That was an awful set of ideas Cameron was working with. It called for no intellectual respect. If you actually look at what he was doing and what he wrote, it would make you laugh. If I had a graduate student who talked like that, I'd throw him out." Warming to his subject, Hebb continues: "Look, Cameron was no good as a researcher... He was eminent because of politics." Nobody said such things at the time, however. Cameron was a very powerful man.

The Scottish-born psychiatrist, who never lost the burr in his voice, kept searching for ways to perfect depatterning and psychic driving. He held out to the CIA front — the Society for the Investigation of Human Ecology — that he could find more rapid and less damaging ways to break down behavior. He sent the Society a proposal that combined his two techniques with sensory deprivation and strong drugs. His smorgasbord approach brought together virtually all possible techniques of mind control, which he tested individually and together. When his Agency grant came through in 1957, Cameron began work on sensory deprivation.

For several years, Agency officials had been interested in the interrogation possibilities of this technique that Hebb himself had pioneered at McGill with Canadian defense and Rockefeller money. It consisted of putting a subject in a sealed environment — a small room or even a large box — and depriving him of all sensory input: eyes covered with goggles, ears either covered with muffs or exposed to a constant, monotonous sound, padding to prevent touching, no smells — with this empty regime interrupted only by meal and bathroom breaks. In 1955 Morse Allen of ARTICHOKE made contact at the National Institutes of Health with Dr. Maitland Baldwin who had done a rather gruesome experiment in which an Army volunteer had stayed in the "box" for 40 hours until he kicked his way out after, in Baldwin's words, "an hour of crying loudly and sobbing in a most heartrending fashion." The experiment convinced Baldwin that the isolation technique could break any man, no matter how intelligent or strong-willed. Hebb, who unlike Baldwin released his subjects when they wanted, had never left anyone in "the box" for more than six days. Baldwin told Morse Allen that beyond that sensory deprivation would almost certainly cause irreparable damage. Nevertheless, Baldwin agreed that if the Agency could provide the cover and the subjects, he would do, according to Allen's report, "terminal type" experiments. After numerous meetings inside the CIA on how and where to fund Baldwin, an Agency medical officer finally shot down the project as being "immoral and inhuman," suggesting that those pushing the experiments might want to "volunteer their heads for use in Dr. Baldwin's 'noble' project."

With Cameron, Agency officials not only had a doctor willing to perform terminal experiments in sensory deprivation, but one with his own source of subjects. As part of his CIA-funded research, he

<sup>2</sup>In his proposal to the Human Ecology Group, Cameron wrote that his subjects would be spending *only* 16 hours a day in sensory deprivation, while they listened to psychic driving tapes (thus providing some outside stimuli). Nevertheless, one of Cameron's colleagues states that some patients, including Mary C. were in continuously. Always looking for a better way, Cameron almost certainly tried both variations.

had a "box" built in the converted stables behind the hospital that housed Leonard Rubenstein and his behavioral laboratory. Undaunted by the limits set in Hebb's work, Cameron left one woman in for 35 days, although he had so scrambled her mind with his other techniques that one cannot say, as Baldwin predicted to the Agency, if the prolonged deprivation did specific damage. This subject's name was Mary C., and, try as he might, Cameron could not get through to her. As the aloof psychiatrist wrote in his notes: "Although the patient was prepared by both prolonged sensory isolation (35 days) and by repeated depatterning, and although she received 101 days of positive driving, no favorable results were obtained."<sup>2</sup> Before prescribing this treatment, Cameron had diagnosed the 52-year-old Mary C.: "Conversion reaction in a woman of the involutional age with mental anxiety; hypochondriac." In other words, Mary C. was going through menopause.

In his proposal to the CIA front, Cameron also said he would test curare, the South American arrow poison which, when liberally applied, kills by paralyzing internal body functions. In nonlethal doses, curare causes a limited paralysis which blocks but does not stop these functions. According to his papers, some of which wound up in the archives of the American Psychiatric Association, Cameron injected subjects with curare in conjunction with sensory deprivation, presumably to immobilize them further.

Cameron also tested LSD in combination with psychic driving and other techniques. In late 1956 and early 1957, one of his subjects was Val Orlikow, whose husband David has become a member of the Canadian parliament. Suffering from what she calls a "character neurosis that started with postpartum depression," she entered Allan Memorial as one of Cameron's personal patients. He soon put her under his version of LSD therapy. One to four times a week, he or another doctor would come into her room and give her a shot of LSD, mixed with either a stimulant or a depressant and then leave her alone with a tape recorder that played excerpts from her last session with him. As far as is known, no other LSD researcher ever subjected his patients to unsupervised trips — certainly not over the course of two months when her hospital records show she was given LSD 14 times. "It was terrifying," Mrs. Orlikow recalls. "You're afraid you've gone off somewhere and can't come back." She was supposed to write down on a pad whatever came into her head while listening to the tapes, but often she became so frightened that she could not write at all. "You become very small," she says, as her voice quickens and starts to reflect some of her horror. "You're going to fall off the step, and God, you're going down into hell because it's so far, and you are so little. Like Alice, where is the pill that makes you big, and you're a squirrel, and you can't get out of the cage, and somebody's going to kill you." Then, suddenly, Mrs. Orlikow pulls out of it and lucidly states, "Some very weird things happened."

Mrs. Orlikow hated the LSD treatment. Several times she told Cameron she would take no more, and the psychiatrist would put his arm around her and ask, "Lassie," which he called all his women patients, "don't you want to get well, so you can go home and see her husband?" She remembers feeling guilty about not following the doctor's orders, and the thought of disappointing Cameron, whom she idolized, crushed her. Finally, after Cameron talked her out of quitting the treatment several times, she had to end it. She left the hospital but stayed under his private care. In 1963 he put her back in the hospital for more intense psychic driving. "I thought he was God," she states. "I don't know how I could have been so stupid. . . A lot of us were naive. We thought psychiatrists had the answers. Here was the greatest in the world, with all these titles."

In defense of Cameron, a former associate says the man truly cared about the welfare of his patients. He wanted to make them well. As his former staff psychologist wrote:

He abhorred the waste of human potential, seen most drastically in the young people whose minds were distorted by what was then considered to be schizophrenia. He felt equally strongly about the loss of wisdom in the aged through mem-

ory malfunction. For him, the end justified the means, and when one is dealing with the waste of human potential, it is easy to adopt this stance.

Cameron retired abruptly in 1964, for unexplained reasons. His successor, Dr. Robert Cleghorn, made a virtually unprecedented move in the academic world of mutual back-scratching and praise. He commissioned a psychiatrist and a psychologist, unconnected to Cameron, to study his electroshock work. They found that 60 percent of Cameron's depatterned patients complained they still had amnesia for the period of 6 months to 10 years before the therapy.<sup>3</sup> They could find no clinical proof that showed the treatment to be any more or less effective than other approaches. They concluded that "the incidence of physical complications and the anxiety generated in the patient because of real or imagined memory difficulty argue against" future use of the technique.

The study-team members couched their report in densely academic jargon, but one of them speaks more clearly now. He talks bitterly of one of Cameron's former patients who needs to keep a list of her simplest household chores to remember how to do them. Then he repeats several times how powerful a man Cameron was, how he was "the godfather of Canadian psychiatry." He continues, "I probably shouldn't talk about this, but Cameron — for him to do what he did — he was a very schizophrenic guy, who totally detached himself from the human implications of his work. . . God, we talk about concentration camps. I don't want to make this comparison, but God, you talk about 'we didn't know it was happening,' and it was — right in our back yard."

Cameron died in 1967, at age 66, while climbing a mountain. The *American Journal of Psychiatry* published a long and glowing obituary with a full-page picture of his not-unpleasant face.

D. Ewen Cameron did not need the CIA to corrupt him. He clearly had his mind set on doing unorthodox research long before the Agency front started to fund him. With his own hospital and source of subjects, he could have found elsewhere encouragement and money to replace the CIA's contribution, which never exceeded \$20,000 a year. However, Agency officials knew exactly what they were paying for. They travelled periodically to Montreal to observe his work, and his proposal was chillingly explicit. In Cameron, they had a doctor, conveniently outside the United States, willing to do terminal experiments in electroshock, sensory deprivation, drug testing, and all of the above combined. By literally wiping the minds of his subjects clean by depatterning and then trying to program in new behavior, Cameron carried the process known as "brainwashing" to its logical extreme.

#### From THE SEARCH FOR THE "MANCHURIAN CANDIDATE":

*The CIA and Mind Control* by John Marks

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<sup>3</sup>Cleghorn's team found little loss of memory on objective tests, like the Wechsler Memory Scale but speculated that these tests measured a different memory function — short-term recall — than that the subjects claimed to be missing.



# profiles

*David Oaks, at 26, has impressive credentials.*

*He graduated in 1977 from Harvard, where he studied government and economics, but "feels a little weird about having been at Harvard."*

*He earns what money he needs doing temporary typing work . . . at 100 words a minute. "They even gave me flowers during National Secretary Week," he added.*

*Aside from these accomplishments, two things motivate David Oaks — personal growth and anti-psychiatry movement work. Combined, these have led to his support of larger issues, like the recent peace march on the United Nations.*

"When you get locked up, you realize that a lot of other people who say they were wrongfully locked up or drugged or oppressed may be right. So you're willing to think and act differently about these things as long as you know how to do it carefully.

"Seven years ago I ran into a problem. I'm manic depressive. What happens is I suddenly start going without sleep, thinking a mile a minute, and having ideas, weird philosophical

## David Oaks: Anti-psychiatry activist

BY CONNIE NEIL

beliefs, ideas about religion, technology, love. These are things everyone thinks about, but I tended to act them out, and so I got locked up.

"Usually the Harvard school authorities pressured me into going to the institution, so although technically I went voluntarily, there was a lot of heavy coercion. During my time at Harvard I was inside about five times for periods from a few days to five weeks.

"In the institution they would give me drugs, sometimes forcibly injecting Thorazine, and put me in seclusion which made me really angry. Thorazine totally wiped out my thoughts and feelings for the period of time they

were giving it to me. While you're on that drug, you're unable to think, can't concentrate or make your thoughts articulate. I have a feeling that still follows me through the years, not as intensive as with ECT people, but I think it affects me still," said Oaks.

While Oaks completed his Harvard education, he was only permitted to stay on there provided he received injections.

"Basically what happened was I totally fell in love with this woman at Harvard, absolutely, ridiculously. I really made an idiot of myself. I was totally fixated on her, couldn't get her out of my mind, wandering the streets, walking by the river, her face always in my memory, always in my mind. I just suddenly realized that this was it.

"Anyway, every time I went crazy I would call her up. At the time I think she just tolerated me and it wasn't really a problem for her. Although in a way I guess she was frightened or intimidated by me, I don't think it was a really heavy thing.

"I was cooped up in a small dormitory room, listening to the stereo and coming out of the closet in terms of being alive. I burst out of there at a million miles an hour. And you're not supposed to do that.

"Another time I went crazy publishing a poetry magazine called 'padan aram' whose motto was 'all experimental art is to some degree reckless' — and these poets had me locked up," said Oaks.

His last day at Harvard was the last time he took an injection. Oaks has not been hospitalized or drugged since then.



"After graduation I did about four years work with the Boston group Mental Patients Liberation Front (P.O. Box 514, Cambridge, Mass. USA 02238). They taught me many things. I wrote my senior paper on the organizational structure of MPLF to analyze how it was organized. Looking at how things are organized has helped ever since in my work for the movement.

"Harvard didn't teach me a thing compared to MPLF who taught me backpacking, friendship, anti-sexism, radical politics, community organizing, grant writing, press releases, dealing with the press, handling meetings, finding that trusted people can filch from the treasury, that your office can be ripped apart — that these things can happen and that you have to go on, that it's all human.

"I gained a lot from all the wonderful people there. I think ex-mental patients are fascinating, a great minority with their own culture, all unusual people. For me, different kinds of people is where it's at. A novelist today could not write about the corporate world because they're all the same. He'd have to write about ex-mental patients because they're willing to be different," explained Oaks.

After eight years in Boston, Oaks left a year ago.

"The reason I left was because I'd been thinking a lot about ways people are controlled. I drew up at my office job, (where I didn't have to do any thinking work) a list of goals in order to get me past the controlling influences of society.

"I decided that society, my past, having to earn money to get by, problems, oppression, media — all these different influences control our minds and the way we think.

"I sort of built a 'space suit', set my goals for everyday life and now I check how they're doing from time to time. The suit makes it possible to walk freely from the mind control.

"My goals are seven: spirituality, expression, thought, health, friends, anti-fascism, and nature's beauty.

"I never let money influence me unless it's necessary for a particular goal. If your goal is to be happier about yourself and you need a car to do that, then you need a job. But perhaps you can bypass the job and car and still feel happier about yourself. I support myself, but money is a problem if I'm going to do it on my own terms," said Oaks.

During this last year on the road David Oaks has contributed his work to other anti-psychiatry groups like the Alliance for the Liberation of Mental Patients in Philadelphia.

"I also helped out a little with *Madness Network News* and the Network Against Psychiatric Assault, who share an office in Berkeley, California," said Oaks.

For the May '82 Conference in Toronto, Oaks arrived early to help with last-minute details and planning. He wrote some press releases, facilitated some Conference meetings and actively supported the Sheraton Sit-In. After the Conference he stayed on to write his impressions for the *Phoenix Rising* Conference issue.

Oaks uses his skills in other political groups — anti-nuclear power, anti-nuclear war, feminist issues, progressive leftist politics — to name his favourites. "I've helped organize a lot of demonstrations," he added.

"For my improved health it is very important to get enough sleep, eat the right food, not take any harmful drugs, have a network of supportive friends, and do political work so you can change a bad system and turn your experience into a positive thing so it won't happen to you again or to other people," said Oaks.

After the peace march, David Oaks returned to his parents' home in Chicago where he is currently working on freelance anti-psychiatry articles for publication.

## ?? Friends of Schizophrenics ??

BY CONNIE NEIL

Ontario Friends of Schizophrenics has a mighty fat stick to shake at the powers that decide how things will go for the psychiatrized. Fifteen hundred families in Toronto alone can't be ignored. When you consider that their first meeting in June 1978 drew fifteen families which have grown to fifteen hundred in four years, and that the Toronto branch president Claire McLaughlin feels that "We are moving slowly. We're a very young group," you have some idea that this growth figure has just begun to climb.

All funding comes from donations. Family membership is \$5 yearly, \$2.50 of which goes to the provincial body. This does not even cover the postage to send newsletters containing summaries of the informational monthly public meetings in Timothy Eaton Memorial Church on St. Clair Avenue West the last Wednesday of each month, excepting December, at 8:00 p.m. Additionally, family support groups meet at 7:30 p.m. in Etobicoke General Hospital on the second Tuesday, and at Sunnybrook Hospital on the third

Tuesday. They have an office at Queen Street Mental Health Centre.

OFS is a relatives group. Several inmates were at the October and November meetings, although none participated in any way. Mostly they were discussed in the possessive tense—"My son is sicker than yours"—although one woman related what worked in her family was equal partnership, fair distribution of chores and individuality acceptance.

OFS has a small pilot out-reach program to help those with no family. It consists of finding and renting apartments, providing furnishings, clothing and a \$150 monthly supplement to Family Benefits. A member family will invite them for dinner and be on 24-hour emergency call. All in the out-reach program take their medication. McLaughlin uses terms like compliance or non-compliance in referring to medication.

When told that the issue was not medication but forced treatment and informed consent, she said, "I don't know any hospital that can force medication on a patient. If a patient is asked if he will take an injection and he says

'no,' well he doesn't get an injection. A patient who is simply extremely difficult to get along with, who is hallucinating at home, who may be causing a lot of property damage, we find generally does not get admitted to hospital. And this is one of the reasons I think our group is important, because we're trying to help families cope with patients hallucinating, not taking medication, acting out, which is very distressing to families and they need help coping with that situation."

Another service of OFS is their home visits, sometimes to families when one member, often the father, is rejecting the schizophrenic diagnosis; sometimes to a pregnant "schizophrenic" who is unaware of her condition and needs pre-natal care.

Experts in related fields regularly speak to the group. The October speakers dealt with the alternative housing programs of Dufferin Residence run by the Salvation Army, Dorset House for women over thirty, and Houselink, a cooperative program. "In terms of housing we're looking at a large facility, I suppose like an institution, where patients would volunteer to come in,

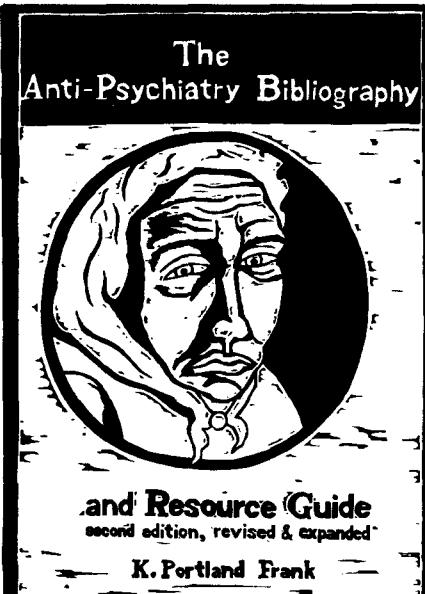
and linked to a hospital, with both active and passive programs," said McLaughlin. "Our patients will need permanent housing in cases of parents' death. Some would leave and find apartments, but could come back. Temporary housing is needed to give families relief. We are seeing family medical problems brought on by stress."

Other speakers have included Dr. Stokes of Penetang to clear up its mystique, a lawyer on wills and trust funds, and a judge on insanity definition and preparation of related criminal defense. "We are seeing patients leave hospital," said McLaughlin, "and immediately go off medication, take out the family car while hallucinating and have tragic driving accidents. Insurance companies do not respond to claims if the patient intended suicide. And if he kills the people in the other car, not only is he incarcerated, but the families are facing tremendous civil suits. We have a lawyer who volunteers advice or defense of this and petty crimes by juveniles."

By far the most popular meetings feature speakers on research. "We have a strong, large medical advisory board," said McLaughlin. "We are interested in research. Dr. Philip Seaman dissects the brains of schizophrenics. He dissects the brains of normal people. They are different under analysis.

"There's no question that the use of neuroleptics could conceivably cause more problems with dopamine receptors," said McLaughlin. "More doctors today are giving patients drug holidays for just that reason. Our people are very nervous about long-term medication. We see patients who go off medication and suddenly have tremendous symptoms never seen before, but in time they go. Neuroleptics wash out of the system in six weeks. Certainly the patients in our out-reach program who are consistently on medication are really doing very well. Those not complying are in much worse shape."

And it is attitudes such as this that make Ontario Friends of Schizophrenics such a potentially dangerous organization. For in the final analysis, the terms they employ are indicative of their condescending, control-oriented attitudes towards "schizophrenics." They use terms like patient, compliance or non-compliance, and mentally ill to describe their members in the community. But when do these patients get to be people? Or be well? The fact that OFS has completely bought the medical model puts it squarely on the side of psychiatry, and I question how much "consumer" criticism can be done from such a hand-in-hand position.



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# the Book-worm turns

## Is There No Place on Earth for Me?

by Susan Sheehan

Houghton Mifflin Company, Boston,  
Mass., 1982, 333 pages.

### REVIEWED BY PATRICIA URQUHART

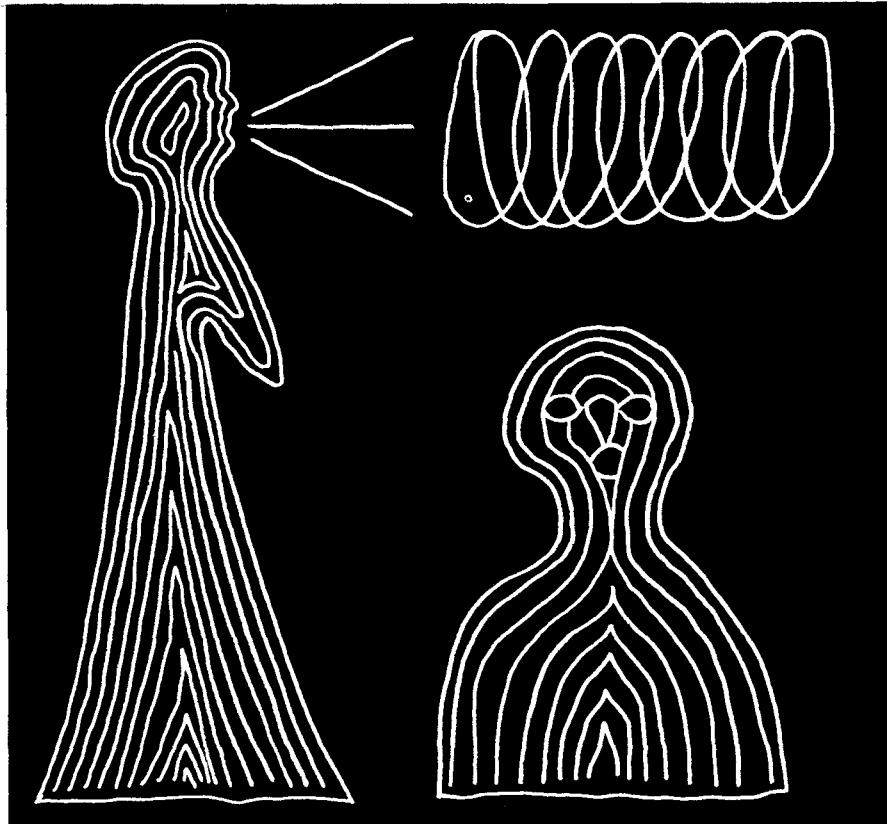
Written by a journalist and staff writer for *The New Yorker*, *Is There No Place on Earth for Me?* purports to be a well-researched and liberal-minded account of the personal and medical history of a woman now in her mid-thirties and commonly diagnosed during the last half of her life as: schizophrenic, chronic, undifferentiated. The coverage and sympathetic press the book has received both in the US and Canada (*Maclean's*, Sept. 20, 1982) confirm the expectation that the author's attitude and handling of the story reflect the latest, most enlightened and morally sensitive thinking on the subjects of "mental illness" and its "treatment". But actually I cannot imagine a stronger (on the personal level) apologia for the status quo in theory and the medical model in practice. The criticism that appears in the account, though often revealing, is always either of individuals — private or professional — or of therapies or the untherapeutic-to-abominable conditions in both home and institutions. Never is there criticism of the fabric of the mental health establishment itself. Rather, both professional intervention and "treatment" are upheld by what is called the "modern" and "scientific" attitude of "biologically oriented psychiatrists", who believe that "mental illness is a physiological or chemical imbalance in the body that is affecting the brain, and should be treated with physical remedies". Not surprisingly, then, Sheehan's ultimate authority, whom she evokes time and time again to comment like a one-man chorus on all the misdiagnoses and controversial therapies, turns out to be a specialist in psycho-pharmacology, acknowledged as Dr. Gideon Seaman.

The existence and diagnosis of schizophrenia, too, are unquestioned here. The author's position on this rein-

forces the medical model of "mental illness" with a vengeance: "... the most enlightened current thinking is that schizophrenia is a variety of illnesses, many of which clearly have a genetic factor that has not yet been documented." From there, Sheehan goes on to talk of "genes of schizophrenia". For the author and her psycho-pharmacological collaborator, schizophrenia exists and is incurable (one is "taught in medical school that schizophrenia is incurable"). Given this point of view, all the issues in approach and "treatment" indeed seem to be reduced to questions of The Right Drug in The Right Dose at The Right Time. Finally, to this agenda, Sheehan adds the apparently progressive suggestion that every psychiatrist with a private — hence lucrative — practice should do the service of taking one back ward inmate into his care or of giving an hour or two a week to working in public hospitals.

Altogether, this book holds some limited interest for the prejudices exhibited and as an indication of the lines of recourse that the mental health establishment is likely to take under attack. The half-truths of which it is full are precisely those most deep-rooted and insidious, those most in the path of clear, truly liberal thinking just now. But it makes still more painful reading when one turns from its perspectives to the subject herself.

Sylvia Frumkin (the ridiculous-sounding pseudonym is due to the author) is the second daughter of a first generation immigrant father and second generation mother, born in East New York. Both her parents were fearful and materially obsessed people who placed high expectations on their daughters' academic success. Sylvia's older sister Joyce more than met these expectations, high-achieving through high school and college and eventually becoming an executive in the fashion



industry, although as an adult she was sufficiently dissatisfied with her personal life to seek counsel. For Sylvia the going was always rougher: she became physically clumsy and careless in appearance and was given to overeating even as a child; her entire school career was one desperate struggle to approach, on rare occasions, her sister's idolized achievements. By her adolescence, Sylvia's father had withdrawn emotionally altogether (only showing much guilt later by his frequent visits when she was hospitalized). Her mother's attitude by adolescence had hardened into petty nagging and continual denigration. She would later comment, for example, after Sylvia's clothes were lost during one admittance into hospital: "It isn't enough that Sylvia has lost her mind. She has to lose all her clothes too."

By high school Sylvia had sought help from a psychiatric social worker who "confirmed Sylvia's fears that something was wrong with her" — a leaden, self-fulfilling prophecy. Soon after the shock of being hit by a car while crossing a street, Sylvia's behaviour became increasingly erratic and she was put on medication; subsequently, she was hospitalized for the first time: diagnosis, "acute, undifferentiated schizophrenia". She was not quite sixteen. Her history henceforth shows the all-too-familiar cyclical pattern ("transinstitutionalization" Sheehan calls it) of institutionalization with some round of "therapy" (one drug or many, mounting in dosage over the years — 15,000 mg. of Thorazine at one point — or electroshock or insulin coma therapy); a gradual lessening of dosages (and discontinuation of ECT or ICT) as "symptoms" abate; the reward of grounds privileges or workshops; and later, the right to move to a transitional centre or halfway house, or back into the hotbed atmosphere of home. Finally, under stress and without stability, she would "decompensate"; that is, her behavior would become more and more extreme and unacceptable and she would be rehospitalized and a new cycle would begin.

The psycho-pharmacological authority comments that "no treatment that she received for 13 years bore any logical relationship to a previous treatment." Indeed the illogicalities are gross, but then, "many psychiatrists . . . don't think her case is uncommon in this respect . . . don't take the time and trouble to study case histories."

Sylvia's high intelligence, imaginativeness and verbal inventiveness resulted in what are seen as brilliant performances whenever she was desperate and manic. Yet one monologue, recorded while she was reading a hospital folder during an admittance and commenting on it to herself, shows the acuteness with which she illuminated even the highest stressed situations:

"Philosophy of Treatment," she read. "'The individual with a problem is best served in his own environment.' I'm against polluting the environment, always have been. 'This is the basic philosophy of the New York State Department of Mental Hygiene and of Creedmore Psy. Center.' They shouldn't use abbreviations. Abbreviations can drive mental patients nuts because they don't know what they mean. 'If he leaves his home to be hospitalized, it is harder for him to return to his former life.' Amen. 'However, for the few who need hospitalization, these facilities are available and every attempt will be made to allow the client privacy, dignity, and comfort.' Privacy? Dignity? Comfort? Bull. All untrue. They're killing people here." (p. 26)

One psychiatrist remarked that "she's a genius at being insane." But Sylvia's is a story of drastically diminishing possibilities. In spite of the intelligence and self-awareness shown by her comments here, the emotional confusion and narrowness of her family life meant that her horizons were not broad — ever.

"When I was at Music and Art, I once had a best friend, Camilla Costello. She was Abbot and Costello's niece. She told me, 'Sylvia, I have many friends, but you're my best friend.' At the same time, I had a therapist named Francine Baden. Francine was my fairy godmother. Those were the best six months of my life, the only normal six months of my life, those six months with Camilla and Francine. I once told Francine Baden, 'Getting well is growing up.' I'm not sure I want to grow up. I'm going to stay Wonder Woman forever."

So even if we agree to speak of Sylvia having "chosen" a "career" at which she was a genius, we shouldn't be misled into overlooking that it was a choice by default — only nominally a choice.

Finally, there is a recurrent, in fact, almost invariable attitude in Sylvia's experience that occurs as regularly in nearly all such histories of those judged mentally ill: the extreme lack of res-

pect for the person's own perceptions, judgments and estimations of their needs. The evidence in this book is that Sylvia — when not desperate — had remarkable insight into her own circumstances, into which people and places were good for her, and which were not. But these perceptions were almost invariably ignored, by-passed or frustrated.

Sylvia Frumkin had, and has, low credibility. More accurately, with rare exceptions, that is all she was ever granted. It is an attitude that shows up with appalling consistency in such "cases", but what I question now is whether this book, with its seemingly sympathetic perspective, does not itself add to the low credibility and lack of respect given Sylvia. Sheehan has been lauded in the press for her heroic actions in "immersing herself in the nether world of mental illness"; indeed, she did undoubtedly spend many hours gathering information firsthand from Sylvia. And, although she claims Sylvia was both "thrilled" with the project and that she "really likes the book" (*Maclean's* interview), I wonder if Sylvia fully trusted her, personally, as a friend rather than as a promoter. Which is not at all the same thing as appreciating, as Sylvia certainly would have, the attention, the limelight. As the author says, "she had always wanted to star."

So I question by what right, if Susan Sheehan had not won Sylvia's real respect and not just her susceptible attention, she could continue to intrude herself into the life of such a defenceless human being. By what personal and morally responsible right, that is, for the "total cooperation" which was given "by the bureaucrats running New York mental illness facilities" is not in doubt. Sylvia Frumkin's story is an unrelenting sequence of one kind of professional intervention and "service" after another, every one with the intention of doing *good* for her rather than *sharing with* her whatever help, private or professional, would follow from simple recognition and respect. I question whether at the same time that Sylvia's dream of starring has been fed, her credibility and self-esteem, as one private and unique and often distressed human being, have not been lowered yet one more time.

For I suspect that, through her patronage and opportune appearance of private crusading, the author has indeed confirmed Sylvia's stardom — and denied her.

**A Mad People's History of Madness,**  
by Dale Peterson, Editor. Pittsburgh,  
PA: University of Pittsburgh Press,  
1982, 368 pp.

### REVIEWED BY DON WEITZ

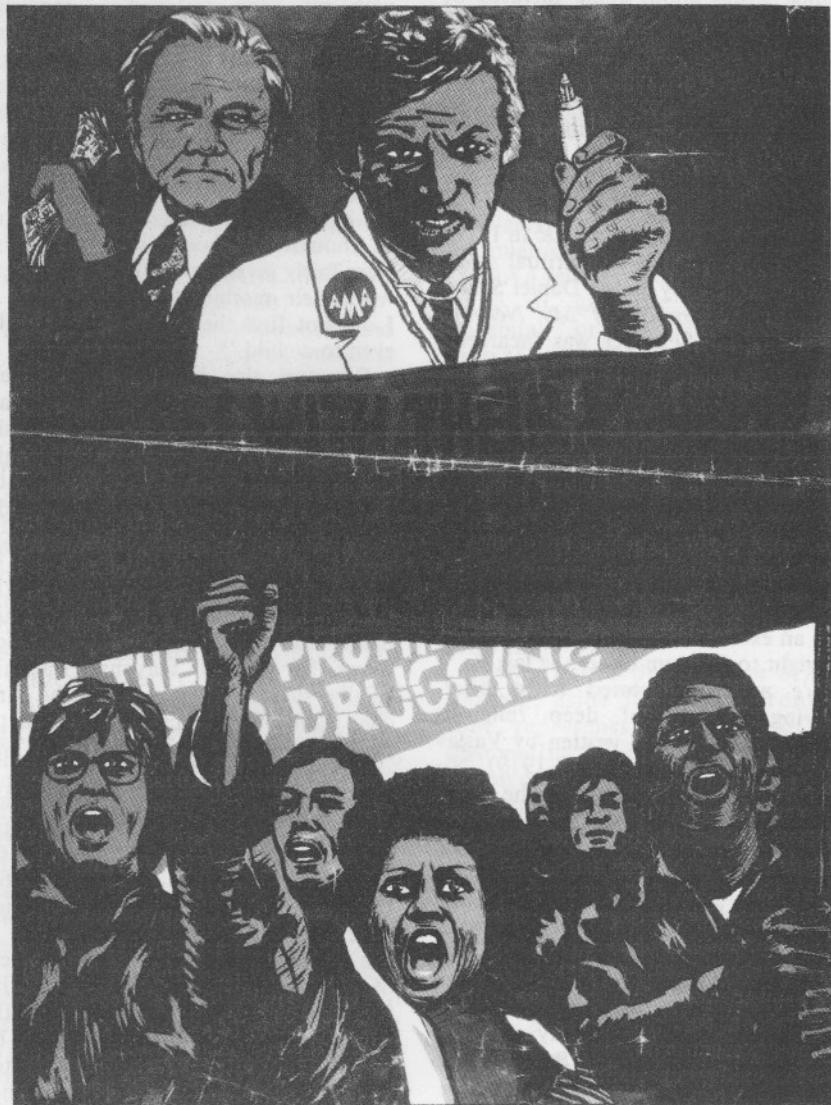
Thankfully, Dale Peterson is not another mental health professional presuming to speak or write for "mental patients." Instead, he's a professor of literature at California's Stanford University and he's compiled some gripping personal accounts of madness and incarceration written by twenty-six "mentally ill" people over the past five hundred years. Although Peterson was never incarcerated or psychiaitized, he worked as a nurse's aide in a California psychiatric institution. (Ken Kesey also worked a few months as a psychiatric aide before he wrote *One Flew Over The Cuckoo's Nest*). It was that experience which stimulated Peterson to produce this book.

*A Mad People's History of Madness* is not the first or best collection of autobiographical accounts of people's experiences with psychiatry, particularly institutional psychiatry, and madness. Other modern anthologies such as Michael Glenn's *Voices From The Asylum* (Harper, 1974), Part I of *Madness Network News Reader* (Glide, 1974) and Charles Steir's *True Stories From The Cuckoo's Nest* (New Republic Books, 1978) are most outstanding for their emotional power and radical perspective.

Although Peterson's purpose is to let the mad speak for themselves about their own madness, his excessively long introductory remarks, commentaries and annoying and irrelevant psychiatric theorizing interfere with the book's purpose and thrust. In the introduction, Peterson sets himself and the reader an almost impossible task by raising too many questions (somewhat rhetorically) which he hopes the book will answer. For example, he asks:

"Is there meaning in madness? Can we know it? What is madness? What was madness? What is the history of madness? Is it a disease, or is it simply a private religion, a little harmless deviance of thought and action? Which is better, institution or no institution? Which is better, psychiatry or no psychiatry? Are we all . . . mad, and is madness really so close to sanity?"

While Peterson doesn't give us any direct answers to these important questions, a careful reading of the book allows us to discover most of them. After reading the numerous chilling accounts of staff/guard abuses of psychiatric inmates and the dehumanizing



atmosphere of institutional life, the reader can easily conclude that the answer to "institution or no institution" is definitely no institution, as well as no psychiatry. And madness is *not* experienced as a disease; the vast majority of writers (except for Mark Vonnegut, who believes he had "schizophrenia") did not feel they were sick or "mentally ill." Most experienced and expressed their madness as agonizing personal, mystical or spiritual experiences, which directly challenge psychiatry's medical model of "mental illness."

If understood and supported by family or friends, especially self-help support groups, madness or craziness can be a period of intense emotional, spiritual or creative growth. In an excerpt from *Beyond All Reason* (1965), Morag Coate gives a sensitive, beautifully written account of how she finally accepted and understood her tortured thoughts and confusion

(labeled "schizophrenia"), partly due to the support of a Laingian psychiatrist. However, when madness is believed to be the work of the devil ("daemonic possession") or an illness and is "treated" in a madhouse or modern psychiatric institution, it is usually torture or hell.

The twenty-six personal accounts in the book span a period of 540 years — 1436 to 1976. This historical approach provides the reader with a very disturbing overview of personal pain and suffering, abuse-humiliation-torture by institutional staff, as well as notable instances of courage and protest by some inmates. For students, researchers and Movement activists, Peterson includes a comprehensive bibliography (over 300 references) of "Writings by Mad People and Mental Patients."

One of the earliest recorded accounts of madness dates back to the Medieval Ages. In her account in 1436, Margery

Kempe writes about being tortured by religious visions and voices of the "devil" or "evil spirits." To many citizens, Kempe usually appeared in a state of frenzy. Peterson comments that she was often "bound hand and foot, with chains of iron" for her "persistent erratic behavior." Kempe barely escaped "death by fire" after being tried and acquitted as a heretic in 1417.

A similar religious or spiritual struggle is described by Judge Daniel Schreber in his *Memoirs of My Nervous Illness* (1903). Schreber was incarcerated for roughly ten years in Germany. For many years, he was obsessed with the idea of "soul murder," suffered "compulsive thinking" and believed he was turning into a woman. (Freud's theory that paranoia is caused by repressed homosexual impulses—since discredited — was largely based on Schreber's case). Judge Schreber finally won his freedom "after two appeals, and an excellent self-defense in court of his right to freedom under the law."

We are also treated to a brief, moving account of deep religious feeling for the world written by Vaslav Nijinsky in his diary (1918-1919). Nijinsky is generally regarded as the greatest dancer that ever lived and a genius. His wife's parents committed him for his unusual or non-conformist behavior and Nijinsky languished in a psychiatric institution in Switzerland for many years until his death. According to Peterson, psychiatrist Eugen Bleuler (inventor of the term "schizophrenia") once "interviewed Nijinsky for ten minutes and then told Romola (his wife) that he was "incurably insane."

The book is also notable for some accounts of protest by a number of courageous inmates. For example, in 1818 Urbane Metcalf tried to inform a British House of Commons investigating committee of numerous abuses committed by staff which occurred while he was locked up for two years in England's notorious Bedlam asylum. Metcalf personally experienced and witnessed routine beatings and complained about them — often quite openly to staff. He also knew that some guards murdered one inmate (the murder was covered up) by drowning him in a bathtub and he witnessed staff manipulating inmates to bully other inmates. For his efforts to expose these abuses, Metcalf was put into solitary confinement for one and a half months.

John Perceval, another Englishman, was incarcerated for one and a half years (1831-32) simply because of his "erratic" behavior which included experiencing "visions and voices." In an excerpt from his *Narrative*, Perceval

mentioned these abuses: "put to bed with my arms fastened . . . medicine forced down my throat . . ." Nevertheless, Perceval protested by generally refusing to admit that he was "insane" and sometimes fighting with staff. He was also sane enough to realize that such "treatment" was in fact punishment, its purpose social control — "to the end of my confinement, men acted as though my body, soul and spirit were fairly given up to their control, to work their mischief and folly upon . . . I did not find the respect paid usually even to a child."

Peterson also includes a brief excerpt by Elizabeth Packard of her account of institutional abuses, which she and many other inmates suffered while incarcerated in an Illinois state mental hospital in the mid 1800s. Packard's minister-husband committed her simply because she refused to accept or espouse his religious beliefs; at the time, a sexist Illinois law permitted husbands to involuntarily commit their wives for trivial reasons. Packard finally succeeded in getting the first civil rights bill for psychiatric inmates passed in Illinois. However, the bill was repealed a few years later.

A more recent account of inmate protest appears in Kenneth Donaldson's *Insanity Inside Out* (Crown, 1976). Donaldson was unjustly incarcerated for roughly fifteen years in a Florida state mental hospital. He became a "jailhouse lawyer" and with the help of a civil rights lawyer finally won his freedom and a landmark decision in the United States Supreme Court by proving that he was illegally committed (he was never dangerous) and not "treated" for his alleged "paranoid schizophrenia." Only two or three years ago, Donaldson was awarded a little over \$30,000 for his many years of suffering and wrongful imprisonment.

Although this book is often gripping, Peterson has the annoying habit of lapsing into medical/psychiatric jargon, e.g., "psychosis," "hallucination," "delusions," "schizophrenia," which betray his uncritical acceptance of the medical model. And I was particularly annoyed by reading almost a whole page in which Peterson summarizes the bogus "biochemical theory of schizophrenia" as propounded by Larry Stein, a researcher with Wyeth Laboratories in Philadelphia. Peterson also repeats the common myth that the "effective anti-psychotic medications" were largely responsible for reducing the large inmate population in U.S. mental hospitals in the 1950s and 1960s.

Finally, the book is not as powerful and up-to-date as it should be. This is because Peterson did not include recent

protest writings by some of the most outspoken anti-psychiatry activists (except for Donaldson) in the Psychiatric Inmates Liberation Movement. Peterson is either unaware of or chooses to ignore the Movement. Had he included writings by ex-inmate activists, the book would have had some political clout and a greater credibility.

**Living and Working with Schizophrenia,**  
by M.V. Seeman, S.K. Littmann, E. Plummer, J.F. Thronton, and J.J. Jeffries. Toronto: University of Toronto Press, 1982, 146 pp.

## REVIEWED BY CONNIE NEIL

*Living and Working with Schizophrenia* is the collective work of five psychiatrists. In addition there is a foreword by writer Margaret Gibson (the only signed piece; other sections are handled anonymously) and personal accounts by two mothers, a father, two "schizophrenics" and a doctor. So it would seem there might be various points of view expressed in the work. On the contrary, all speak with a single voice: the established view of psychiatry that those once labelled as "schizophrenic" must forever take neuroleptic medication which, although it cannot cure them, should probably make their symptoms less bothersome to those around them.

This represents a fairly new tack for the psychiatric profession, in that previously the cloak of mystery and secrecy included not just the "patient"—the one most concerned with "treatment"—but also the parents, siblings, spouse or children of the affected person, and usually the group s/he lives with and will return to after "treatment". Now psychiatry recognizes the benefits of wooing the relatives of the "schizophrenic" to help with the management of their prescribed program.

Under "Basic Information" (about two-thirds of the book) they cover what schizophrenia is, inpatient and outpatient treatment, medication, how relatives can help, support for relatives, work and school, and the future. The latter third consists of the personal accounts mentioned above and appendices of agencies, services, self-help relatives groups and suggested readings.

According to the authors, schizophrenia is a "variety of illnesses in each of which there may be somewhat different symptoms and for which the cause may also be different." Well, I'm glad

they cleared that up. It has long been suspected that "schizophrenia" is a *Catch-22* label in which all questionable problems or people can conveniently be dumped.

The cause is listed as a genetically passed vulnerability which is triggered in a person's twenties or thirties. Stress contributes through faulty dopamine (a natural chemical) transmission in the brain. These complex transmissions are the subject of the bulk of research. In post mortems, they discovered that "schizophrenics" have more dopamine receptors. But they state "it may be partly a result of neuroleptic treatment." This acknowledged paradox—the treatment listed as a possible cause—makes it difficult for informed consumers to wholeheartedly accept that prescribed neuroleptics, given their other distressing "side effects", are good for you. They also discovered through new x-ray techniques (CT scans) areas of shrinkage in the brains of some, but "it is not known if these irregularities produce the symptoms of schizophrenia or if they are a reaction to the illness." Questionable results further caution consumer use in that "positive symptoms (additions, like hearing voices) are more likely than negative (losses, like lessened drive or pleasure) to ease with medical treatment." In other words, psychiatry may have part of an answer, not THE answer. And yet they insist, (forcibly injecting neuroleptics if necessary) that consumers consider this THE answer, regardless of what permanent damage may be done to the brain.

Diagnosis, they tell us, is not easy and "can be made with confidence only when the patient is fully alert." Medicated people, troubled, removed from their environment to incarceration are not likely to be alert, and yet diagnosis is often the reason given for institutionalization.

Symptoms include delusions (thought control, discrimination, body at distance), auditory hallucinations, disturbances of feelings (inappropriate, flat, personal relationships, ecstasy), slowness of movement, and/or a distinct break in life (behaviour or personality). Early warning signs are diminished ability to concentrate, increased self-consciousness and irritability, uncontrollable moods, difficulties in thinking, social withdrawal, increasing suspicion of other people's motives and an inability to sleep.

When you read over all these symptoms and signs, they seem both general and non-threatening. Yet "schizophrenia" is probably the most feared, most violent, shameful and mysterious label that can be given. Likely these connotations are the

reason for the secrecy of the diagnosis—from family and affected person alike. What other illness is kept secret to this extent? Perhaps cancer, because it can kill you. "Schizophrenia" is not fatal, but as there is no cure, once labelled the person is forever a "schizophrenic."

The book groups "schizophrenics" into those who:

1. respond to medication and resume their life,
2. respond to medication, but need family counselling, and
3. do not respond to medication, and are referred for thorough medical evaluation and family counselling.

Conveniently forgotten from this grouping is the one-third of all labelled "schizophrenics" who recover without medical intervention. Because psychiatry cannot discern which ones will recover without "treatment," all suspected cases are prescribed neuroleptics and, if that does not work, ECT, an admittedly controversial "treatment" for "schizophrenics."

In the "Outpatient Treatment" chapter, self-help groups are discussed as presenting a consumer viewpoint to which psychiatry should pay careful attention. As examples of their problem with consumer criticisms, they point to: (1) Judi Chamberlin's *On Our Own* as having "important things to say about mental patients' associations but which categorically rejects medication;" (2) to psychiatrist Thomas Szasz who found her book "an honest and intelligent assault on psychiatric atrocities" but who "rejects the commonly held view (of schizophrenia) as an illness of the brain;" and (3) to Theresa Spitzer's *Psychobattery* which "attacks the use of psychotherapy where medication is indicated." They would like to see psychiatry and consumers be willing to listen and learn from one another and direct the reader to their list of self-help groups. However, only relatives' groups are listed. Not one of the many ex-inmate groups that have formed across North America and the world is mentioned.

The "Medications" chapter provides excellent and complete information, covering twenty neuroleptics by their generic names plus several brand names. (Fluphenazine (Moditen, Prolixin) which is injected as fluphenazine decanoate (Modicate) is covered in this issue's *Phoenix Pharmacy*.) One particularly patronizing comment regarding tardive dyskinesia, the irreversible brain damage resulting from long term medication and seen in tics and facial spasms, cannot pass without note: "Families may find these tics a nuisance, although most patients do

not seem aware of them and often feel they are a small price to pay for the security of staying free of psychosis." What a pompous comment, indicative of a consistently patronizing tone throughout the book.

As the book is chiefly written with relatives of "schizophrenics" as the target readers, it is not surprising that several chapters deal with their problems. They show how background information can help with diagnosis. In case of a relapse, there are a half-dozen ways to get the "patient" to "hospital," or deal with violence, withdrawal or suicidal talk. Relatives groups are praised. And the personal accounts make one realize s/he is not alone.

Approaching work or school, a scholastic assessment builds self-confidence. And although there may be problems—punctuality, initial passivity, extra time off, stress in crowds, unexpected anger, slowness—those able to work make loyal, reliable, indispensable employees.

*Living and Working with Schizophrenia*, aside from its patronizing tone, represents a clear case of professional/institutional bias in relation to "schizophrenia." The authors are all psychiatrists who work out of the Clarke Institute and they are dedicated to propounding the biological model of "mental illness."

## INSIDE OUT

**Two first-person accounts of what it means to be labeled 'Mentally Retarded'**

*Robert Bogdan & Steven J. Taylor*

What does it mean to be 'mentally retarded'? This book gives some of the answers ... answers that many people will not want to hear. The authors, specialists in treating and teaching the handicapped, have interviewed two former inmates of institutions for the retarded. They let them tell their stories in their own words; true and painfully revealing they are powerful indictments of our knowledge of, our thinking about, and our ministrations to the mentally handicapped.  
\$14.95

**University of Toronto Press**



# phoenix pharmacy

## MODITEN: Big Brother in injectable form

BY DR. CALIGARI

A new drug is being widely used in the treatment of mental illness. It is long acting and used by injection — its name is fluphenazine (Prolixin-C). Is this the thalidomide of the 70s? I would like to have the opinion of other doctors. Whilst it is still new, maybe we are lulled into a false sense of security, but are we justified in using a drug, which may take up to six weeks to eradicate from the tissues, without being sure of its safety? Its side effects alone are legion. A study of 13 papers gives the following: Common side effects reported are — lethargy, drowsiness, dizziness, muscular incoordination, paresthesia (skin numbness-C), hypotension, blurring of vision, confusion, nausea, vomiting and aches and pains. Parkinsonism is extremely common. Incidence in reports varies from 100 percent to 24 percent with many reports about 50 percent.

Other reported side-effects include psychotic relapse and glaucoma."

"The simple fact that a number of prisoners are walking the yard in this institution like somnambulists, robots and vegetables as a result of this drug (Prolixin), should be reason enough to make people apprehensive as to the effect it is having."<sup>2</sup> (quote from a petition addressed to the California Senate Committee on penal institutions by La Raza Unida, a Chicano organization of prisoners at California Mens Colony).

Prolixin (fluphenazine) is an 'anti-psychotic' consciousness constrictor with enormous implications and ramifications. When Prolixin was first developed, it was merely one more Thorazine-type drug marketed in tablet/pill form and as fluphenazine hydrochloride, a short acting injectable form with effects lasting a few days. Injectable forms of Thorazine type downers are the main form of coercive, forced drugging.

*In Canada, Prolixin is called either Moditen or Modicate.*

It is easy to 'mouth' pills, that is to hide pills under the tongue, in the cheeks or back of throat, etc., and then spit them out later. As mentioned before a large number of people 'given' such psychiatric drugs do not like the drug's effect on body and mind and would *never* take such drugs voluntarily. Thus, numerous techniques of avoiding such drugs have been invented by psychiatric inmates.

With liquid, or concentrate form, given as tasteless, colorless, odorless syrups in cups, or hidden in drinks or foods, it is obviously harder to avoid the drugs. However, with two to four psychiatric 'technicians' holding an unwilling psychiatric inmate and a nurse, technician or doctor "armed" with a syringe full of such drugs, avoiding forced drugging becomes almost an impossibility. Far more frequently than those on the 'outside' would ever believe, psychiatric drugs are forcibly injected into people in the name of 'treatment', "cure" and control. This is psychiatric RAPE, and any forced treatment equals TORTURE!

It is one thing to get an injection of a mind/muscle crusher drug like Haldol, Thorazine, Stelazine, etc., with the injections' effect lasting 8-12 hours and then slowly disappearing over a day or two. It is quite another situation when the injection contains long acting versions of these drugs immersed in oils with the drugs' effects lasting anywhere from 2-8 weeks. Prolixin Enanthate, and now the newer Prolixin Decanoate, are long acting injectable forms of Thorazine whose effects last longer than 4 weeks from *one* injection.

Thus, 25mg (one injection or one cc,

cubic centimeter of Prolixin Decanoate), a comparatively small dose of orally taken pills, in this long acting injectable form is capable of causing muscle rigidity and zombieism for 4-6 weeks. Think of it, 4-6 weeks of mind and muscle control with only one injection lasting at most two minutes from beginning to end (longer if there is a struggle first, which there often is).

Once the injection is given the person getting this mental/muscle glue has absolutely no way of doing anything about this drug and its effects. There is no way of controlling the strength of the drug once the shot is given. Thus, after one shot of Prolixin, the next month of your life will, in effect, be controlled by other people/the psychiatric system, i.e., psychiatrists, nurses, technicians, social workers, conservators, etc., by means of a drug, which has been deposited in your ass and which slowly seeps into your blood stream day . . . after day . . . after day . . .

No wonder to prison prisoners and psychiatric prisoners, Prolixin is seen as psychiatry's most deadly and damaging psychic poison, and both hated and feared. Who gives the psychiatric system the right to force injections of such drugs into people? Drugs that can cause permanent brain damage, drugs that cause suicidal drug induced depressions and despair, drugs that cause mind and muscle misery, drugs that chemically violate both body and mind?

"After one month of this hell I was released to my sister. I immediately threw all the pills they gave me down the toilet. Three days later (after a shot of Prolixin-C) my whole body went rigid. I kept drooling at the mouth and my legs would not support me. The pain in my head was intense . . . We found out this poison they had given me, Prolixin, had to be taken with the antidote, Cogentin. The 8 weeks it took

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to completely eliminate this drug from my system was the horror of my life. I had a continuous sickening feeling throughout my body. Each minute of this feeling was an hour. The headaches were constant and I had no concentration, only intense irritation at anyone. I had no resistance to sheer terror. When I was living through this, I thought how merciful death would be."<sup>3</sup>

E.R. Squibb, the drug company that manufactured Prolixin, a big money winner, is reaping rich profits from a drug that is a horror in action for many. Prolixin ads continually emphasize how much money can be saved (cost-effectiveness, the 11th commandment of the bureaucracy) with Prolixin injections as compared to pills taken every day, psychotherapy, or other forms of 'helping'.

Now we live in the age of legal psychiatric 'addiction', called 'maintenance therapy'. Prolixin clinics and Prolixin 'maintenance' is hailed by shrinks as 'the answer' to all those problems of drug refusal, the answer to social control. Prolixin is 'the answer', the simple chemical 'answer' to all the complexities of life that lead to 'freak outs' and 'freak ins'. Ultimately this simplistic way of answering complicated life situations reveals itself for what it is, drug controlled therapeutic tyranny, drug dictators in white coats and injectable forms, polypharmacy . . . Hitler would have loved Prolixin!

With injections of Prolixin, 4-6 days after the injection, the highest concentration of the drug in the blood occurs. Then the blood concentration of the drug very slowly goes down over the 2-6 weeks. That is why severe muscle reactions and suicidal drug created 'depressions' are most likely to occur 4-6 days after the injection.

In addition to the severe muscle reactions occurring most frequently 4-6 days after Prolixin injections, the muscle rigidifying-zombifying nature of Prolixin is such that I have seen numerous people looking like waxed vegetables 4-8 weeks after their last injections. This is to say nothing of the state of those who get Prolixin every two weeks, a popular injection 'schedule' these days. Unlike oral drugs which can be stopped if a person has a severe muscle reaction or allergic reaction; Prolixin once injected lasts for at least a month and thus large doses of 'anti-parkinsonian' drugs must be given for Prolixin muscle reactions; inevitably they provide only a partial relief to say nothing of the dangers and drug induced 'bummers' created by the anti-parkinsonians.'

Muscle rigidity and cramps is, however, not the only damaging effect of Prolixin. Besides all the other, non-muscular side-effects, i.e., dry mouth, blurred vision, impotence, sedation, etc., Prolixin is also capable of causing severe drug created 'depressions' or drug induced states of despair and hopelessness. Again, it is often between the 4th and 6th day after the injections that such suicidal hopelessness and drug despair start to reach their height; and it is impossible to determine how many such Prolixin suicides there have now been. Disguised Drug Deaths!

"A week after admission, he received his fortnightly injection (of Prolixin-C). Twenty-four hours later, he became withdrawn, refused food, and took to his bed in mid-afternoon. He appeared sad and miserable, and was unwilling to discuss his state of mind. He remained in this depressed state two days. When he returned to normal, he said that he felt the same way when he attempted suicide. A similar depressive reaction recurred when the injection was repeated a fortnight later. A check on the previous three months showed that he had had an injection of fluphenazine enanthate four days before his suicidal attempt."<sup>4</sup>

"Case 11 — Man aged 41. Inpatient in a mental hospital for six years . . . He was started on intramuscular fluphenazine enanthate, 25 mg every month, which was changed to fluphenazine decanoate three months later. Six days after the first injection of fluphenazine decanoate, he cancelled a promising interview for a job and committed suicide by drowning on the 13th day after the injection."<sup>5</sup>

Today Prolixin injections are being ever more widely used. This drug 'solves' the problem of getting psychiatric and prison inmates to take their pills. It's easy to give, saves time and insures complete control. More and more community mental health centers — community control centers are starting Prolixin 'clinics'. Prolixin IS the 1984 mind/muscle control tool, here today! GONE TOMORROW!, I hope.

Dr. Caligari,  
Madness Network News,  
October, 1976

1. D. West, "Dangers of Fluphenazine", letter to the Ed., Brit. J. Psych. 1970.
2. La Raza Unida Statement.
3. NAPA statement.
4. R. deAlaraon et al, "Severe Depressive Mood Changes Following Slow-Release Intramuscular Fluphenazine Injection", Brit. Med. J. Sept., 1969, p. 565.
5. Ibid. p. 565.

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## GIVING THEM THE BIRD



In this issue, we are proud to award two well-deserved Phoenix Pheathers for outstanding successes against awesome odds.

Our first Pheather goes to the *Coalition to Stop Shock* in Berkeley, California. The Coalition, consisting of nine community and self-help groups of ex-psychiatric inmates and supporters including the Network Against Psychiatric Assault (NAPA), succeeded in banning shock in Berkeley by educating and mobilizing thousands of people about the many real horrors of electroshock. Led by ex-psychiatric inmate and shock victim Ted Chabasinski, the Coalition first succeeded in putting the issue of shock on the ballot as a referendum by collecting 2500 signatures on a petition when only 1400 were needed (See Nov./82 issue.). Then, in a municipal election held last November 2nd, the residents of Berkeley voted by a clear majority (62%) to support the shock ban. The ban rules that any psychiatrist or doctor who authorizes or administers electroshock in Berkeley faces both a \$500 fine and six months in jail. This is the first time that voters in any city in North America have been given the opportunity to decide whether to accept or reject a so-called medical "treatment" and it represents a very big victory for the International Psychiatric Inmates Liberation Movement and all psychiatric inmates who have been or will be subjected to this brain-damaging, psychiatric procedure.

Our second Pheather is awarded jointly to Justin Clark, David Baker, and Judge John Matheson, three people who fought the system and won. Justin, a 20-year-old cerebral palsy victim, fought against an application by his father to have Justin declared mentally incompetent and to have a legal guardian put in charge of his affairs. With the help of his lawyer, David Baker, Executive Director of ARCH (Advocacy Resource Centre for the Handicapped), Justin struggled for the right to make decisions about his own life, and in particular, to choose to leave the Rideau Regional Centre, where he has lived since he was two and to seek a fuller and more independent life in a group home. On November 25, Judge Matheson handed down a compassionate and intelligent verdict which was a victory for handicapped and/or institutionalized people everywhere when he declared Justin Clark mentally competent and free to live his own life. (See this issue of Phoenix, page 19.)



We're awarding this issue's Turkey Tail to the High Park Concerned Citizens Committee for their continued harrassment of the residents of the group home at 114 Indian Road. Despite losing their battle with City Council to change the group home by-law, several committee members repeatedly carried protest signs in front of the home for "mentally handicapped" ex-prisoners. Some of the residents expressed fears for their personal safety in the face of this kind of blatant intimidation. It seems to us that the only people posing any serious threat to this community are those so-called "concerned citizens."

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# Rights and Wrongs

## Psychiatric Treatment: Your Right to Decide

BY CARLA MCKAGUE

The law dealing with consent to medical treatment is of two kinds. First there is "common law", which is the rules developed by the courts over many years by dealing with specific cases. In addition there is "statute law", which consists of laws passed by governments and explicitly written down.

Common law applies except where there is statute law to change it. So it is important to understand *both* the common law rules *and* the written law of your province or territory.

At common law psychiatric treatment, whether in or out of an institution, is subject to the same rules as any medical treatment. One of those rules is that the treatment must be consented to. The only exception is an emergency situation in which consent cannot be given (for example, because the person is unconscious) and in which there is a serious threat that the person will die or suffer grave and permanent physical impairment unless treated.

A consent can be explicit or implicit. An explicit consent is a written or oral agreement to undergo a particular treatment. An implicit consent is one given without particular words of agreement, such as holding your arm out for an injection.

### Who Can Consent?

Usually the person consenting to or refusing the treatment will be the person the doctor wants to treat. However, that person may be legally "incompetent" to make the decision. A young child, for example, is not considered to be qualified to make a decision about treatment, and the responsibility is usually given to the parents.

If a person is undergoing severe emotional distress, and especially if he

or she is hallucinating or hearing voices, he or she may be judged incompetent to make treatment decisions. In this case, the common law is not entirely clear about who, if anyone can make the decision. In general, the person's nearest relative is given that power.

At common law, there is no difference between a voluntary and an involuntary inmate with respect to the right to decide about treatment. The only difference is between the competent and incompetent inmate.

In several parts of Canada, written laws have changed the common law position. In British Columbia, Saskatchewan, Manitoba, New Brunswick and the North West Territories, an involuntary inmate cannot make these decisions. In Quebec, the Public Curator has the responsibility of making decisions for an incompetent psychiatric inmate.

In Ontario, the refusal of a competent inmate (or the nearest relative of an incompetent one) to psychiatric treatment can be challenged by the doctor before a Regional Mental Health Review Board. This board has the power to override a refusal and order the person to undergo treatment.

If someone else is given the power to consent or refuse for you because of your incompetency, that other person has the responsibility of making *the decision you would have made if you were competent*, if there is any way of knowing what that is. If there is no way of knowing your wishes, the person should make the decision he or she considers to be in your best interests.

### How Can I Be Found Incompetent?

Usually the person who decides whether you are competent will be the doctor who wants to treat you. (There

will probably be a strong temptation to find you competent if you agree with the doctor's proposal and incompetent if you disagree). What he or she has to decide is whether you have the capacity to understand the information given to you and make a logical decision based on it.

### What Is a Legal Consent?

It makes no difference legally whether a consent is in writing or oral, and a consent can be withdrawn at any time simply by stating that you have changed your mind. However, to be legally valid, a consent must meet three tests: it must be given by a *competent* person who is legally entitled to give it; it must be *informed*; and it must be *voluntary*.

### What Is "Informed Consent"?

The doctor has an obligation to give you enough information so that you can make a reasoned decision. He or she should tell you about your condition, describe what will probably happen if you do not undergo treatment, explain the effects of the treatment (both good and bad), and tell you about possible alternative treatments. The doctor is not required to tell you absolutely everything. If a treatment has a side effect that is serious but very rare (such as the possibility of dying from a blood test), it need not be mentioned. If a side effect is common but not at all serious (such as slight stomach bleeding from aspirin), this also need not be mentioned.

There is a decision of the Ontario Health Disciplines Board which states that a doctor has an obligation to a person who is taking major tranquilizers to discuss with the person the risks of tardive dyskinesia (see *Phoenix Rising*, vol. 3, no. 2, for a description of this serious and frequently-occurring

effect). A survey done in Ontario in 1981 by the Coalition On Psychiatric Services (COPS), reported in *Phoenix Rising*, vol. 2, no. 4, showed that of more than 100 ex-inmates surveyed, many of whom were on these drugs, not one was told about T.D. In fact, few were given *any* information about their treatment beyond vague assurances that "this will help you". If you are found incompetent, this medical information must be given to the person deciding for you.

## What is "Voluntary Consent"?

"Voluntary" means much more than not being physically forced to undergo treatment. The doctor may not threaten you with commitment, discharge, loss of privileges or any other kind of reprisal if you refuse. As well, he or she may not try to persuade you by saying that you will be released earlier or get some other benefit if you agree. You must reach your decision without threats or promises of any kind.

The COPS survey mentioned above found that this requirement is routinely ignored in Ontario psychiatric institutions. There are many cases of people being "persuaded" to accept treatment they want to refuse (and many more of people being forcibly treated in spite of their refusal).

## How Can I Assert My Right to Decide?

First, *know the law* in your province or territory, and what your rights are.

Second, if you think there is a danger that at some time in the future you will be found incompetent, make sure your wishes are known *now*. Go to a lawyer or a legal clinic and ask to have a formal declaration drawn up stating that if you are ever found incompetent, you do not wish to have a particular treatment or treatments authorized on your behalf. If possible, get a statement from a psychiatrist that at the time of making this declaration you are legally competent to make such a decision. Arrange with the lawyer that if and when you are declared incompetent, he or she will approach the hospital on your behalf and argue that the person giving the substituted consent is bound by your wishes. If possible, discuss your wishes in advance with the person who would be authorized to decide for you.

Third, if you are found incompetent, consider getting legal help to challenge that finding in court.

Fourth, make it clear to your doctor that you know the legal requirements about information and voluntariness, and that if the doctor does not comply you will consult a lawyer. If the doctor

refuses to give you information or attempts to coerce you into agreeing to treatment, get legal help immediately.

If none of this works, then continue to refuse firmly, and preferably in the presence of witnesses. It is unwise, however, to resist physically, as in some places the law allows the doctor to use drugs to "restrain" you, and this may well provide the doctor with an excuse for drugging you to prevent harm to the staff or other inmates.

## What Can I Do If I Have Been Treated Without Consent?

If you have been treated in a way that is against the law, consider taking legal action against the doctor or institution. One possibility is to file a complaint with your provincial College of Physicians and Surgeons. The College will look into your complaint and decide whether it is serious enough for a Discipline Board hearing. (Only about one complaint in twenty gets this far). If the Discipline Board decides your complaint is justified, it can reprimand the doctor, suspend him, or remove him from the rolls immediately. A decision of the College can be appealed to the Health Disciplines Board.

*"The role of consent, especially for the history and epistemology of psychiatry, is so overarching in importance that it is impossible to exaggerate it . . . it is consent and consent alone that justifies cure and treatment (as opposed to control and torture)."*

—Thomas Szasz, M.D.  
*Schizophrenia: The Sacred Symbol of Psychiatry (Basic Books, 1976, p. 134)*

A second possibility is court action, which can be of three different kinds. First, you can lay charges under the *Criminal Code* of assault and battery, since any unauthorized touching is legally a battery. There are other possible criminal charges as well, such as "administering a noxious sub-

stance", which are worth considering. If you are successful, the doctor (and any other staff members you have charged) will have a criminal conviction. The difficulty here is that once you have laid the charge the Crown Attorney has the right to prosecute on your behalf, and also the right to drop the charge if he feels it is not justified.

Second, you can charge a violation of the mental health legislation of your province or territory. In Ontario, for example, anyone violating the *Mental Health Act* may be fined up to \$10,000, and some other provinces provide for fines or imprisonment. The same problem arises with respect to the right of the Crown Attorney to take over and dismiss your charges.

Third, you can bring a civil suit for damages. This will only work if you can prove that you were in fact damaged by the unauthorized treatment — for example, that ECT affected your memory, or lithium caused kidney damage, or Haldol produced tardive dyskinesia. If you are successful, the doctor or institution will have to pay you damages to compensate for your injury. You should be aware that this kind of suit can take a long time and can be very expensive, and that the chances of winning are not very good.

## How Can I Get Legal Help?

If you cannot afford to pay a lawyer, check with the Legal Aid Society in your province. The Society will tell you whether you qualify for free legal assistance from a Legal Aid Clinic or by way of a Legal Aid Certificate. (Some provinces have both these options available, while some have only one). If you have a good case, you should be able to get legal help at little or no cost to you, although the Legal Aid Plan may put strict limits on how much time and money your lawyer can spend on your case.

## Conclusion

The law does provide some protection (although not enough) of your right to make your own decisions about psychiatric treatment. But this protection is useless so long as doctors and other psychiatric professionals know that they can ignore the law safely because inmates are too afraid or too upset or too ignorant of the law to exercise their legal rights. The only way to make sure that our rights are protected is to insist upon them, and to take action against people who infringe upon them.

*Carla McKague is a Toronto lawyer, an ex-psychiatric inmate, and an ON OUR OWN member.*

# Anti-psychiatry Bibliography (Sixth Instalment)

Prepared by Don Weitz

Chamberlin, Judi. *On Our Own: Patient-Controlled Alternatives to the Mental Health System*. New York: Hawthorn Books, Inc. (1978); McGraw-Hill (1979), paper, \$6.50.

An extremely articulate and powerful attack on the psychiatric system including the medical model by an outstanding ex-inmate activist in the Psychiatric Inmates Liberation Movement. Ex-inmate-controlled residences, crisis centres, drop-ins and support groups are advocated as alternatives to psychiatric institutions. Essential reading for all ex-inmates, Movement activists and others committed to radically changing the "system."

Field, Ellen. *The White Shirts*. Self published (1964). Available from author: P.O. Box 4132, Town Center Station, Irvine, CA. 92716. (price unknown).

A collection of hard-hitting personal accounts, essays and poems by an angry psychiatric survivor who clearly sees through and rebels against psychiatric "treatment" as social control. One of the earliest examples of protest writing coming out of the Movement.

Marks, John. *The CIA and Mind Control: The Search for the Manchurian Candidate*. An alarming exposé of the CIA's uses and results of behavioral/mind control techniques during the 1950s and 1960s in the United States, Canada and Europe. The complicity of some high-ranking psychiatrists and psychologists is clearly revealed. A masterpiece of investigative reporting.

Marshall, John. *Madness: An Indictment of the Mental Health System in Ontario*. (Based on the public inquiry commissioned by the Ontario Public Service Employees Union) Toronto: OPSEU (1982), paper, \$7.95.

An investigative reporter's critique of Ontario's "mental health system" from a staff perspective with some reasonable recommendations for change, including a public investigation into psychiatric "treatment" in the province. However, the book is considerably weakened by its lack of testimony from ex-psychiatric inmates, its token criticism of staff abuses or violations of

inmates' rights, and a reluctance to attack institutional psychiatry.

Schefflin, Alan W., and Opton, Edward M. Jr. *The Mind Manipulators*. New York: Paddington Press Ltd. (1978), hardcover. \$14.95.

"A scholarly, heavily annotated yet readable account of the growth of mind-control technology, including lobotomy and the newer forms of psychosurgery, electronic brain stimulation, chemical castration, and electroshock. The authors explore the validity of 'brainwashing' and hypnosis as a means of explaining the dominance of some individuals over others." (Reprinted from *Psychiatry As Social Control: An Annotated Bibliography* by Network Against Psychiatric Assault).

Schrag, Peter. *Mind Control*. New York: Pantheon (1978), hardcover, \$10.

"... a stinging indictment of the mind controllers, those who use mind manipulation (psychiatric propaganda), psychotherapy (temporary or permanent injury to the brain by means of psychoactive drugs, electroshock, psychosurgery) in their attempts to maintain and reinforce the family and social status quo. The implicit message of this book is a warning: we face a growing epidemic not of 'mental illness' but of psychiatric 'treatment' to control and punish the socially different (... labeled mentally ill) ..." (Reprinted from *Psychiatry As Social Control: An Annotated Bibliography* by Network Against Psychiatric Assault).

Sexton, Anne. *To Bedlam And Part Way Back*. Boston: Houghton-Mifflin Company (1960), paper, \$5.50.

A brilliant collection of poignant and haunting poems, many of which touch on the poet's alienation and incarceration in a psychiatric institution.

Smith, Dorothy E., and David, Sara J. (Eds.). *Women Look At Psychiatry*. Vancouver: Press Gang Publishers. (price unknown, out of print).

A good collection of Canadian writings by a few ex-psychiatric inmates and feminist therapists attacking sexism and oppression in psychiatry. With the exception of Eve-Lynne Rubin's

scathing attack on psychoanalysis, there is too much theorizing, but personal protest pieces by Judi Chamberlin, Marsha Enomoto, Barbara Findlay and Barbara Joyce are well worth reading.

Szasz, Thomas S. *The Myth of Psychotherapy*. Garden City, New York: Anchor Press/Doubleday (1978), paper, \$6.50.

Psychotherapy is dissected and exposed as rhetoric, not "treatment". Freud, Jung and other founders of modern psychotherapy are severely criticized for medicalizing the art of conversation and persuasion. Another major assault on the medical model which Szasz began in 1961 with publication of *The Myth of Mental Illness*.

Wertham, Frederic. *A Sign For Cain*. New York: Macmillan (1966), hardcover, \$17.95, (paperback not available).

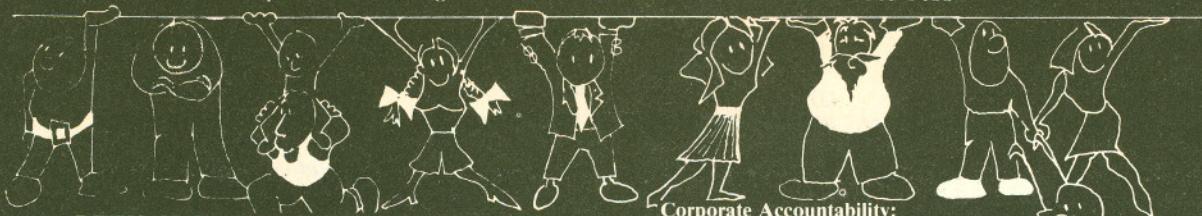
A psychiatrist with a social conscience explores and condemns all forms of human violence. The book features the first published exposé of the mass murder of hundreds of thousands of psychiatric inmates (people "devoid of value" or "useless eaters") by German psychiatrists in Nazi Germany in the early 1930s — a prelude to the genocide in Nazi concentration camps. See Ch. 9, "The Euthanasia Murders," 150-186.

**NOTE:** *Psychiatry As Social Control: An Annotated Bibliography* is an excellent anti-psychiatry bibliography with over 60 references. It was compiled by members of Network Against Psychiatric Assault (NAPA/California), Alliance for the Liberation of Mental Patients (ALMP/Philadelphia) and Mental Patients Liberation Front (MPLF/Boston). Copies are available for \$1 each plus 30¢ for mailing from: NAPA, 558 Capp St., San Francisco, CA. 94110, or ALMP, 112 St. 16th St., No. 1305, Philadelphia, PA. 19102.



# COMMUNITY FORUM ON SHARED RESPONSIBILITY

Top Floor 49 Wellington Street East Toronto Ontario M5E 1C9 361-0466



## LET'S SUPPORT EACH OTHER

The following people are participants in *The Community Forum on Shared Responsibility*, a Toronto social justice network. We want to extend a welcome to all readers of Phoenix Rising to join with us in the struggle for justice.

### Peace Movement

Andrew Van Velzen	361-0466	Cruise Missile Conversion Project
Franz Hrazdira	424-1895	Christian Movement for Peace
Joe Mihevc	968-9264	Cruise Missile Conversion Project
David Wright	361-1444	Newtonbrook United Church
John McLoughlin	690-9242	Toronto Assoc. for Peace
Ken Hancock	534-2714R	Alliance for Non-Violent Action
Robert Penner	537-5540R	Cruise Missile Conversion Project
Danya Agar	694-7922R	East End Peace Action
Maria Louladabis	654-6405R	Youth Coalition For Peace
Frank Showler	466-0566R	Cn. Friends Service Committee
David Martin	537-0438	U of T Anti-Nuclear Group

### Environment:

Eric Salmond	481-5018	The Conservation Council of Ontario
Marilyn Aarons	978-7014	The Foundation of Aggregate Studies
John Willis	922-3011	The Preservation of Agricultural Land
Gayle Richardson	978-6155	Energy Probe
Doug MacDonald	366-9717	Greenpeace
<b>Native People:</b>		Pollution Probe
Barbara Walsh	921-6042	The Cn. Environmental Law Assoc.
Richard Powless	366-3527	Journalist
<b>Penitentiary System:</b>		Union of Ontario Indians
Jake Friesen	922-6128	Quaker Committee on Jails & Justice
Ronny Yaron	667-0999	Toronto Justice Council
<b>Police/Justice System:</b>		
Wilson Head	221-8227	Canadian Civil Liberties Assoc.
David Walsh	361-1124	Citizens' Independent Review of Police Activities (CIRPA)

### Latin American Solidarity:

David Zukus	537-0445	Development & Peace
Ray O'Toole	261-7135	Scarborough Foreign Mission Soc.
Art Blomme	463-7812	Peru Support Group
Alison Acker	534-1707R	C.O.S.P.E.S.
Eva Gulbinowicz	965-2561	Peru Support Group
Peter Stevens	964-6560	Canadian Action for Nicaragua
Barbara Stewart	921-7639R 865-3750	Canadian Action for Nicaragua
Dan Anstett	364-8228	Tor. Guatemala Solidarity Group
Andrew Van Velzen	361-0466	C.O.S.P.E.S.
Gini Dickie	531-3912R	Chile Ontario

### South African Apartheid:

Betsy Alkenbrack	967-5562	Tor. Committee for the Liberation of South Africa
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### Psychiatric Inmates' Rights:

Don Weitz	596-1079R	On Our Own
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### Health System:

Michele Harding	465-6438	Ontario Health Coalition
Trevor Hancock	961-8459	Physician-Medical Reform Group
Michael Stogre	469-1123	Physician-Jesuit Centre
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Angela Pritchard	463-0618	Bridgehead Trading
Geoff Love	366-1518	Is Five Foundation

### Labour

Lynda Arbour	767-4763	Teachers for Social Justice
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### Community Worker Recruitment Network:

John O'Leary	923-3591	Frontier College
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### Women:

Marilou McPhedran	367-7450	Ad Hoc Council of Women
Lynda Ryan Nye	694-1072	Ad Hoc Council of Women
Margaret Hancock	534-2714R	Women's Action for Peace
Mariana Valverde	532-8989R	Internat'l. Women's Day Committee
Pamela Tylee	651-7141R	Internat'l Women's Day Committee

### North-South Issues

David Baugh	929-3041	U of T Doctoral Program
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### Education:

Monica Armour	929-0270	Education Consultant
Katy Walsh	669-0146	Teacher, Public School Board
Lyle McBurney	781-3591	Ont. Assoc. of Alternative & Independent Schools

### Cathy Moffat

Cathy Moffat	485-5972	Student Christian Movement / YWCA Development Educ. Comm. Literacy Program, Frontier College
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### John O'Leary

John O'Leary	923-3591	Urban Alliance on Race Relations
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### Racial Relations:

Carol Tator	598-0111	Christian Leadership Council
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### Political Accountability:

Gerald Vandezande	979-2443	Citizens for Public Justice
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### Immigration & Refugee Policy:

Yonas Haile-Michael	961-9831	Ethiopian Association in Toronto
Khurshed Wadud	463-3662	East Indian Refugee Aid Committee

### Energy Conservation/Recycling:

Alan Englestad	979-2443	Citizens for Public Justice
Marilyn Aarons	978-7014	Energy Probe
Iris Kairow	239-5453	Toronto Recycling Action Committee
Peter Robinson	757-3277	East York Community Dev. Corp.
Geoff Love	366-1518	Is Five Foundation

### Family/Children Issues:

Cecilia Smith	929-3101	Mental Health/Toronto Council
Kenise Murphy	699-1296	Crescent Town Kidsplan

### Childdrive Parkdale

Ann Pohl	537-3520	Childdrive Parkdale
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### The Media:

Wilson Head	221-8227	World Conf. on Religion & Peace
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### William Doyle-

Marshall	923-0853	Media Consultant/Writer
Mary Jo Leddy	361-0761	Catholic New Times
Stephen Ridley	482-3341	Writer/Advertising
Pat Donohue	487-9369	Writer
Murray MacAdam	461-3488R	Cruise Missile Conversion Project

### David Smiley

David Smiley	368-0146	Toronto Clarion
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### Robert Penner

Robert Penner	537-5540R	Cruise Missile Conversion Project
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### Ikram Makki

Ikram Makki	965-2967	Lawyer
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### Farm/Agricultural Issues:

Verna Flowers	826-4150	Ont. Coalition to Preserve Foodlands
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### Ann Pohl

Ann Pohl	537-3520	Ont. Coalition to Preserve Foodlands
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## ...IN SEARCH OF COMMUNITY THROUGH JUSTICE

For further information call 361-0466

Note: The organizations listed are for purposes of identification of the individual's area of interest, and are not intended to imply any formal association with The Community Forum.

*Continued from page 12.*

1. E. Fuller Torrey. *Schizophrenia and Civilization*. N.Y.: J. Aronson, 1980, p. 4.
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4. August B. Hollingshead and Fritz C. Redlich. *Social Class and Mental Illness: A Community Study*. N.Y.: Wiley, 1958. The classic study of classism in psychiatry based on a comprehensive and follow-up studies in New Haven, Conn.; its major findings and conclusions are still relevant and valid.
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24. Leonard Roy Frank. *The History of Shock Treatment*. Self-published, 1978. (Copies available from Leonard R. Frank, 2300 Webster St., San Francisco, CA 94115.) For other excellent, hard-hitting exposes, see: Peter R. Breggin, *Electroshock: Its Brain-disabling Effects*, N.Y.: Springer, 1979; John Friedberg, *Shock Treatment Is Not Good For Your Brain*, San Francisco: Glide, 1976; Phoenix Rising, vol. 1, no. 3 (fall 1980) — shock issue.
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# commentary

## Mental health and violence against women: a feminist ex-inmate analysis



*This position paper is the result of a workshop conducted at the 10th Annual International Conference on Human Rights and Psychiatric Oppression, held in Toronto, Canada, on the 14-18 of May, 1982. We do not claim to be representative of all female ex-inmates, given our feminist perspective, our largely middle-class values, our race (white and North American), and our age (24-37). The members of the workshop met to discuss alternatives to the mental health system in dealing with issues of violence against women. As female ex-inmates we have concerns such as rape, battery, expression of anger, that need to be addressed from our particular perspective. As feminist survivors of psychiatry and violence, we have formulated an analysis which has not been articulated by either the women's movement or the anti-psychiatry movement.*

### **Psychiatry and Violence Against Women are Related**

1. We are raped, battered and blamed. We are told that we have asked for it, and our childhoods are endlessly psychoanalyzed to find the causes of our "masochistic" behaviour. This perpetuates the cultural acceptance of violence against women by "blaming the victim".
2. When we react by getting upset and getting angry at being raped, battered, pushed around and down, we get therapy, we get treatment, we get locked up in mental institutions. There, we are subject to further sexual harassment.
3. When we do turn for support to the system, we learn several things. Men define and judge our experience in terms of quality and quantity: rape on the street by a stranger compared to rape by an acquaintance, lover or stranger, compared

to incest and battery. Certain groups of women are particularly vulnerable according to their status in society: women who are prostitutes or on welfare are taken less seriously than white, middle-class married mothers of two. This causes women to become divided amongst themselves, by denying the pervasiveness of violence in our culture and in all of our lives. The similarities in our experiences with violence are far more important than the particular details or circumstances of our victimization.

4. As women, our credibility is challenged, our words are discounted, regardless of what we say. If we outwardly express our pain by crying or shaking with rage, we are labeled hysterical. On the other hand, if we remain calm, the experience of our victimization is denied or not taken seriously. For ex-inmates, or any women with a record of "mental illness" this problem is exacerbated.

Our status as madwomen is used against us: we're lying, we're hallucinating, or it doesn't matter anyway.

5. Our sisters, feminist therapists, also fail us. They label us, reject us, or just don't see the connections we do.
6. We join the ex-inmate movement, and expect to find sexism, but will not accept the failure of members to recognize it and be accountable for it.
7. Finally, we recognize that we are in a position of relative privilege. We are out of the psychiatric system, we are articulate, and the support we get from each other gives us the strength to speak out. Our passion and urgency derive from the awareness of all the women who are truly powerless; in institutions or after-care, restrained, secluded, drugged, shocked, raped and battered. We have a responsibility to protest what is happening to our sisters.

### **Where Do We Turn When We Are Raped or Battered?**

Raped or battered, we suffer overwhelming feelings including rage, shame, humiliation, powerlessness, self-doubt and guilt. Where do we turn? Ideally, we would turn to our friends, family and community, expressing our anger and sadness safely, and mobilizing our resources in struggle for change. Sometimes, and to some degree, this happens. Unfortunately, these resources for support are usually not available to us, for a variety of reasons.

One set of concerns arises from cultural attitudes which are male defined and violent. When we turn to the people we love, we find that it is still unacceptable to admit that we have been victims of rape or battering. We are judged, or blamed, or politely ignored. It is also unacceptable to admit a need or desire for support.

The second set of concerns has to do with race, class, status, and geography. Some of us have access to resources over which we are more or less in control. For instance, white middle-class feminists may receive support from some women's groups when raped or battered. Some of us can afford to take a vacation or even move if we need to get away from dangerous or abusive living situations. A wealthy woman who protests battering has a better chance of buying sympathetic and competent legal assistance. A woman who can visit a private physician or nurse practitioner or other



health care giver is in a much better position than one who must go to an emergency room for first aid, and there are countless other ways in which women of colour, poor women, women who are prostitutes, single women, and lesbians are denied help.

If we admit that we have been raped or battered, need support, or are hurt by our victimization, we are very likely to come into some contact with the mental health system. Some of us turn to counsellors or therapists because we are told that this is the place to go if we are in emotional distress. Some of us know that we need to talk to other women about what is happening to us, and the only place to find each other may be in a "support group" in a crisis centre or clinic within the mental health system. Others of us are turned into the mental health system because we protest or show our pain. A battered woman who knocks on neighbours' doors, screams for help, or repeatedly calls the police runs a serious risk of being committed to a mental institution. This is particularly true for women less valued by the dominant culture, including black women or women without economic power. Increasingly, we even find that grassroots or feminist alternative support systems are being infiltrated, co-opted, or swallowed whole by the mental health system.

#### **How The Mental Health System Acts Against Us**

1. The first problem is that the mental health system is involved at all. Violence against women is not a personal or individual issue, but a political reality. The concept of "mental health" implies a corresponding pathology, but women who are survivors of violence are not ill. The focus on the individual is destructive for two reasons. Firstly, focusing on the individual woman leads to blaming the victim, either overtly, or through the therapeutic process which searches for hidden motivation. Secondly, this focus leads to an assessment of the rapist/woman-violator as suffering from an individual pathology. He is thus relieved of responsibility for his actions, and the socio-cultural values encouraging violence against women are obscured. We know that rapist/woman-violators are not peculiar. Women's experience attests to this fact. All women are aware that men assume our availability and access to our bodies. This constant is manifested in every facet of our lives; in advertising, in harassment on the street, in the media and in our relationships. Even by the ad-

mission of mental health professionals, it is impossible to distinguish between rapists and "normal" men.

2. Increasingly, our experiences with violence are described in terms of pathological syndromes. For example, there have appeared in the literature references to "rape trauma syndrome", "incest survivors' syndrome" and "battered woman's syndrome". Women have uncritically welcomed this acknowledgement of problems that, until recently, were never discussed. As feminist ex-inmates, we regard as destructive the involvement of mental health "experts" in this discussion. We don't need psychologists to validate our experience. Some of the negative effects of this are:

- a) A hierarchy is created based on the circumstances of our assault. A woman who is gang-raped or raped by a stranger on the street is seen as having undergone a "better rape" than a woman who has been raped by an acquaintance. However, a woman who is raped by her husband or the man with whom she is intimately involved is seen as pathological for remaining in the relationship. Women who have been raped by men of a "lower" race or class

are seen as "more raped" and are therefore more readily believed.

- b) When we label our experiences in terms of syndromes, these artificial distinctions act as barriers to recognizing our common experience, supporting each other and working together for change.
- c) This delineation is a theft of our right and our responsibility to describe our own oppression.
- d) The delineation of symptoms and reactions implies a correct response, which seeks to further control us.

The involvement of the mental health system in issues of violence against women tranquilizes us, either literally or figuratively. At worst, some of us are committed to institutions, and there we are subjected to the most blatant forms of psychiatric oppression: forced drugging, shock, isolation and restraint. Even at best, in relatively supportive, sympathetic and non-coercive situations, we are talked out of our anger or "helped" to direct it in more "appropriate" ways.

The mental health system is insidiously taking over the fight against violence against women. In the face of dwindling financial resources, mental health centres are scrambling for new clients and popular projects to be funded. Women's centres are being co-



opted, at least in the United States, by becoming professionalized and by accepting monies from mental health agencies. Another example arises in the fight for compensation for victims of violent crime. Where compensation is provided at all, as in Canada, validation of pain and suffering as well as of medical expenses is required. We reject the notion that we need a psychiatrist's note to prove that we are upset about our assaults.

#### **Why Feminist Therapy Has Failed Us**

Women in a patriarchal culture face threats of violence and oppression on a daily basis. Feminism is a base of support for women to come together to share collective strategies on how to deal with our common oppression. Women come to the Movement with huge expectations and needs for support, and, often disappointed, turn to feminist therapy to fill that void. This and other uses of feminist therapy are extremely problematic to us as feminists who are former psychiatric inmates who recognize therapy for what it is: a mechanism of social control.

Treating women's emotions as illness does nothing to "restore sanity". Instead, this bastardization of caregiving is a direct contradiction to the central tenet of feminism, i.e., that the personal is political. The history of professionalization of medical treatment should give us as feminists some ideas about the problems of this hierarchical misogynist structure. Men became frightened of the power of women practicing healing arts, labeling them witches and lesbians and worked to destroy them.

Individualizing, personalizing, or therapizing the very real social-cultural, psychological, and physical oppression in women's lives isolates women from themselves, each other, and collective action. This process leaves us without a healthy way to talk about and deal with our feelings. As soon as a woman's feelings become too intense, they are fragmented, segmented, and isolated to the professional therapeutic realm. Therapy is so powerful that it can not only cure the victim, but also cures the victimizer. Would it not be healthier to cure the disease?

As long as feminist therapy exists, with its arbitrary distinctions between therapist and patient, and between women who are well enough to be helped by feminist therapy and those "too sick" and in need of institutionalization, so will psychiatry as a method of social control for all women. All women are vulnerable to the excesses of the psychiatric system. Feminist therapists, like all therapists, maintain the

professional privilege to commit women against their will, "for their own good". This imbalance in power cannot be overcome. Even more unfortunate is the fact that feminists in growing numbers are becoming therapists, thus supporting the notion of extreme emotions as illness with the need for hierarchical professional intervention.

The kind of "patients" feminist therapists want and attract are not at all dissimilar to the type of female patients Schofield (1960) found with whom male therapists "felt they were most efficient and effective with in therapy". The patient was described as being between the ages of 20-40, without any advanced education. This has been described as the "YAVIS syndrome": young, attractive, verbal, intelligent and successful, or in other words, "normal". Continuing to treat "normal" problems as though they were abnormal not only preys on women's needs for support via an exploitative capitalistic relationship, but also perpetuates and abnormalizes caregiving. This does nothing to change women's perceptions of ourselves as "sick", and in need of "objective", "professional" treatment. Instead, by continuing to "treat" women in "professional therapeutic" relationships, one fosters those self-doubts about one's mental health. If women are treated in abnormal ways, we will feel abnormal, and will expect others to view us as such.

How can feminist therapists realistically expect us, the victims of psychiatry, to believe that this or any other "radical therapy" is different and will bring about any real change, when they cannot clearly delineate what feminist therapy is or critically differentiate between feminist therapy and other forms of psychiatric oppression? A somewhat dated, but still relevant study by Broverman et. al. (1970) illustrated that clinicians, both male and female, utilize masculine definitions of mentally healthy behaviour. It is not altogether surprising that those characteristics associated with being a mental patient — passive, dependent, manipulative, and indecisive — also fit the socially prescribed role for women in this culture. The feminist therapy movement has suggested that consumers of their services need to become better consumers by learning how to choose a therapist. This "How to Buy a Refrigerator" argument not only diminishes the therapist's responsibility, but also ignores women who have had all choice removed in their lives, most directly by the legal system, and more indirectly by the coercive nature of the therapeutic

process. This is a more subtle and insidious form of the "blame the victim" theory which has been used to explain virtually every kind of oppression. In addition, this argument totally ignores class issues. Few women can afford to buy a refrigerator — or an hour of talk — when they are now making less than 59¢ for every dollar a white man makes in North America. Estimates show that this figure will be even lower for women of colour. How does an hour of talk change the fact that incest, rape, battery and harrassment are cultural norms? All therapies are an abstraction of reality which keep women talking and not acting. Describing our experience as rape syndromes, as symptoms of incest victims, or by the proper psychiatric label for battered women does not change our experience. Feminist therapies, like all other therapies, are not looking to the survivors for guidance, but are instead relying on clinical judgement. They are not asking us, they are placating us. Treating our anger and our pain as illnesses gets therapists paid by the insurance schemes, but leaves us feeling more "crazy". Nor have feminist therapists taken a position on other critical issues: civil commitment, coercive voluntary commitment, shock, forced drugging. How then are we to trust you? And finally, feminist therapy is a contradiction in feminist terms. Feminism began and continues to survive relying on consciousness raising as the essence for women to come together and support each other, and to collectively define our issues. We are aware of the harmful consequences of having "professionals" define and deal with our issues. Feminist therapy is a part of the psychiatric system and as such it is a method of social control which mirrors larger society.

#### **A Place for Anger**

Our anger is real. Our anger at our experiences of oppression as women and as psychiatric inmates, of being raped, beaten, locked up, drugged, shocked, is valid and strong. It is not a "symptom" to be drugged or therapized away. It is, instead, a source of our power, a fuel for our outrage and our activism. We will not allow anyone — psychiatrist or feminist therapist — to convince us that we are sick because we are enraged, because we refuse to calm down and "adjust" to a "reality" that defines us as inferior. We completely reject the idea that there is an inappropriate degree of anger, an inappropriate length of time for our anger, or an inappropriate object for our anger. We rejoice in our identities as madwomen, as furies, strong and proud.

## A Summary of Our Analysis

The powers that stand behind the systematic attacks on people who are labeled "mentally ill" are the same powers that stand behind woman-hating in the lives of all women, behind the continuation of violence against women. This power is contained in our economic system, within the system of male supremacy. As feminists and ex-psychiatric inmates, this is the point where issues of violence against women and psychiatric assault come together.

The psychiatric system is, in effect, a microcosm of society. Both play an important role in defining how society will operate. In western capitalist society, men are responsible for participation in the labour force, while women are expected to be primarily child care providers, to reproduce the labour force. These sexual roles have become defined as "normal". However, the psychiatric professionals have defined these roles in terms of pathology. The male sex-role is generally regarded as "mentally healthy", while the female sex-roles are "mentally unhealthy". Thus, women are placed in a position whereby, to be healthy women, we must be "unhealthy people", and to be "healthy people", we must be unhealthy women. Women become both "normal" and "abnormal" at the same time. Furthermore, when one defines another human being as "abnormal" or "different", one can more easily justify any maltreatment, including rape, battering and other violence. In the extreme, we see those defined as "different" (Jews, mentally retarded, etc. in Hitler's Germany or Stalin's Russia) as examples of justified violence against those who are different.

Just as the psychiatric system serves the purposes of social and economic control around the world, so violence against women serves the social and economic control of women.

As female ex-inmates, we take back the pride and dignity of self. We take back our credibility. We demand the right and power to define our own needs, issues, and most importantly, our own strategy for support and political action, without "professional" intervention.

### Where We Go From Here

1. We challenge the feminist community to recognize our experience and analysis as ex-inmate women, rather than ignoring us, rejecting us as sick or crazy, or being embarrassed by us. In particular, we ask feminist therapists to acknowledge the contradiction in what they do.
2. We demand that men accept the responsibility for violence against women, and acknowledge the perva-

siveness of misogynous assault, and the fact that this violence is a deliberate strategy for social control. We challenge them to stop rape and abuse.

3. We ask our brothers in the ex-inmate /anti-psychiatry movement to recognize the sexism in the movement, at this conference, and in their relationships. We ask neither for an admission nor a denial of guilt, but a willingness to develop an analysis of this sexism, and a commitment to develop strategies for change.

4. We all have a responsibility to be aware of the role of class, race, and status in the violation of women. We accept this responsibility personally for ourselves, and most explicitly refuse to take part in an anti-rape movement that lends credibility or strength to an attack on people of colour.

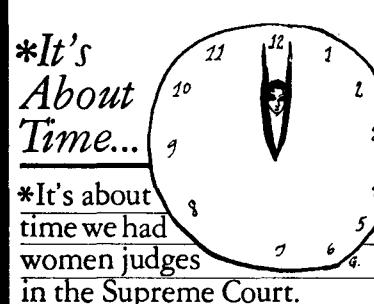
We know that it is important to recognize the value of the least powerful among us, not only because we care about our sisters, but because it is in

our own self-interest to stay together. If lesbians are unsafe and unvalued, every one of us is in trouble. If the rape of women of colour is condoned, then all women are potential victims. If we fail to recognize that a husband forcing sex on a woman is rape, then we are saying that the men we choose always have access to our bodies. If it is acceptable to rape or beat up prostitutes, then not a single one of us is safe. If madwomen, "retarded" women, or women prisoners are acceptable targets for violence, we can all be subject to assault. We speak here because silence is complicity, and we will not consent to assault on any woman. Each of us is precious, unique and valuable.

Virginia Raymond, Austin, Texas  
Dana Lear, On Our Own, Toronto

Rene Bostick, Columbus, Ohio  
Laurie Bradford, Big Mama Rag,  
Denver, Colorado

Judi Chamberlin, Summerville,  
Massachusetts  
Susan Price, Toronto  
Jeanne Dumont, Ithaca, New York



\*It's about time we had women judges in the Supreme Court.

\*It's about time to recognize the rights of Indian Women.

\*It's about time to give welfare mothers a chance.

\*It's about time to change court procedures for rape cases.

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# ON OUR OWN

On Our Own gave its annual Christmas Party on December 26th for its members, featuring a traditional turkey dinner and dance. Many thanks go to all On Our Own members who worked so hard at making it a BIG success. A big THANK YOU also goes to the Red Cross who donated food hampers and toys for our members to make the season a little merrier.

## GRANT NEWS

Last year, a grant received from the City of Toronto under the Community Economic Development grant enabled us to pay the store manager's salary and part of our bookkeeper's salary. This year, the Community Development grant was increased, allowing us to hire an assistant store manager (George Lefebvre) and increase the hours of our truck driver (Roger Anderson) to full-time, as well as increasing the salary of our store manager, Hope Scoville. It is largely due to Hope's efforts that the Mad Market has been doing so well this year.

The Ministry of Health has given us funds under their Winter Experience Program to enable On Our Own to hire nine people at minimum wage for 20 weeks. This has greatly increased our staff in the store, the Drop-In Centre and the office. On Our Own has always had members working in the store and the Drop-In Centre on a volunteer basis, but as a result of these new hirings, the need for volunteers will not be as great for the next 20 weeks. After that period, however, we will again be in need of members volunteering to help in the Mad Market and the Drop-In Centre.

We are now seeking funding to enable us to get the Mad Grapevine out to its members and supporters on a monthly basis rather than every other month. If any member of On Our Own wants to receive the newsletter and hasn't as of yet, call the office (699-3192) and ask to be put on the mailing list.

The last general meeting was held on December 30 and two new board members were elected.

On Our Own has decided to try to provide a monthly dinner before the general meeting on the last Thursday of every month, for the members attending the meeting. This will hopefully encourage members to attend these meetings. Anyone wishing to help out or donate goods for these dinners can call the On Our Own office (699-3192).

The Drop-In Centre is now open 7 days a week for members of On Our Own — on Monday to Saturday from 5 to 11 pm and on Sunday from 1 to 11 pm. Two of the people hired under the Winter Experience Program will be running the social recreation program in the Drop-In. As well, in the future, we hope to expand the hours in which the Drop-In will be open. Keep watching the Mad Grapevine for further details. New programs include: regular film nights, dances, a women's rap group, cooking classes and bingo. If anyone has any ideas or suggestions, you can attend the Social Recreation Committee Meeting every Monday at 7:00 pm.

# the MAD MARKET

1860 QUEEN ST. EAST  
OPEN MONDAY - SATURDAY 9am - 7pm  
MANAGER: HOPE SCOVILLE

... IS A NON-PROFIT USED  
GOODS STORE RUN BY MEMBERS  
OF ON OUR OWN ( a self-help  
group of ex-psychiatric in-  
mates ).

ALL MERCHANDISE IS DONATED.  
WE WILL PICK UP ANYWHERE IN  
THE CITY.

WE HAVE THE BEST DEALS IN  
TOWN ON ALL USED GOODS.

CALL US FIRST.

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# PUBLICATIONS AVAILABLE

* <i>Phoenix Rising</i> , vol. 1, no. 1. Boarding homes in Toronto; Valium; gays and psychiatry; and more — not available at present.	\$2.50
* <i>Phoenix Rising</i> , vol. 1, no. 2. Prison psychiatry; Thorazine; blindness and emotional problems; commitment; and more.	\$2.50
* <i>Phoenix Rising</i> , vol. 1, no. 3. Electroshock; Haidol; how to say no to treatment; a Toronto drug death; and more.	\$2.50
* <i>Phoenix Rising</i> , vol. 1, no. 4. Women and psychiatry; lithium; involuntary sterilization; battling the insurance companies; and more.	\$2.50
* <i>Phoenix Rising</i> , vol. 2, no. 1. From Kingston Psychiatric to City Hall — an alderman's story; tricyclic antidepressants; access to psychiatric records; and more.	\$2.50
* <i>Phoenix Rising</i> , vol. 2, no. 2. Kids and psychiatry; Ritalin; informed consent; special education; and more.	\$2.50
* <i>Phoenix Rising</i> , vol. 2, no. 3. The Movement; injectable drugs; Canadian groups; and more.	\$2.50
* <i>Phoenix Rising</i> , vol. 2, no. 4. Psychiatry and the aged; drug deaths; legal chart; and more.	\$2.50
* <i>Phoenix Rising</i> , vol. 3, no. 1. tenth International Conference; class bias in psychiatry; paraldehyde; and more.	\$2.50
* <i>Phoenix Rising</i> , vol. 3, no. 2. The housing crisis; Tardive Dyskinesia; Titicut Follies; and more.	\$2.50

## Phoenix Publications:

1. <i>Don't Spyhole Me</i> , by David Reville. A vivid and revealing personal account of six months in Kingston Psychiatric Hospital (included in vol. 2, no. 1 of <i>Phoenix Rising</i> ).	\$1.25
2. <i>Kids and Psychiatry</i> . a report on children's psychiatric services in Canada (included in vol. 2, no. 2 of <i>Phoenix Rising</i> ).	\$1.25
3. <i>The Movement</i> . A history and fact sheet of the Psychiatric Inmates Liberation Movement.	\$1.25
4. <i>Legal Chart</i> . A province by province breakdown of the rights of psychiatric inmates.	\$1.75

Distributed by ON OUR OWN:

**On Our Own: Patient-Controlled Alternatives to the mental Health System**, by Judi Chamberlin (McGraw-Hill Ryerson).

"Required reading for 'mental health' professionals . . . who still believe that 'mental patients' are too 'sick', helpless and incompetent to run their own lives."

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"We regret that the cost of reprints has made it necessary to raise the price of back issues to \$2.50.

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I include mailing costs of:

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## *ON "SCHIZOPHRENIA"*

*" 'Schizophrenia' has never been, is not now, and probably never will be a bona fide medical diagnostic term . . . Psychiatrists don't know what 'schizophrenia' is, and don't know how to diagnose it . . . 'Schizophrenia' has more to do with freedom and slavery than with health and disease . . . more with politics than genetics . . . the ceaseless manufacture of disease names in psychiatry, together with a total lack of evidence of them — from agoraphobia to schizophrenia — is the greatest scientific scandal of our scientific age. "*

*Dr. Thomas S. Szasz*  
Schizophrenia: the sacred symbol  
of psychiatry (1976)